LEE L. JOHNSON
TREASURER
SYMBOL HEALTHCARE, INC.

direct line (208) 401-1369
direct fax (208) 576-6909
lee.johnson@pennantservices.com

PUGET SOUND HOSPICE OF PIERCE COUNTY

December 30, 2021

RECEIVED
By CERTIFICATE OF NEED PROGRAM at 10:39 am, Dec 30, 2021

CN22-20

Delivered via box.com

Eric Hernandez, Program Manager
Certificate of Need Program
Department of Health
111 Israel Road SE
Tumwater, WA 98501

RE: Hospice Certificate of Need Application for Symbol Healthcare, Inc., d/b/a Puget Sound Hospice of Pierce County

Dear Mr. Eric Hernandez,

Accept the attached as Symbol Healthcare, Inc. d/b/a Puget Sound Hospice of Pierce County's Certificate of Need application proposing a new hospice agency to provide services to Medicare and Medicaid eligible patients in King County.

Please note that payment was made by check (# 0090030) mailed via USPS Priority Mail Express for 1-Day Delivery. Tracking number 9481 7036 9930 0041 2543 59.

Thank you for the opportunity to submit this application. Should you have any questions, please do not hesitate to contact me.

Sincerely,

Lee Johnson
Treasurer

Hospice Agency Certificate of Need
Application Packet

Contents:

Application submission must include:

- One electronic copy of your application, including any applicable attachments – no paper copy is required.
- A check or money order for the review fee of $21,968 payable to Department of Health.

Include copy of the signed cover sheet with the fee if you submit the application and fee separately. This allows us to connect your application to your fee. We also strongly encourage sending payment with a tracking number.

Mail or deliver the application and review fee to:

Mailing Address:

Department of Health
Certificate of Need Program
P O Box 47852
Olympia, Washington 98504-7852

Other Than By Mail:

Department of Health
Certificate of Need Program
111 Israel Road SE
Tumwater, Washington 98501

Contact Us:
Certificate of Need Program Office 360-236-2955 or FSLCON@doh.wa.gov.

Application Instructions

The Certificate of Need Program will use the information in your application to determine if your project meets the applicable review criteria. These criteria are included in state law and rules. Revised Code of Washington (RCW) 70.38 and Washington Administrative Code (WAC) 246-310.

General Instructions:

- Include a table of contents for application sections and appendices/exhibits
- Number **all** pages consecutively
- Make the narrative information complete and to the point.
- Cite all data sources.
- Provide copies of articles, studies, etc. cited in the application.
- Place extensive supporting data in an appendix.
- **Provide a detailed listing of the assumptions you used for all of your utilization and financial projections, as well as the bases for these assumptions.**
- Under no circumstance should your application contain any patient identifying information.
- Use **non-inflated** dollars for **all** cost projections
- **Do not** include a general inflation rate for these dollar amounts.
- **Do** include current contract cost increases such as union contract staff salary increases. You must identify each contractual increase in the description of assumptions included in the application.
- **Do not** include a capital expenditure contingency.
- If any of the documents provided in the application are in draft form, a draft is only acceptable if it includes the following elements:
  a. identifies all entities associated with the agreement,
  b. outlines all roles and responsibilities of all entities,
  c. identifies all costs associated with the agreement,
  d. includes all exhibits that are referenced in the agreement, and
  e. any agreements in draft form must include a document signed by both entities committing to execute the agreement as submitted following CN approval.

Do not skip any questions in this application. If you believe a question is not applicable to your project, explain why it is not applicable.

Answer the following questions in a manner that makes sense for your project. In some cases, a table may make more sense than a narrative. The department will follow up in screening if there are questions.

Program staff members are available to provide technical assistance (TA) at no cost to you before submitting your application. While TA isn't required, it's highly recommended and can make any required review easier. To request a TA meeting, call 360-236-2955 or email us at FSLCON@doh.wa.gov.

RECEIVED
By CERTIFICATE OF NEED PROGRAM at 10:39 am, Dec 30, 2021

Certificate of Need Application
Hospice Agency

CN22-20

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

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

Signature and Title of Responsible Officer  ***Treasurer*** Email Address **Lee.Johnson@pennantservices.com**	Date 12/29/21 Telephone Number **208-401-1369**
Legal Name of Applicant The Pennant Group Inc. Address of Applicant 1675 E Riverside Dr, Suite 150. Eagle, Idaho 83616	Provide a brief project description ☒ New Agency ☐ Expansion of Existing Agency ☐ Other: _____ Estimated capital expenditure: $___5000_____
Identify the county proposed to be served for this project. Note: Each hospice application must be submitted for one county only. If an applicant intends to obtain a Certificate of Need to serve more than one county, then an application must submitted for each county separately. _____King County _____	

SYMBOL HEALTHCARE, INC.,
d/b/a Puget Sound Hospice of Pierce County
Certificate of Need Application
Establish a Medicare/Medicaid Certified Hospice Agency
in
King County

December 2021

Contents

Introduction

With this application, Symbol Healthcare, Inc., d/b/a Puget Sound Hospice of Pierce County is seeking to establish a Medicare and Medicaid certified hospice agency in King County. This project is seeking to expand our hospice services in the post-acute care continuum.[1] Furthermore, Symbol has an established presence in Washington State with affiliate home health and hospice agencies in several counties, including King, Pierce, Snohomish, Skagit, San Juan, Aston, Garfield, Benton, Franklin, Mason and Grays Harbor Counties.

Puget Sound Hospice of Pierce County will operate under the philosophy and model of all affiliates of its ultimate parent company, the Pennant Group ("Pennant"), and Pennant's home health and hospice company, Cornerstone Healthcare, Inc.[2] Specifically, that to provide the best outcomes to our patients' health care must be a community-driven service—we must be able to adapt to the specific needs of the communities in which we operate, while simultaneously providing world-class care. This application sets forth in detail how Puget Sound Hospice of Pierce County's unique operating structure sets it apart as the applicant best situated to meet the hospice care needs of the residents of King County. Three facets of our structure are worth noting at the outset.

First, Pennant's organizational structure is a "flat leadership" structure. Pennant does not operate as a heavy-handed, top-down corporate structure wherein programs are mandated regardless of whether they're applicable or needed in each community. Local leaders of Pennant-affiliated agencies such as Puget Sound Hospice of Pierce County are empowered to run their agency to meet the specific needs of their respective communities; in fact, not only are they empowered to do so, understanding and meeting the specific needs of their community is an expectation.

Second, all Pennant affiliates, such as Puget Sound Hospice of Pierce County, enjoy the support of a world class service center that includes experts in the field of hospice. The Pennant Service Center will contract with Puget Sound Hospice of Pierce County, to provide it with exceptional services such as quality monitoring and improvement, revenue cycle management and protection, legal services, accounting services, HR support, accounts payable, information technology support, EMR software support, business intelligence and operational data monitoring, clinical resource support including education and quality assessment, HIPAA compliance monitoring, clinical and billing compliance support and monitoring, Medicare, Medicaid and state licensing, regional operations resources, and more. This Service Center is comprised of individuals who have designated themselves as "Resources," as opposed to "Corporate Headquarters." What this means is agencies such as Puget Sound Hospice of Pierce

[1] Throughout this application, "Symbol" will refer to the corporate entity that owns and operates both Puget Sound Hospice of Pierce County and Puget Sound Home Health. References to "Puget Sound Hospice of Pierce County" will refer to only Symbol's hospice operations, and may also be refered to as "Agency"

[2] As referenced below, Cornerstone Healthcare, Inc. is a subsidiary of the Pennant Group, Inc., and wholly owns Symbol Healthcare, Inc.

County have a team of hospice experts who view themselves as partners and peers, dedicating their professional lives to the agency's success.

Lastly, as a long-standing home health provider within King County, Symbol has become a trusted community partner that has provided diverse and unique care for thousands of patients that has resulted in clinical outcomes that rank among the best in the country. Our locally led care team understands the home health needs of King County and the Puget Sound area, and continue to make uncompromising strides to provide not only comprehensive patient care, but exceptional clinical quality outcomes. The Washington state average for home health skilled care is 3.5 stars. Our agency has averaged 4.0 stars or above for clinical outcomes and patient survey results during the the last several years, we are proud knowing that our patients receive some of the best hands on care in the state.[3]

With the addition of providing hospice care in King County, Symbol will be able to provide more care along the spectrum of post-acute care. Longstanding partnerships and narrowed networks currently exist with upstream post acute care providers and community referral sources in King County. In addition, Puget Sound Home Health is a community member of the Northwest Healthcare Response Network whose purpose is through collaborative planning, exercises, trainings, and coordination of resources, to build a disaster resilient healthcare system.This will have a significant impact on our community in King County, as we'll be better able to provide patients with the right care, in the right place, at the right time. Symbol's proposal set out in this application will demonstrate that Puget Sound Hospice of Pierce County is uniquely situated to provide exceptional hospice care in King County.

These three facets, along with others set out in this application, uniquely position Puget Sound Hospice of Pierce County to provide a level of care that its competitors in King County simply can't match; the exact type of community-based care that Washington's Certificate of Need program is designed to produce. As you will see in this application, our proposal illustrates why Puget Sound Hospice of Pierce County is the best choice to meet the hospice care needs of the residents of King County

[3] Washington state average is 3.5 stars. https://data.cms.gov/provider-data/topics/home-health-services

Applicant Description

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

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

   The Pennant Group Inc.
   1675 E Riverside Dr, Suite 150. Eagle, Idaho 83616

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

The Pennant Group, Inc. is a Delaware Corporation, Symbol Healthcare, Inc.'s (the licensee) UBI number is 604 111 051.

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

   Lee Johnson, Treasurer of Symbol Healthcare, Inc.
   1675 E. Riverside Drive, Suite 150, Eagle, ID 83616
   208-401-1369
   Lee.Johnson@pennantservices.com

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

There are no consultants authorized to speak on our behalf.

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

The organizational chart is shown at **Exhibit 1.**

6. Identify all healthcare facilities and agencies owned, operated by, or managed by the applicant or its affiliates with overlapping decision-makers. This should include all facilities in Washington State as well as out-of-state facilities. The following identifying information should be included:
   - Facility and Agency Name(s)
   - Facility and Agency Location(s)
   - Facility and Agency License Number(s)

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

The list of all healthcare facilities and agencies owned, operated by, or managed by the applicant are shown at **Exhibit 2.**

Project Description

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

This is not an existing agency.

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

This is not an existing agency.

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

Puget Sound Hospice of Pierce County
4002 Tacoma Mall Blvd., Ste. 204, Tacoma, WA 98409

4. Provide a detailed description of the proposed project.

We are applying for both King and Pierce Counties as new agencies under Symbol Healthcare Inc. Should we be awarded a certificate of need for both counties, we will serve both counties from the Tacoma office. If either King or Pierce are awarded a certificate of need, we will serve the county from the Tacoma office. The King + Pierce pro forma's are found at **Exhibit 10**.

Puget Sound Hospice of Pierce County will be a state licensed and Medicare/Medicaid certified hospice agency in King County. By adding a hospice service line to our already existing home health agency, we can better manage patient's care more timely and appriopriately. Some individuals might prefer to have hospice services rather than home health and many home health patients end up bridging to hospice services, and with this project we'll be able to facilitate both. Often patients build a significant relationship with their care team and they don't want to change organizations. By having a hospice line, we can better support the residents of King County and their long term healthcare needs.

As with all Cornerstone-affiliated hospice agencies, Puget Sound Hospice of Pierce County will provide exceptional patient-specific care, allowing the patient to choose

where they reside, whether it be in a home setting, long term care facility, assisted living, adult family home, homeless shelter, or in a temporary location such as an acute care hospital. The delivery of care will be provided by an interdisciplinary team of experienced and specially trained hospice professionals providing medical, physical, emotional, social, grief, and spiritual support to the patient and their family.

Puget Sound Hospice of Pierce County's interdisciplinary staff will work in coordination with the patient's physician(s), other applicable health care providers, and the patient and his/her family to establish personalized hospice care goals for pain and symptom management. We will provide each patient all necessary hospice services and supplies, including physician and nursing, chaplain, social worker, volunteer services, therapy, medical supplies, DME, pharmacy services, and bereavement support for family and friends. Further, Puget Sound Hospice of Pierce County will provide all appropriate levels of care (i.e., routine, respite, continuous, and general in-patient) to meet the patient's palliation needs and manage their terminal illness and related conditions.

As with all Cornerstone-affiliated hospice agencies, Puget Sound Hospice of Pierce County approaches hospice care with the foundational belief that to produce the best patient outcomes, health care must be tailored to the specific needs of its community. All Cornerstone-affiliated agencies accomplish this by adopting a model where local leaders are provided the opportunity and challenged to operate a community-centered agency. There is no corporate headquarters dictating mandatory practices that may not address specific community needs. This project will operate no differently, and because of this, we're confident that we will be able to provide the residents of King County with the best possible hospice care.

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

Puget Sound Hospice of Pierce County will be available and accessible to the entire geography of King County. Puget Sound Home Health has served the entire geography of King County for many years, and we intend to continue this level of coverage with the addition of the hospice service line.

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

Event	**Anticipated Month/Year**
CN Approval	September 2022
Design Complete (if applicable)	N/A
Construction Commenced* (if applicable)	N/A
Construction Completed* (if applicable)	N/A
Agency Prepared for Survey	January 2023
Agency Providing Medicare and Medicaid hospice services in the proposed county.	After applying for the state license and Medicare, we

	will be serving Medicare and Medicaid patients as a state licensed hospice starting January 1, 2023. May 2023 is the anticipated Medicare certification date, Medicare certification also initiates the Medicaid eligibility application process. Medicaid eligibility approval can take months with COVID slowdowns. We may be Medicaid eligible in September of 2023. Please see the timeline on p.12.

* If no construction is required, commencement of the project is project completion, commencement of the project is defined in WAC 246-310-010(13) and project completion is defined in WAC 246-310-010(47).

The WAC definition of “commencement” is (13) “Commencement of the project" means whichever of the following occurs first: In the case of a construction project, giving notice to proceed with construction to a contractor for a construction project provided applicable permits have been applied for or obtained within sixty days of the notice; beginning site preparation or development; excavating or starting the foundation for a construction project; or beginning alterations, modification, improvement, extension, or expansion of an existing building. In the case of other projects, initiating a health service.

In this case, as it does not include construction, commencement means initiating a health service.

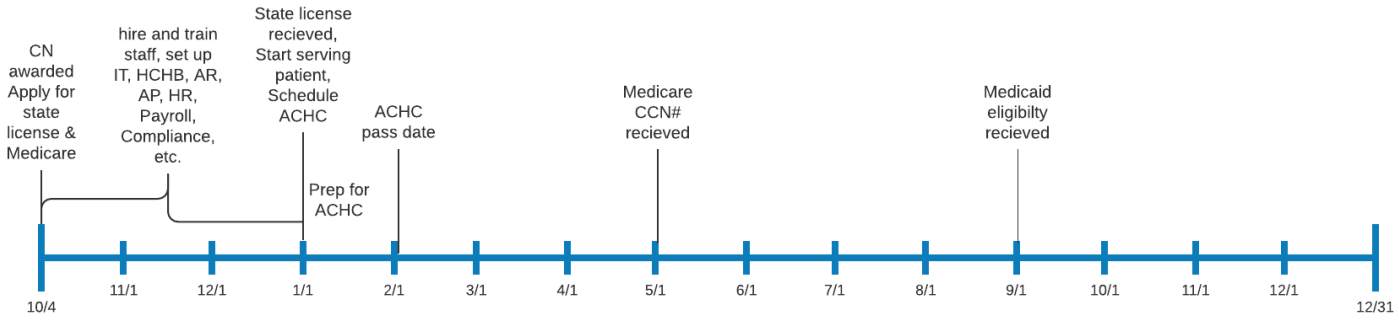
The WAC definition of “health service” is (29) "Health services" means clinically related (i.e., preventive, diagnostic, curative, rehabilitative, or palliative) services and includes alcoholism, drug abuse, and mental health services.

We will initiate health services the moment we serve our first patient with palliative or hospice services starting January 1, 2023.

Medicare certification and Medicaid eligibility do not happen at the same time. Medicare certification, which is when the agency receives the CCN# (CMS Certification Number), initiates the ability to apply for Medicaid eligibility. Approval of Medicaid eligibility will happen months after Medicare certification. Please see the timeline on p. 12. We will be serving Medicare and Medicaid patients for months before we are Medicaid eligible, and

we will be reimbursed by Medicare and Medicaid eventually for all the patient care we provide from ACHC accreditation forward.

CN Award to Medicaid Eligibility Timeline



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

X Skilled Nursing	X Durable Medical Equipment
X Home Health Aide	X IV Services
X Physical Therapy	X Nutritional Counseling
X Occupational Therapy	X Bereavement Counseling
X Speech Therapy	X Symptom and Pain Management
X Respiratory Therapy	X Pharmacy Services
X Medical Social Services	X Respite Care
X Palliative Care	X Spiritual Counseling
X Other (please describe) Massage, Pet Therapy, Music Therapy, Reiki, Aromatherapy, and We Honor Veterans program.	

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

This application is not proposing to expand an existing hospice agency.

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

This application is not proposing to expand the service area of an existing hospice agency.

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

Puget Sound Hospice of Pierce County will serve patients of all ages and diagnosis and is committed to serving all patients regardless of race, color, religion (creed), gender, gender expression, age, national origin, disability, marital status, sexual orientation, English proficiency, or military status, and will ensure that all populations have access to services through its charity care policy. Furthermore, Puget Sound Hospice of Pierce County's admission, charity care, and non-discrimination policies reflect our commitment to caring for Medicare, Medicaid, and any patients who may have an inability to pay for care.

The top three causes of death in King County are cancer, heart disease, and Alzheimer's Disease.[4] According to a recent prospective cohort study on cancer and non cancer deaths, hospice is significantly underutilized, particulary in those with a non-cancer diagnosis (heart disease and dementia).[5] With heart disease being the second leading cause of death in Washington State, it is likely that residents of King County are underutilizing necessary hospice care. With our proposed project, King County residents should have access to timely and high-quality hospice services. The benefits of providing those services can provide the residents of King County the most appriopriate level of care at their most vunerable time of life. For instance, research has shown that patients with Congestive Heart Failure who chose hospice care lived for an average 29 days longer[6] and may be associated with a modest cost savings.[7]

Alzheimer's disease is the third leading cause of death in King county. Dementia and Alzheimer's disease is expected to increase in King county two-fold from 27,887 in 2015 to 67,797 residents in 2040.[8] Additional populations Puget Sound Hospice of Pierce County expects to care for, per the leading causes of death in King County include patients with diagnosis of stroke, chronic lower respiratory disease, diaetes, chronic liver disease, influenza/pneumona.

The nature of hospice is to provide timely and high-quality care to the most vunerable patients and families of all diagnoses and ages as they experience perhaps the most fragile time in their life. Patients and family are more likely to report a favorable end of life experience when hospice and palliative care is chosen as compared to hospitalization.[9] Accessibility to a timely hospice provider of the patient's choice is critical to providing the most appriopriate type of care and individualized care to best meet the patient's and family's needs.

The mortality table below identifies Leading Causes of Death for Washington Residents.

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[4] Washington State Department of Health, Death Certificate Data 2015

[5] Cagle JG, Lee J, Ornstein KA, Guralnik JM. Hospice Utilization in the United States: A Prospective Cohort Study Comparing Caner and Noncancer Death. JAGS 2020;68:783-793.

[6] Connor S, Pyenson B, et al. 2007 Comparing hospice and non-hospice patient survival among patients who die within a three-year window. *J Pain Symptom Manage* 33:38-46.

[7] Pyenson B, Connor S, et al. 2004 Medicare cost in matched hospice and non-hospice cohorts. *J Pain Symptom Manage,* 28:200-10. 2

[8] King County Community Health Needs Assessment 2018/2019.

[9] Finestone AJ, Inderwies G. 2008 Death and dying in the US: the barriers to the benfits of palliative and hospice care. *Clinical Interventions in Aging*. 3(3):595-599.

Table 1

Mortality Table C2. Leading Causes of Death for Residents, 2015				
Rank	Causes of Death and ICD-10 Codes	Number	Percent[1]	Cumulative Percent
	All Causes	**54,514**	**100.0**	
1	Malignant Neoplasms (C00-C97)	12,658	23.2	23.2
2	Diseases of the Heart (I00-I09,I11,I13,I20-I51)	10,987	20.2	43.4
3	Alzheimer's Disease (G30)	3,489	6.4	49.8
4	Unintentional Injury (Accident) (V01-X59,Y85-Y86)	3,188	5.8	55.6
5	Chronic Lower Respiratory Diseases (J40-J47)	3,151	5.8	61.4
6	Cerebrovascular Diseases (I60-I69)	2,693	4.9	66.3
7	Diabetes Mellitus (E10-E14)	1,805	3.3	69.7
8	Intentional Self-Harm (Suicide) (X60-X84,Y87.0)	1,136	2.1	71.7
9	Chronic Liver Disease & Cirrhosis (K70,K73-K74)	1,021	1.9	73.6
10	Influenza and Pneumonia (J10-J18)	851	1.6	75.2
	All Other Causes	13,535	24.8	100.0

Washington State Department of Health, Center for Health Statistics, death certificate data 2015

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

The letter of intent is found at **Exhibit 5.**

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

Puget Sound Hospice of Pierce County will be certified by Medicare and Medicaid eligible. This application does not propose the expansion of an existing agency.

IHS.FS._____N/A_____

Medicare #:_____N/A_____

Medicaid #:_____N/A_____

Certificate of Need Review Criteria

A. Need (WAC 246-310-210)

WAC 246-310-210 provides general criteria for an applicant to demonstrate need for healthcare facilities or services in the planning area. WAC 246-310-290 provides specific criteria for hospice agency applications. Documentation provided in this section must

demonstrate that the proposed agency will be needed, available, and accessible to the community it proposes to serve. Some of the questions below only apply to existing agencies proposing to expand. For any questions that are not applicable to your project, explain why.

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

Puget Sound Hospice of Pierce County is not an existing agency.

COUNTY	Identify Year	Identify Year	Identify Year
Total number of admissions			
Total number of patient days			
Average daily census			

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

COUNTY: King	2023	2024	2025	2026
Total number of admissions	99	173	260	360
Total number of patient days	6180	10739	16139	22381
Projected average daily census	17	29	44	61

To remain consistent with utilization of the DOH need methodology as the basis for this project rationale, population forecasts for 2023 though 2026 have been estimated using the same assumptions that are used in the eight step methodology contained in WAC 246-310-290. The calculation for the assumption of population growth within each age cohort for each projected year is: (year 2022 - year 2021) + year 2022 = year 2023

This same calculation is used for the unmet patient days in our pro forma financials projections for year 2023 through 2026. Our 2023 through 2026 projections for unmet patient days, unmet patient days percent per year, patient days, annual admissions for unduplicated patients, monthly admissions for unduplicated patients, and average daily census are shown in **Table 2 on page 19**. This information, data and assumptions are also shown in the *Assumptions and Calculations* and pro forma at **Exhibit 10.**

We anticipate many of our Puget Sound Home Health of King County patients choosing to bridge to our hospice if they elect the hospice benefit. Puget Sound Home Health of King County's average daily census is approximately 90. Based on historical averages, 5-10% of these patients will bridge to hospice. Considering this, our utilization estimates are conservative, as these patients will be in addition to patients who choose Puget Sound Hospice of Pierce County from other places in the community.

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

We understand that there may be unforeseen challenges getting an agency established. We did not forsee a worldwide pandemic in 2020 when Cornerstone was starting up its hospice in Snohomish County, nor did we anticipate the pandemic lasting as long as it has. While it has been a challenge to start a hospice with unique restrictions and conditions on providing hands on care to patients, we were able to adjust our care according to the needs of the clients, care settings, and state and federal guidance. We have been successful in Snohomish County operating an agency that is caring for individuals who need hospice care, despite the global pandemic.

Cornerstone operates across 14 states and has consistently seen a significant barrier to hospice services being a general misunderstanding about when hospice is appropriate and what it entails. Unsurprisingly, we've also seen a lack of education about hospice care. As discussed above, hospice is underutilized in King County and we believe by educating health care providers we will be able to help the residents in King County receive the most appropriate level of individualized care. We hope to break down barriers by integrating ourselves with hospital systems, local physician groups, community centers, nursing homes, private duty providers, and other providers to provide education as to the nature and benefit of timely, appropriate hospice care. In fact, an Ensign skilled nursing facility has already welcomed Symbol the opportunity to educate their medical staff on hospice and palliative care that can be provided within a skilled nursing facility.

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

Our project seeks to address the unmet need for additional hospice services in King County. The need for additional hospice agencies, as determined by the eight step methodology contained in WAC 246-310-290, which is found below, indicates an unmet Average Daily Census (ADC) of **-8** in 2021, **39** in 2022 and **85** in 2023. This unmet ADC translates into unmet patient days of **-2,759** in 2021, **14,070** in 2022, and **30,899** in 2023.

The need for additional hospice agencies is determined by the same methodology referenced above. As applied to King County, it identifies the need for **two** additional hospice providers. Please see the Step 8 table below for a summary of the unmet ADC per year and the numeric need of **two** new hospice agencies.

The eight step methodology led us to the determination that this application is not an unnecessary duplication of services for King County, rather, there is significant umnet need, which requires **two** new hospice providers. The methodology is as follows, key numbers are highlighted for clarity:

WAC246-310-290(8)(a) **Step 1**:
Calculate the following two statewide predicted hospice use rates using department of health survey and vital statistics data:
WAC 246-310-290(8)(a)(i) The percentage of patients age sixty-five and over who will use hospice services. This percentage is calculated by dividing the average number of unduplicated admissions over the last three years for patients sixty five and over by the average number of past three years statewide total deaths age sixty-five and over.
WAC246-310-290(8)(a)(ii) The percentage of patients under sixty-five who will use hospice services. This percentage is calculated by dividing the average number of unduplicated admissions over the last three years for patients under sixty-five by the average number of past three years statewide total of deaths under sixty-five.

Use Rates	
0-64	**25.67%**
65+	**60.15%**

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

0-64					65+				
County	**2018**	**2019**	**2020**	**2018-2020 Average Deaths**	**County**	**2018**	**2019**	**2020**	**2018-2020 Average Deaths**
King	**3,264**	**3,275**	**4,456**	**3,665**	**King**	**9,917**	**10,213**	**11,186**	**10,439**

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

0-64			65+		
County	**2018-2020 Average Deaths**	**Projected Patients: 25.67% of Deaths**	**County**	**2018-2020 Average Deaths**	**Projected Patients: 60.15% of Deaths**
King	**3,665**	**941**	**King**	**10,439**	**6,279**

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

						0-64		
County	**Projected Patients**	**2018-2020 Average Population**	**2021 projected population**	**2022 projected population**	**2023 projected population**	**2021 potential volume**	**2022 potential volume**	**2023 potential volume**
King	**941**	**1,885,115**	**1,918,470**	**1,930,192**	**1,941,913**	**958**	**963**	**969**

						65+		
County	Projected Patients	2018-2020 Average Population	2021 projected population	2022 projected population	2023 projected population	2021 potential volume	2022 potential volume	2023 potential volume
King	6,279	310,572	337,771	350,881	363,992	6,829	7,094	7,359

WAC246-310-290(8)(e) **Step 5**:
Combine the two age cohorts. Subtract the average of the most recent three years hospice capacity in each planning area from the projected volumes calculated in Step 4 to determine the number of projected admissions beyond the planning area capacity.

County	2020 potential volume	2021 potential volume	2022 potential volume	Current Supply of Hospice Providers	2020 Unmet Need Admissions*	2021 Unmet Need Admissions*	2022 Unmet Need Admissions*
King	7,786	8,057	8,328	7,830.33	-44	226	497

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

				Step 6 (Admits * ALOS) = Unmet Patient Days			
County	2021 Unmet Need Admissions*	2022 Unmet Need Admissions*	2023 Unmet Need Admissions*	Statewide ALOS	2021 Unmet Need Patient Days*	2022 Unmet Need Patient Days*	2023 Unmet Need Patient Days*
King	-44	226	497	62.12	-2,759	14,070	30,899

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

				Step 7 (Patient Days / 365) = Unmet ADC		
County	2021 Unmet Need Patient Days*	2022 Unmet Need Patient Days*	2023 Unmet Need Patient Days*	2021 Unmet Need ADC*	2022 Unmet Need ADC*	2023 Unmet Need ADC*
King	-2,759	14,070	30,899	-8	39	85

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

Step 7 (Patient Days / 365) = Unmet ADC				Step 8 - Numeric Need	
County	2021 Unmet Need ADC*	2022 Unmet Need ADC*	2023 Unmet Need ADC*	Numeric Need?	Number of New Agencies
King	-8	39	85	TRUE	2

As discussed in our response to number 2 above, to remain consistent with utilization of the DOH need methodology as the basis for this project rationale, population forecasts for 2023 though 2026 have been estimated using the same assumptions that are used in the eight step methodology contained in WAC 246-310-290. The calculation for the assumption

of population growth within each age cohort for each projected year is: (year 2022 - year 2021) + year 2022 = year 2023

This same calculation is used for the unmet patient days in our pro forma financials projections for year 2023 through 2026. Our 2023 through 2026 projections for unmet patient days, unmet patient days percent per year, patient days, annual admissions for unduplicated patients, monthly admissions for unduplicated patients, and average daily census are shown in **Table 2 below.** This information, data and assumptions are also shown in the *Assumptions and Calculations* and pro forma at **Exhibit 10.**

Table 2

Projection Year-KING	2023	2024	2025	2026
unmet patient days	15450	23864	32279	40693
unmet patient days % per year	40%	45%	50%	55%
Patient Days	6180	10739	16139	22381
Annual admissions - Unduplicated Patients with ALOS of 62.12	99	173	260	360
Monthly Unduplicated Patient admissions	8	14	22	30
Average Daily Census (ADC)	17	29	44	61

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

Puget Sound Hospice of Pierce County plans to support King County in its entirety.

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

King County will be served in its entirety by Puget Sound Hospice of Pierce County. Puget Sound Hospice of Pierce County clinical staff will be available 24hours/per day, seven days a week, to meet patient and family needs. We plan to provide our full range of services for all residents of King County.

Within King County, gaps of up to 10 years in life expectancey have been found in different neighboords.[10] Residents in South King County have been identified as one of the most diverse communites in the county and experience disparities in multiple health and social indicators. Puget Sound Home Health of King County has an established footprint in South King County to align with hospice and other upstream healthcare providers to bridge the gap of some of these health disparities and to transition patients to hospice services faster and more appriopriately.

7. Provide a copy of the following policies:

[10] King County Communith Health Needs Assessment 2018/2019

- Admissions policy shown at **Exhibit 6**
- Charity care or financial assistance policy shown at **Exhibit 6**
- Patient Rights and Responsibilities policy shown at **Exhibit 6**
- Non-discrimination policy shown at **Exhibit 6**
- Death with Dignity policy shown at **Exhibit 6**

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

8. If there is not sufficient numeric need to support approval of this project, provide documentation supporting the project's applicability under WAC 246-310-290(12). This section allows the department to approve a hospice agency in a planning area absent numeric need if it meets the following review criteria:
    - All applicable review criteria and standards with the exception of numeric need have been met;
    - The applicant commits to serving Medicare and Medicaid patients; and
    - A specific population is underserved; or
    - The population of the county is low enough that the methodology has not projected need in five years, and the population of the county is not sufficient to meet an ADC of thirty-five.

      Note: The department has sole discretion to grant or deny application(s) submitted under this subsection.

As shown in the Need section above, there is sufficient numeric need to support approval of this project.

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

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

1. Provide documentation that demonstrates the immediate and long-range capital and operating costs of the project can be met. This should include but is not limited to:
    - Utilization projections. These should be consistent with the projections provided under the Need section. **Include all assumptions.**
    - Pro Forma revenue and expense projections for at least the first three full calendar years of operation using at a minimum the following Revenue and Expense categories identified at the end of this question. **Include all assumptions.**
    - Pro Forma balance sheet for the current year and at least the first three full calendar years of operation. **Include all assumptions**.
    - For existing agencies proposing addition of another county, provide historical revenue and expense statements, including the current year. Ensure these are in the same format as the projections. For incomplete years, identify whether the data is annualized.

Revenue **Expenses**

Medicare, including Managed Care	Advertising
Medicaid, including Managed Care	Allocated Costs
Private Pay	B & O Taxes
Other, [TriCare, Veterans, LNI, etc.] detail what is included	Depreciation and Amortization
Non-operating revenue	Dues and Subscriptions
	Education and Training
	Employee Benefits
	Equipment Rental
	Information Technology/Computers
Deductions from Revenue:	Insurance
(Charity)	Interest
(Provision for Bad Debt)	Legal and Professional
(Contractual Allowances)	Licenses and Fees
	Medical Supplies
	Payroll Taxes
	Postage
	Purchased Services (utilities, other)
	Rental/Lease
	Repairs and Maintenance
	Salaries and Wages (DNS, RN, OT, clerical, etc.)
	Supplies
	Telephone
	Travel (patient care, other)
	Other, detail what is included

The documentation that demonstrates the immediate and long-range capital and operating costs of the project can be met is shown at **Exhibit 10.**

2. Provide the following agreements/contracts:
    - Management agreement.
    - Operating agreement
    - Medical director agreement
    - Joint Venture agreement

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

The medical director contract is shown at **Exhibit 3.** The Service Center operational agreements are shown at **Exhibit 8**. The other listed agreements/contracts do not apply.

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

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

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

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

The draft lease agreement is shown at **Exhibit 4.**

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

Item	Cost
a. Land Purchase	$N/A
b. Utilities to Lot Line	$ N/A
c. Land Improvements	$ N/A
d. Building Purchase	$ N/A
e. Residual Value of Replaced Facility	$ N/A
f. Building Construction	$ N/A
g. Fixed Equipment (not already included in the construction contract)	$ N/A
h. Movable Equipment	$ N/A
i. Architect and Engineering Fees	$ N/A
j. Consulting Fees	$ N/A
k. Site Preparation	$ N/A
l. Supervision and Inspection of Site	$ N/A
m. Any Costs Associated with Securing the Sources of Financing (include interim interest during construction)	N/A
1. Land	$ N/A
2. Building	$ N/A
3. Equipment: Phone System, IT/Computers	$5,000
4. Other	$ N/A
n. Washington Sales Tax	$ N/A
Total Estimated Capital Expenditure	**$5,000**

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

The Pennant Group Inc. is responsible for the estimated capital costs identified above. Pennant's 10Q is shown at **Exhibit 9.**

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

We expect the following start-up costs to total $15,500.

Recruitment - $5,000 estimated based on Cornerstone's past experience with starting

new hospice operations. Includes external postings on job boards that include; LinkedIn, Indeed, Career Builder, and Glassdoor. We will also identify and attend any applicable and timely job fairs. We will also contact the local colleges and local healthcare professional associations.

Marketing/Advertising - $4,000 estimated based on Cornerstone's past experience with starting new hospice operations. Advertisements in local media including print, notifying of our grand opening, including holding a meet and greet for local healthcare administrators and other community partners. We will also develop marketing brochures and patient packets.

Travel - $6,500 estimated based on Cornerstone's past experience with starting new hospice operations. This accounts for essential Resources traveling to and from the Pennant Service Center to provide necessary support, including HR, IT, and Clinical Resources. This will continue for a period of 60-90 days.

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

The Pennant Group Inc. is responsible for the estimated start-up costs identified above. Pennant's 10Q is shown at **Exhibit 9.**

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

This project will not have a negative impact on the costs and charges of health services in the planning area. Hospice care has been shown to be cost-effective and is documented to reduce end of life costs. This project proposes to address the hospice agency shortage in the county and will improve acess to care. Over time, this will reduce the cost of end of life care and benefit patients and their families.

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

The capital and start-up costs of this project are minimal, estimated at $20,500, they will not have an unreasonable impact on the costs and charges of health services in the planning area. Hospice care has been shown to be cost-effective and is documented to reduce end of life costs. This project proposes to address the hospice agency shortage in the county and will improve acess to care. Over time, this will reduce the cost of end of life care and benefit patients and their families.

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

The numbers in the payer mix table below are averages across all Cornerstone-affiliated hospice agencies.

Payer Mix	Percentage of Gross Revenue	Percentage by Patient
Medicare	94.6	95.2
Medicaid	4.0	3.73
Commercial	1.2	.87
Self pay	.2	.2
Total	100	100

Source: Applicant

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

This project does not propose the addition of a county for an existing agency.

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

Table 3
Equipment List[11]

Item	Cost
Phone System	$2,000
Computer/IT equipment	$3,000
Total	**$5,000**

Source: Applicant

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

The Pennant Group Inc. is the source of financing. The commitment of funds letter is shown at **Exhibit 12.**

[11] All costs include sales tax.

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

This project will not be debt financed through a financial institution.

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

The most recent audited financial statement for Cornerstone Healthcare Inc., is shown at **Exhibit 10**. The 10Q of the applicant, The Pennant Group Inc., is shown at **Exhibit 9.**

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

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

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

Table 4 shows all FTE's by category for the county.

Table 4

KING CO

Clinical Staff by FTE	2023	2024	2025	2026
Registered Nurse	2.5	4.4	6.6	9.2
Certified Nursing Assistant	1.7	2.9	4.4	6.1
Licensed Clinical Social Worker	0.6	1.0	1.5	2.0
Spiritual Care Coordinator	0.6	1.0	1.5	2.0
Director of Clinical Services	0.4	0.7	1.1	1.5
Total	5.8	10.1	15.1	21.0
Compensation and Benefits				
Registered Nurse	203,172	353,056	530,605	735,819
Certified Nursing Assistant	52,825	91,795	137,957	191,313
Licensed Clinical Social Worker	40,070	69,631	104,647	145,120
Spiritual Care Coordinator	31,604	54,920	82,539	114,461
Director of Clinical Services	46,560	80,909	121,597	168,625
Payroll Taxes & Benefits	112,269	195,093	293,204	406,601
Total	486,500	845,403	1,270,550	1,761,938
Administrative Staff by FTE				
Administrator	0.5	0.5	0.5	0.5
Business Office Manager, Medical Records, Scheduling	0.6	1.0	1.5	2.0
Intake	1.0	1.0	1.0	1.0
Community Liaison	0.6	1.0	1.5	2.0
Total	2.6	3.5	4.4	5.6
Administrative Compensation and Benefits				
Administrator	50,000	50,000	50,000	50,000
Business Office Manager, Medical Records, Scheduling	28,218	49,036	73,695	102,197
Intake	52,000	52,000	52,000	52,000
Community Liaison	36,684	63,746	95,804	132,856
Payroll Taxes & Benefits	50,071	64,435	81,450	101,116
Total	216,973	279,216	352,949	438,169

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

This application does not propose the expansion of an existing agency into another county.

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

The assumptions used to project the number and types of FTE's identified for this project are based upon the average numbers and types used across all Cornerstone-affiliated hospice agencies, which include two Washington state hospice agencies. The Washington state hospice numbers are consistent with these averages.

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

Puget Sound Hospice of Pierce County is confident that our proposed staff to patient ratio is appropriate for several reasons. First, Cornerstone-affiliated hospice agencies have found that operating at these ratios is optimal to produce quality outcomes. Additionally, these ratios were in two separate Conerstone-affiliates 2018 hospice CN applications for Thurston and Snohomish Counties, respectively, which the CN Department found to be appropriate.[12] Table 5 below shows these ratios.

Table 5

Type of Staff	Staff to Patient Ratio
Registered Nurses	1:12 (day) and .8:12 (evenings and weekends)
Certified Nursing Assistant	1:10
Social Work	1:30
Spiritual Care Coordinator	1:30

[12] Those affiliates were Symbol Healthcare, Inc., and Glacier Peak, Healthcare, Inc. Both of these agencies' CN applications were approved.

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

Dr. William Elledge is our contracted medical director, his professional license number is **MD00012053**.

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

Dr. Elledge is contracted. The medical director contract is at found at **Exhibit 3.**

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

Devin Rothwell is the Administrator, professional license numbers do not exist for this profession. The other key staff have not yet been identified.

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

As this is not an existing agency, these names and professional license numbers are not available.

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

In addition to Symbol operating a home health agency in King County, its ultimate parent company, Pennant, owns 134 healthcare organizations across 14 states, including a senior living home in Redmond, Washigton, and home health agencies that operate in King, Pierce, Snohomish, Skagit, San Juan, Aston, Garfield, Benton, and Franklin counties. Additionally, Cornerstone owns Washington-based hospice agencies that service Snohomish, Aston, Garfield, Thurston, Grays Harbor, and Mason counties. In the experience of Pennant- affiliated health care agencies, health care employees are drawn to the Pacific Northwest Region for its outdoor experiences, culture and vitality, making recruiting generally easier than other parts of the country. Additionally, if Pennant-affiliated health care agencies have qualified and experienced staff in good standing that want to move to King County, or to transition from long-term carm or home health to hospice, we are able and willing to support that relocation or transition.

Both Symbol and its affiliates also have strong and proven histories of recruiting and retaining quality staff. We offer a competitive wage scale, a generous benefit package, and a professionally rewarding work setting, as well as the potential for financial assistance in furthering training and education.

Cornerstone has access to utilize a variety of recruitment resources, including the use of social media and internet recruitment platforms such as LinkedIn, Indeed, Monster and Glassdoor, among others, and due to our employees' high job satisfaction we have found great success in recruiting through our staff's network of other skilled healthcare professionals.

The following provides additional details as to Puget Sound Hospice of Pierce County's approach to recruiting and retention.

Recruiting

Puget Sound Hospice of Pierce County leaders will continually perform the following recruiting activities.

- Identify any opportunity to recruit at local job fairs and State and National associations websites and confences.
- Maintain a liaison with career/placement staff at regional colleges, universities, and clinical certification organizations to actively recruit its students, including offering clinical shadowing and volunteer opportunities.
- Join applicable healthcare professional associations.
- Utilize national talent search companies.
- Meet community market wages, recruiting and sign on bonuses.
- Provide leadership and advancement opporunites for staff to elevate within Cornerstone.
- Post positions within Cornerstone's multistate organizations.

Puget Sound Hospice of Pierce County's Administrator and DCS will continually identify open positions. Determination of open positions will be based necessary staff members needed based on hospice IDT caseloads and ADC growth. This will be continuously assessed to ensure staff to patient ratios remain appropriate to maintain consistent delivery of quality patient care and ensure the IDT team/staff are not overburdened.

Once an open position has been identified the agency's leaders will do the following.

- Email HR/Payroll Group with the standard subject line: Recruiting Need Discipline. The content of this email will set out the following information as to the open position:
- FTE
- Discipline
- Territory
- Rate Sets
- Urgency of fill: Immediate, moderate, low
- Potential Hire date
- Bonus – Sign on – automatic for urgent need, hard to fill.

- Post open position in Workday via human resource information system provided by Pennant Services.
- Post open position on job boards on LinkedIn, Indeed, Career Builder, Glassdoor.
- Share the job posting on agency social media.

Once a candidate has been identified the agency will follow its standard screening process:

Step 1. Conduct phone interview of candidate, screening for relevant experience, positive attitude, and discuss compensation.
Step 2. DCS in-person or video conference interview with clinical candidate; Administrator or DCS in-person or video conference interview with administrative candidate.
Step 3. Ride-along with clinical staff (only clinical candidates with little or no hospice experience)
Step 4. Candidate interviewed by 2-4 agency staff.

Once agency leadership decide to extend the candidate an offer the agency will follow its standard process:

- Agency administrator or HR designee will:
- Provide candidate with offer letter setting out the duties of the position, rate of compensation, start date, and directions on how to accept the offer.
- Perform a background check compliant with state law, which will include primary source verification of licensure, if applicable.
- Instruct candidate as to how to perform drug screen.
- Perform reference checks for references identified by candidate.
- Notify candidate on necessary items to bring on start date for onboarding (e.g., identification documentation for I-9).
- Inform agency leaders and appropriate staff regarding the candidate's acceptance/rejection of offer, candidate's start date, and any additional pertinent information.

Retention

- With retention even more important than recruitment, all Pennant-affiliates are provided resources and support from the Pennant Services Center to provide rigorous department orientation, clinical and safety training, initial and ongoing competencies assessments, and performance evaluations.
- Staff will be trained on our core values: Celebration, Accountability, Passion for Learning, Love One Another, Customer Second, Ownership. These core values will guide all of our decisions and will form the basis for expectations of the staff.
- Agency will have weekly rounding/one-on-one sessions during first 90 days with director or designee. Quarterly thereafter.

- Staff will have 90-day and annual reviews, allowing open dialogue about the employee's performance, concerns, and feedback.
- We offer programs for CEU and tuition reimbursement.
- We offer competitive benefits, including health care, dental, vision, paid time off, and more.
- We perform an anonymous employee satisfaction survey annually to gauge employee satisfaction.
- We provide ongoing professional training based on needs identified in our QAPI program, annual compliance and profession-specific training, and regular in-service training.

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

Puget Sound Hospice of Pierce County's office hours of operation will be 8 am to 5 pm, Monday through Friday, however, we will provide hospice services 24 hours a day, 7 days a week. Puget Sound Hospice of Pierce County admissions packet will include instructions to the patient and family/caregiver as to how to reach the agency at all hours. During non-business hours, Puget Sound Hospice of Pierce County's main phone number will be rolled to an on-call phone. This phone will be assigned to an on-call nurse.

If the on-call nurse does not answer (extraneous circumstance), the outgoing message will instruct the client/caregiver to call the nurse administrator on-call if no return call occurs within 15 minutes.

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

While this is not an existing agency, all Cornerstone hospice agencies (and home health agencies) have a method for assessing customer satisfaction and quality improvement. Each of these agencies has a robust process to ensure Federal, State and local guidelines for customer satisfaction and quality improvement are met.

Customer Satisfaction is a critical element for our quality program and reflects the patient and family experience. We partner with Strategic Heathcare Programs (SHP) for this process. SHP mails the Consumer Assessment of Healthcare Providers and System (CAHPS) survey to the appriopriate designee identified by our electronic medical record (EMR) system vendor, Home Care Home Base (HCHB), and collects the data from the responses. Those responses are then summarized into useable data for use in interdisciplinary meetings (IDG) and quality assurance/performance improvement (QAPI) programs to address customer perceptions and improve community relationships.

To help drive our quality improvement, we have partnered with SHP. Through SHP we are able to view our quality metrics in real time. We also utilize partnership with HCHB to provide data and reporting based on direct patient contact and the patient record. These partners combined with our processes related to IDG meetings and QAPI programs drive patient satisfaction and quality improvement and help build a reputation within our communities of being a hospice provider of choice.

Accurate documentation is a critical necessity that is supported by our internal compliance department and agency leadership with regular review intervals. HCHB helps ensure we have all required documentation at the initiation of service and subsequent visits in areas such as Hospice Item Set (HIS) information, Symptom Management, and Service Intensity. HCHB is integrated with SHP to help us develop trends related to Hospice Quality Reporting Program (HQRP) elements. HCHB also provides an avenue to document opportunities for improving on avoidable events in areas like infection control, patient compliants, falls, and medication errors. We can then use this information to help focus the discussion in our IDG meetings and to drive areas of improvement in our QAPI programs.
Quality improvement is largely driven by our IDG. The main purpose of our IDG meeting is to bring together key hospice professionals to review and discuss the hospice needs for each individual patient and their family. We mentioned above, individualized care plans help drive the best patient outcomes. The IDG also establishes policies governing the day-to-day provision of services, which include agency programs to ensure our clinicians are skilled in providing hospice care.

Lastely, our QAPI program is designed to drive great patient outcomes. Our QAPI program wil be regularly reviewed by our leadership team and our govering body. More frequency reviews of performance improvement projects (PIP) developmed through our QAPI program occur in the IDG meeting. One of the main purposes of our QAPI program is to measure, analyze and track quality indicators to drive the best quality outcomes and patient satisfaction possible.

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

As this is not an existing agency, this does not apply

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

As this is not an existing agency, this does not apply

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

Strategic Healthcare Programs (SHP)[13]
Home Care Home Base (HCHB)
DME Vendor
Pharmacy Vendor
Medical Supply Vendor
eSolutions – accounting interface
Workday – HR interface
Lippincott – electronic educational/procedural tool for clinicians
Focura – Leading document management and HIPPA compliant communication for clinicians
Providor Link – for community physicians
Relias Learning – clinician focused learning tool
TigerConnet—HIPAA compliant communitcation for cliniciains

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

As this is not an existing agency, this does not apply.

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

As this is not an existing agency, this does not apply.

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

The list below demonstrates some of our already existent relationships with Puget Sound Home Health.

Some of the established referral relationships include but are not limited to:

Swedish First Hill Campus	Seattle VA Medical Center
Harborview Hospital	Seattle Cancer Care Alliance
Felton Health Care Specialists	The Hearthstone
Shoreline Health and Rehab Center	Bothell Health Care
MultiCare Auburn Medical Center	St. Anne Hospital CHI Franciscan
Canterbury House	Avalon Care Center Federal Way
MultiCare Covington Medical Center	Judson Park
Burien Nursing and Rehab Center	St. Francis Hospital CHI Franciscan
The Home Doctor	Dr. Jude Verzosa
North Auburn Rehab & Health	Stafford Suite Seatac
Virginia Mason Medical Center	Dr. Ranu Choudhary
CrownHealth	Garden Terrace Healthcare Center

[13] Note, the Applicant has contracts with many of these vendors as part of Pennant- or Cornerstone-wide enterprise contracts, which helps with cost containment.

Renton Rehab	Talbot Rehab Center
Redmond Care and Rehab	Aegis Living West Seattle
Park West Care Center	MultiCare Dispatch Health

18. Identify whether any facility or practitioner associated with this application has a history of the actions listed below. If so, provide evidence that the proposed or existing facility can and will be operated in a manner that ensures safe and adequate care to the public and conforms to applicable federal and state requirements. WAC 246-310-230(3) and (5)
    a. A criminal conviction which is reasonably related to the applicant's competency to exercise responsibility for the ownership or operation of a hospice care agency; or
    b. A revocation of a license to operate a health care facility; or
    c. A revocation of a license to practice a health profession; or
    d. Decertification as a provider of services in the Medicare or Medicaid program because of failure to comply with applicable federal conditions of participation.

Neither Symbol, Cornerstone, nor Pennant have any history of 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. Further, they have never been adjudged insolvent or bankrupt in any state or federal court. And, none have been involved in a court proceeding to make judgment of insolvency or bankruptcy with respect to the applicants.

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

Much like the Hospitals for Healthier Community (HHC) Priorities have outlined (CHNA, 2019), we are committed to aligning with hospitals/health systems, and the post-acute care community to improve access to care for King County residents. Relationships and partnerships have already been established with our home health agengies in King, Pierce, Snohomish, Skagit, and San Juan counties. Examples are MultiCare and CHI Fanciscan hospitals 2020 narrowed home health networks in South King County. Strong community and large hospital systems referral relationships exist in all of these counties to address the needs of King County and Puget Sound residents. In addition, Pennant Group has an assisted living facility in King County.

The Ensign Group, Cornerstone's former parent company, has partnered with the Pennant Group to improve the care continuum. Ensign provides skilled nursing and rehabilitative services in the post-acute care sphere. Specific to this project, Ensign has a long standing skilled nursing facility within King County that we will partner with and address unwarranted fragmentation of healthcare upstream and downsteam services. With the above relationships, partnerships, and associations, we believe we can provide

the continuity of care and prevent unwarranted fragmentation of services through quick and thoughtful bridging and referrals to hospice services.

20. Provide a discussion explaining how the proposed project will have an appropriate relationship to the service area's existing health care system as required in WAC 246-310-230.

As a long-established provider in King County, Symbol has strong and ongoing relationships with existing healthcare systems in King County and surrounding counties. Symbol works closely with community partners, local hospital systems, private duty providers, physicians, and in home care physiciain groups. In fact, as mentioned above, Cornerstone's operational model is for each agency to engage in and seek market-specific care and opportunites within each county services are available. This is best accomplished through partnerships with other health care providers. This partnership takes many forms, including sharing of coordination of care, assisting and coordinating appriopriate admissions, mutually driven quality outcomes, preventing hospital readmissions, and patient satisfication.

Symbol has been involved in the community ongoing efforts in King County and other counties to battle the COVID-19 pandemic. With the most recent COVID-19 pandemic surges, Puget Sound Home Health of King County was able to utilize its narrowed network with Multicare and CHI Franciscan to provide overflow for their increased number of referrals and COVID-19 positive patients. In addition, Puget Sound Home Health of King County is a member of the Northwest Healthcare Response Network that helps assist with disaster preparedness, responses, and surge efforts.

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

We are proud to share that none of Cornerstone's 63 home health and hospice agencies have exhibited a pattern of conditional level findings.

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

This question is inapplicable based on the answer to the question immediately preceding this one.

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

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

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

    - Alternative A: Take no Action
    - Alternative B: Apply for and Receive CN
    - Alternative C: Purchase Existing Hospice

Please see our response to #2 below for the discussion.

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

Table 6 provides the comparison of this project with alternatives that were rejected.

Table 6

Alternative A: Take no Action	
Criteria	**Results**
Access to Hospice Services	There is no advantage to taking no action in terms of improving access. The disadvantage is that taking no action does nothing to address the need for additional hospice agencies in King County. Therefore, this option does not address the access to care problem that exists.
Quality of Care	There is no advantage to taking no action regarding quality of care. The disadvantage with taking no action is driven by shortages in access to hospice services. With time, access would tighten and there would be adverse impacts on quality of care.
Cost and Operating Efficiency	With this option, there would be no impacts on costs. The disadvantage is that there would be no improvements to cost efficiencies.
Staffing Impacts	The advantage is not hiring/employing additional staff. There are no disadvantages from a staffing perspective.
Legal Considerations	No Legal considerations.
Decision	This alternative was not chosen; it does not improve access to health care services and it could have a negative impact on the quality of care.
Alternative B: Apply for and Receive CN	
Criteria	
Access to Health Care Services	This project meets current and future access issues identified in King County. It will increase access to care. With this project, there are no disadvantages to access to health care services.

Quality of Care	This project meets and promotes quality of care in King County. There are no disadvantages.
Cost and Operating Efficiency	Puget Sound Hospice of Pierce County will be able to leverage fixed costs, such as the lease, by spreading fixed costs over the hospice and home health services. Cost and operational efficiency will be affected by minimal operating expenses during the initial startup period before it achieves volume that covers fixed and variable costs.
Staffing Impacts	This project will create new jobs that benefit King County. These new jobs also provide paths for staff who are dedicated to efficient delivery of hospice services. There are no disadvantages; Cornerstone Healthcare Inc. and Symbol have a proven track record of hiring and retaining quality staff.
Legal Considerations	The advantage: Puget Sound Hospice of Pierce County staff will be able to provide hospice services to King County residents. This will improve access, quality, and continuation of care. The disadvantage: CN approval is required; this requires time and expense.
Decision	This alternative was selected because it will improve access to health care services, it enhances quality and continuation of care, it leverages existing fixed costs and has no negative impacts on staffing. Finally, this project will quicky be executed and it does not require undue legal or regulatory requirements.
Alternative C: Purchase Existing Hospice	
Criteria	
Access to Health Care Services	The disadvantage is that an acquisition may not add additional capacity for hospice services in King County when compared to alternative A and alternative B. Also, at present, we do not know of a hospice agency for sale in King Co.
Quality of Care	The advantage: This option could enhance quality and continuation of care in King County. There are no aparent disadvantages to this option.
Cost and Operating Efficiency	The disadvantage: The acquisition of an existing hospice requires considerable up front cost and time to purchase and complete due diligence.
Staffing Impacts	The advantage for staffing is that the staff from the existing agency already exists. This option potentially creates no new jobs, which does not benefit King County.
Legal Considerations	There are no advantages. The disadvantage is that an acquisition takes considerable time and resources to conduct due diligence.
Decision	This alternative was not chosen; it does not improve access to health care services, it may add additional costs and effort related to acquiring an existing agency, and it requires considerable time and resources related to legal and due diligence requirements. Finally, we are not aware of any hospice agencies in King County for sale.

3. If the project involves construction, provide information that supports conformance with WAC 246-310-240(2):
    - The costs, scope, and methods of construction and energy conservation are reasonable; and
    - The project will not have an unreasonable impact on the costs and charges to the public of providing health services by other persons.

Our project does not involve construction.

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

Following are some examples of the ways we use innovations in the delivery of care, effectively increasing efficiency in the delivery of care, promoting quality assurance, and fostering cost effectiveness.

HomeCare HomeBase- HCHB is the leading electronic medical records system in the nation that is specific to home health and hospice agencies. HCHB was designed by home health and hospice industry leaders and integrates compliance measures and tools to ensure the requirements of pertinent regulations are met. We are also able to customize HCHB to meet any other specific needs we may have (compliance with state specific regulations, meeting the needs of particular patient populations, addressing a certain payer mix, etc.).

HCHB Analytics- Analytics is the tableau (visualization of data software) reporting platform that is build by HCHB and integrates all of the HCHB data to tableau. HCHB supplies a stock set of reports that can be used for preparation for upcoming regulation changes, productivity management/regulation and quality reporting management. The reports can be built and customized be a certain tableau report builder for all of our specific reporting needs.

Forcura- Forcura is a totally HIPAA compliant document management, referral management, order tracking, and wound measurement/management solution that integrates directly with HCHB to allow the transmission of patient data between the two platforms. Forcura is available to office workers via a dashboard and field workers via mobile application for each use. This application provides our users with a more seamless referral acceptance for quicker processing, more accurate wound measurement tracking tools for more accurate documentation between multiple caregivers, order tracking, and automatic processing of orders out and back in with auto populated details for quicker, more seamless order processing.

In Addition to these innovative tools, we believe we are a partner of choice to payors, providers, patients and employees in the healthcare communities we serve. As a partner, we focus on improving care outcomes and the quality of life of our patients in home or

home-like settings. Our local leadership approach facilitates the development of strong professional relationships, allowing us to better understand and meet the needs of our partners. We believe our emphasis on working closely with other providers, payors and patients yields unique, customized solutions and programs that meet local market needs and improve clinical outcomes, which in turn accelerates revenue growth and profitability.

We are a trusted partner to, and work closely with, payors and other acute and post-acute providers to deliver innovative healthcare solutions in lower cost settings. In the markets we serve, we have developed formal and informal preferred provider relationships with key referral sources and transitional care programs that result in better coordination within the care continuum. These partnerships have resulted in significant benefits to payors, patients and other providers including reduced hospital readmission rates, appropriate transitions within the care continuum, overall cost savings, increased patient satisfaction and improved quality outcomes. Positive, repeated interactions and data-sharing result in strong local relationships and encourage referrals from our acute and post-acute care partners. As we continue to strengthen these formal and informal relationships and expand our referral base, we believe we will continue to drive cost effectiveness and quality outcomes.

Hospice Agency Superiority

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

Multiple Applications in One Year

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

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

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

2. If the answer to the previous question is yes, clarify:
   - Are these applications being submitted under separate companies owned by the same applicant(s); or
   - Are these applications being submitted under a single company/applicant?
   - Will they be operated under some other structure? Describe in detail.

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

4. In the event that the department can approve more than one county for the same applicant, further pro forma revenue and expense statements **may** be required.
    - If your applications propose operating multiple counties under the same license, provide combined pro forma revenue and expense statements showing the first three full calendar years of operation assuming approval of all proposed counties.
    - If your applications propose operating multiple counties under separate licenses, there is no need to provide further pro forma revenue and expense statements.

We are applying in four counties: Pierce, King, Spokane and Skagit Counties. The following list shows the financial pro formas we included in this application:

- Assumptions and calcs
- Pro forma income statement
- Pro forma balance sheet
- Cornerstone HC inc. + Puget Sound Hospice-**King** pro forma income statement
- Cornerstone HC inc. + Puget Sound Hospice-**King** pro forma balance sheet
- Cornerstone HC inc. + Pierce + King + Skagit + Spokane pro forma income statement
- Cornerstone HC inc. + Pierce + King + Skagit + Spokane pro forma balance sheet

Certificate of Need Program Revised Code of Washington (RCW) and Washington Administrative Code (WAC)

Certificate of Need Program laws RCW 70.38

Certificate of Need Program rules WAC 246-310

Certificate of Need Program 'Frequently Asked Questions'

Commonly Referenced Rules for Hospice Projects:

WAC Reference	Title/Topic
246-310-010	Certificate of Need Definitions
246-310-200	Bases for findings and action on applications
246-310-210	Determination of Need
246-310-220	Determination of Financial Feasibility
246-310-230	Criteria for Structure and Process of Care
246-310-240	Determination of Cost Containment
246-310-290	Hospice services—Standards and need forecasting method.

Certificate of Need Contact Information:
Certificate of Need Program Web Page
Phone: (360) 236-2955
Email: FSLCON@doh.wa.gov

Licensing Resources:
In-Home Services Agencies Laws, RCW 70.127
In-Home Services Agencies Rules, WAC 246-335
Hospice Agencies Program Web Page

Organizational Chart

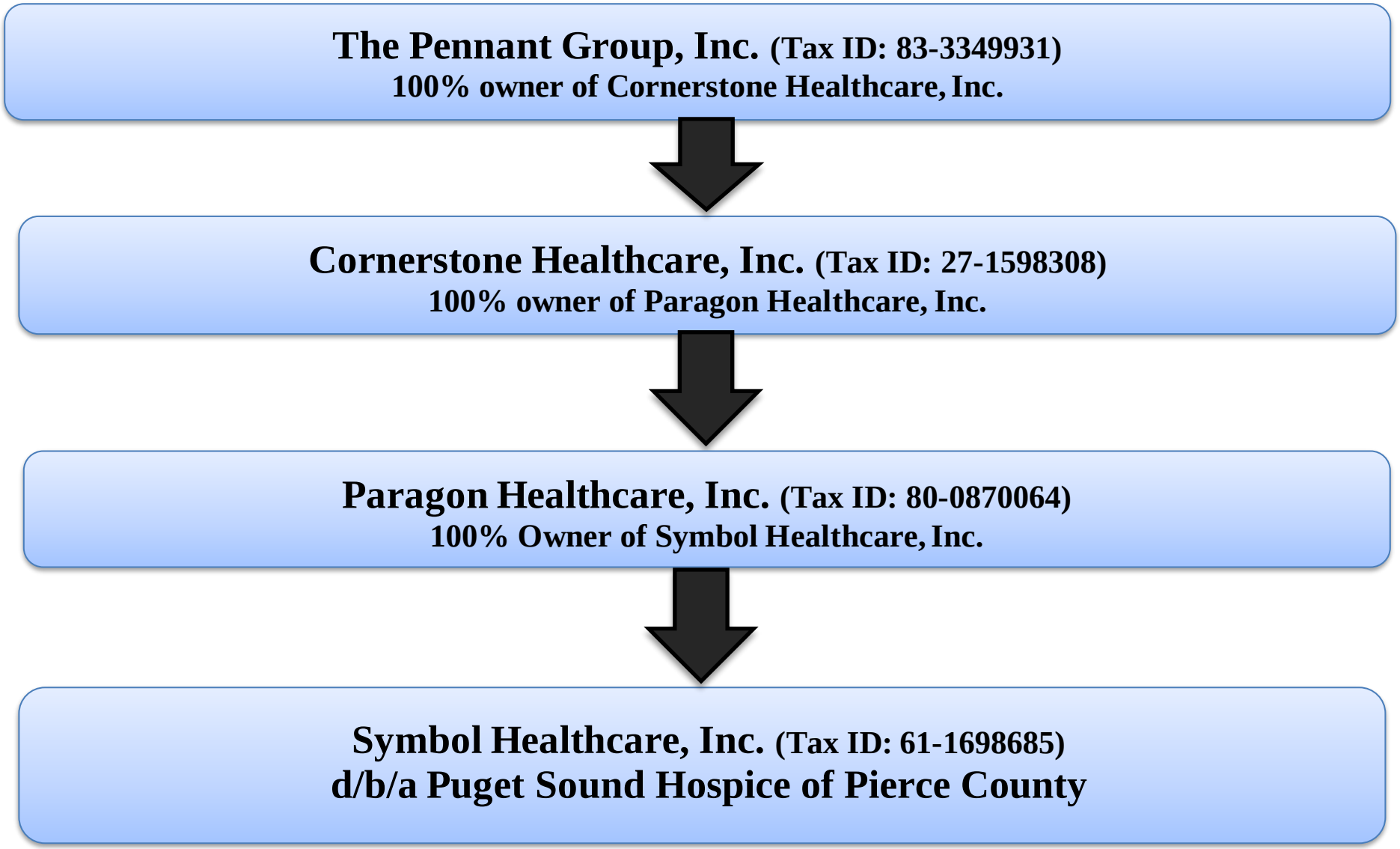

EXHIBIT 2

Subsidiaries of Applicant, **The Pennant Group, Inc.**

Entities Owned by **Cornerstone Healthcare, Inc.**

	Agency/Facility Name	Type	Street Address	City	State	ZIP Code	CCN	State Lic. No.	Accrediting Body
1	A Gentle Touch Home Care	Home Care	1173 South 250 West, Suite 401B	St. George	UT	84770	N/A	2020-PCA-UT000269	Not Accredited
2	Agape Hospice & Palliative Care	Hospice	4400 East Broadway Blvd., Suite 400	Tucson	AZ	85711	03-1614	HSPC9712	Joint Commission
3	All County Home Health	Home Health	37131 Interstate 10 West, #400	Boerne	TX	78006	743120	019469	Not Accredited
4	All County Hospice	Hospice	37131 Interstate 10 West, #400	Boerne	TX	78006	671756	019469	Not Accredited
5	Alpha Home Health	Home Health	10530 19th Ave SE, Ste 201	Everett	WA	98208	507107	IHS.FS.60793191	Not Accredited
6	Alpha Hospice	Hospice	10530 19th Ave SE, Ste 201	Everett	WA	98208	501546	IHS.FS.61032013	ACHC
7	Buena Vista Hospice	Hospice	2545 West Hillcrest Drive, Ste 130	Thousand Oaks	CA	91320	051787	550000060	The Joint Commission
8	Buena Vista Palliative Care & Home Health	Home Health	2545 West Hillcrest Drive, Ste 130A	Thousand Oaks	CA	91320-22297	55-7165	050000273	CHAP
9	Buena Vista Valley Hospice	Hospice	16909 Parthenia Street, Ste. 102-B	Northridge	CA	91343	551620	550001417	The Joint Commission
10	Buena Vista Valley Palliative Care & Home Health	Home Health	16909 Parthenia Street, Ste. 302-A	Northridge	CA	91343	057252	980000471	Not Accredited
11	Careage Home Care	Home Health	203 E. Bow Drive	Cherokee	IA	51012-1214	167405	N/A	Not Accredited
12	CMS-Kinder Hearts Home Health	Home Health	1102 Early Blvd.	Early	TX	76802	677177	20902	Not Accredited
13	Columbia River Home Health	Home Health	7105 W. Hood Place, Suite B-201	Kennewick	WA	99336-3807	507061	IHS.FS.60875683	Not Accredited
14	Comfort Hospice	Hospice	6655 West Sahara Ave, Ste A114	Las Vegas	NV	89146	291520	8955	The Joint Commission
15	Connected Home Health	Home Health	7515 NE Ambassador Pl., Ste C	Portland	OR	97220-1379	387146	13-1509	Not Accredited
16	Connected Hospice	Hospice	7515 NE Ambassador Pl., Ste C	Portland	OR	97220-1379	381563	16-1065	ACHC
17	Custom Care Home Health	Home Health	4811 Merlot Avenue, Suite 110	Grapevine	TX	76051	679672	015646	Not Accredited
18	Custom Care Hospice	Hospice	4811 Merlot Avenue, Suite 110	Grapevine	TX	76051	451635	013152	Not Accredited
19	Elevate Home Care	Home Care	310 Lashley St., Ste 109	Longmont	CO	80504	N/A	04Z850	Not Accredited
20	Elevate Home Care	Home Care	4891 Independence St., Suite 285	Wheat Ridge	CO	80033	N/A	10Z779	Not Accredited
21	Elite Home Health	Home Health	1370 Bridge Street	Clarkston	WA	99403	507111	IHS.FS.60384078/HH-197	Not Accredited
22	Elite Hospice	Hospice	1370 Bridge Street	Clarkston	WA	99403	501533	IHS.FS.60384078/HH-197	Not Accredited
23	Emblem Home Health	Home Health	3205 W. Ray Road, Ste 2B	Chandler	AZ	85226	037253	HHA6969	Not Accredited
24	Emblem Home Health Phoenix	Home Health	301 East Bethany Home Road, Suite C-278A	Phoenix	AZ	85012	03-7438	HHA10676	Not Accredited
25	Emblem Hospice	Hospice	3205 W. Ray Road, Ste 2A	Chandler	AZ	85226	031595	HSPC5656	Not Accredited
26	Emblem Hospice Tucson	Hospice	7225 N. Oracle Rd., Ste 202	Tucson	AZ	85704	031624	HSPC7080	Not Accredited
27	Excell Home Care	Home Health	1200 SW 104th St., Ste D	Oklahoma City	OK	73139	377534	HC7462	Not Accredited
28	Excell Hospice	Hospice	1200 SW 104th St., Ste D	Oklahoma City	OK	73139	371610	HO4151	Not Accredited
29	Excell Private Care Services	Home Care	4631 N. May Ave	Oklahoma City	OK	73112	N/A	HC7932	Not Accredited
30	Finding Home Medical Services	Physician Group	47 6th Avenue	Page	AZ	86040	Z244229	N/A	Not Accredited
31	Finding Home Medical Services	Physician Group	55 W. Willowbrook Dr., Suite 103	Meridian	ID	83646	20010640	N/A	Not Accredited
32	Finding Home Medical Services	Physician Group	1385 West 2200 South, Suite 201	West Valley City	UT	84119	U000098817	N/A	Not Accredited
33	Gateway Hospice	Hospice	103 2nd Ave NE	Clarion	IA	50525	161556	N/A	Not Accredited
34	Horizon Home Health	Home Health	63 W Willowbrook Drive	Meridian	ID	83646-1656	137065	HH-139	ACHC
35	Horizon Home Health East	Home Health	1411 Falls Ave East, Suite 615	Twin Falls	ID	83301-3458	137114	HH-237	Not Accredited
36	Horizon Hospice	Hospice	63 W Willowbrook Drive	Meridian	ID	83646-1656	131520	N/A	ACHC
37	Horizon Hospice East	Hospice	1411 Falls Ave East, Suite 615	Twin Falls	ID	83301-3458	131516	N/A	Not Accredited
38	Hospice of Missoula	Hospice	1900 S. Reserve St.	Missoula	MT	59801-6455	27-1525	13573	Not Accredited
39	Hospice of the Pines	Hospice	13207 E. State Route 169, Ste. A	Dewey	AZ	86327	031559	HSPC8180	Not Accredited
40	Hospice of the South Plains	Hospice	4413 82nd Street, Ste 135	Lubbock	TX	79424	671667	016805	Not Accredited
41	Kinder Hearts Home Health	Home Health	842 N. Mockingbird Lane	Abilene	TX	79603-5729	679193	017913	Not Accredited
42	Kinder Hearts Hospice	Hospice	842 N. Mockingbird Lane	Abilene	TX	79603-5729	671790	017766	CHAP
43	Lake Powell Physical Therapy	Therapy Group	43rd Sixth Avenue	Page	AZ	86040-7500	Z198792	OTC7784	Not Accredited
44	Namaste Home Health	Home Health	6000 E. Evans Ave., Suite 2-400	Denver	CO	80222-5411	067471	04K559	Not Accredited
45	Namaste Hospice	Hospice	6000 E. Evans Ave., Suite 2-400	Denver	CO	80222-5411	061545	1704DM	Not Accredited
46	Pasco SW Home Health		2764 Compass Dr., Ste 244	Grand Junction	CO	81506	67535	04H560	Not Accredited
47	Physician Home Care	Physician Group	1385 W. 2200 South, Suite 202	West Valley City	UT	84119	U000102236	N/A	Not Accredited
48	Preceptor Home Health	Home Health	W175N11117 Stonewood Dr., Ste 100	Germantown	WI	53022	52-7313	1171	CHAP
49	Preceptor Hospice	Hospice	W175N11117 Stonewood Dr., Ste 100	Germantown	WI	53022	52-1593	2033	CHAP
50	Preceptor Therapy	Therapy Group	W175N11117 Stonewood Dr., Ste 100	Germantown	WI	53022	K100579730	N/A	Not Accredited
51	Emblem Hospice Central	Hospice	4225 West Glendale Ave. Suite A200	Phoenix	AZ	85051	03-1579	HSPC10253	Not Accredited
52	Emblem Hospice West	Hospice	1801 S Jentilly Lane, Ste. A10	Tempe	AZ	85281	031678	HSPC10844	ACHC
53	Puget Sound Home Health	Home Health	4002 Tacoma Mall Blvd Ste 204	Tacoma	WA	98409-7702	507101	IHS.FS.60332035	Not Accredited
54	Puget Sound Home Health of King County	Home Health	4002 Tacoma Mall Blvd Ste 204A	Tacoma	WA	98409	507122	IHS.FS.60751653	Not Accredited
55	Puget Sound Hospice	Hospice	4002 Tacoma Mall Blvd Ste 204	Tacoma	WA	98409-7702	TBD	IHS.FS.61032138	ACHC
56	Resolution Hospice	Hospice	363 N Sam Houston Parkway E, Suite 545	Houston	TX	77060	74-1720	20685	The Joint Commission
57	Resolutions Hospice Austin	Hospice	1101 Arrow Point Drive Ste 301	Cedar Park	TX	78613	67-1631	019485	Not Accredited
58	Resolutions Hospice Houston	Hospice	12600 N Featherwood Dr Ste 108	Houston	TX	77034	67-1722	019607	CHAP
59	Riverside Home Health Care	Home Health	402 SE G Street	Grants Pass	OR	97526	38-7143	13-1542	Not Accredited
60	River Valley Home Health	Home Health	149350 Ukiah Trail, Ste 102	Big River	CA	92242	059373	550001658	Not Accredited
61	River Valley Home Health	Home Health	1990 N McCulloch Blvd, Ste. 109	Lake Havasu	AZ	86403-3606	037402	HHA7444	Not Accredited
62	River Valley Home Health	Home Health	1317 S. Joshua Ave, Ste Q	Parker	AZ	85344	037297	HHA7419	Not Accredited
63	River Valley Hospice	Hospice	149350 Ukiah Trail, Ste 103	Big River	CA	92242	751698	550003021	Not Accredited
64	River Valley Hospice	Hospice	2649 Hwy 95, Unit H	Bullhead City	AZ	86442	031636	HSPC7364	Not Accredited
65	River Valley Hospice	Hospice	1740 East Beverly Ave. Suite B	Kingman	AZ	86409	03-1661	HSPC10256	ACHC
66	River Valley Hospice	Hospice	1317 S. Joshua Ave., Ste P	Parker	AZ	85344	031639	HSPC7545	Not Accredited
67	Sacred Heart Home Health Care-Tucson	Home Health	2504 East River Road, Suite 100	Tucson	AZ	85718	03-7144	HHA10800	Not Accredited
68	Safe Harbor Home Care	Home Care	5473 Kearny Villa Road, Suite 110B	San Diego	CA	92123-1160	N/A	374700005	Not Accredited
69	Seaport Home Health	Home Health	5473 Kearny Villa Road, Suite 100	San Diego	CA	92123	059303	550001427	Not Accredited
70	Seaport Hospice	Hospice	5473 Kearny Villa Road, Suite 110A	San Diego	CA	92123	551745	550002260	Not Accredited
71	Sequoia Home Health	Home Health	830 Hillview Ct., Suite 225	Milpitas	CA	95035-4550	058496	550000575	The Joint Commission
72	Sequoia Hospice	Hospice	830 Hillview Ct., Suite 180	Milpitas	CA	95035-4563	921794	550003611	ACHC
73	Stonebridge Home Care North	Home Care	1385 West 2200 South, Suite 203	West Valley City	UT	84119	N/A	PCA-UT000903	Not Accredited
74	Stonebridge Home Care Solutions	Home Care	1664 S Dixie Drive, Ste C105	St. George	UT	84770	N/A	N/A	Not Accredited
75	Stonebridge Home Care Solutions	Home Care	55 W. Willowbrook Drive, Suite 101	Meridian	ID	83646	N/A	N/A	Not Accredited
76	Stonebridge Home Care Solutions	Home Care	1385 West 2200 South, Suite 201	West Valley City	UT	84119	N/A	2019-PCA-UT000767	Not Accredited
77	Stonebridge Home Care South	Home Care	961 W Center Street	Orem	UT	84057	N/A	PCA-UT000904	Not Accredited
78	Symbii Home Health	Home Health	1916 N 700 W, Suite 110	Layton	UT	84041	467231	HHA-77779	Not Accredited
79	Symbii Home Health	Home Health	240 W Burnside Ave, Ste B	Chubbuck	ID	83202	13-7110	HH-233	Not Accredited
80	Symbii Home Health	Home Health	625 S Washington St, Ste B	Afton	WY	83110	537073	15291	Not Accredited
81	Symbii Home Health Bear River	Home Health	1153 North Main, Suite B 100/110	Logan	UT	84341-2573	467219	HHA-UT000158	Not Accredited
82	Symbii Home Health South	Home Health	1385 W. 2200 South, Suite 202	West Valley City	UT	84119	46-7342	HHA-UT00618	Not Accredited
83	Symbii Hospice	Hospice	1916 N 700 W, Suite 110	Layton	UT	84041	461567	HOSPICE-102378	Not Accredited
84	Symbii Hospice	Hospice	240 W Burnside Ave, Ste B	Chubbuck	ID	83202	13-1552	N/A	Not Accredited
85	Symbii Hospice	Hospice	625 S Washington St, Ste B	Afton	WY	83110	531525	15290	Not Accredited
86	Symbii Hospice Bear River	Hospice	1153 North Main, Suite B 100/110	Logan	UT	84341-2573	461550	UT000157	Not Accredited
87	Symbii Hospice South	Hospice	1385 W. 2200 South, Suite 202	West Valley City	UT	84119	46-1606	HOSPICE-UT00619	Not Accredited
88	Zion's Way Home Health	Home Health	47 6th Avenue	Page	AZ	86040-1015	037290	HHA5463	Not Accredited
89	Zion's Way Home Health	Home Health	1173 South 250 West, Suite 401	St. George	UT	84770	467243	HHA-106473	Not Accredited
90	Zion's Way Hospice	Hospice	47 6th Avenue	Page	AZ	86040-1015	031594	HSPC5462	Not Accredited
91	Zion's Way Hospice	Hospice	1173 South 250 West, Suite 401	St George	UT	84770	461559	Hospice-106446	Not Accredited

Recently Acquired Entities Awaiting CHOW Approval

	Agency/Facility Name	Type	Street Address	City	State	ZIP Code	CCN	State Lic. No.	Accrediting Body	Acquired
1	Custom Care Home Health - Ft. Worth	Home Health	7261 Hawkins View Drive	Forth Worth	TX	76132	45-8125	21109	The Joint Commission	05/01/21

2	**First Call Hospice**	**Hospice**	6929 Sunrise Boulevard, Ste 180	Citrus Heights	CA	95610	05-1721	TBD	Not Accredited	06/16/21
3	**Harmony Hospice**	**Hospice**	5550 South Jones Blvd.	Las Vegas	NV	89118	29-1514	TBD	CHAP	10/01/20
4	**Kinder Hearts Hospice of Amarillo**	**Hospice**	1901 Medi Park Dr., Suite 1030	Amarillo	TX	79106	67-1768	TBD	CHAP	09/01/21
5	**Peaceful Heart Hospice**	**Hospice**	41870 Kalmia Street, Ste 165	Murrieta	CA	92562	55-1620	TBD	Not Accredited	10/01/21
6	**Seaport Scripps Home Health**	**Home Health**	3750 Convoy Street, Suite 220	San Diego	CA	92111	05-7602	TBD	Not Accredited	10/01/21

Entities Owned by **Pinnacle Senior Living LLC**

	Agency/Facility Name		Street Address	City	State	ZIP Code	CCN	State Lic. No.	Accrediting Body
1	**Amarsi Assisted Living**	**Assisted Living**	5125 North 58th Avenue	Glendale	AZ	85301	N/A	AL11230C	Not Accredited
2	**Brenwood Park Assisted Living**	**Assisted Living**	9535 West Loomis Road	Franklin	WI	53132	N/A	0015615	Not Accredited
3	**Bridgewater Memory Care**	**Assisted Living**	900 Autumn Ridge Drive	Granbury	TX	76048	N/A	102889	Not Accredited
4	**California Mission Inn**	**Assisted Living**	8417 Mission Drive	Rosemead	CA	91770-1188	N/A	198603161	Not Accredited
5	**California Mission Inn – Rose Manor**	**Assisted Living**	4825 Earle Avenue	Rosemead	CA	91770-1176	N/A	198603163	Not Accredited
6	**Cambridge Square Retirement Center**	**Assisted Living**	2700 Avenue N	Rosenberg	TX	77471	N/A	000890	Not Accredited
7	**Canyon Creek Memory Care**	**Assisted Living**	4257 Lowes Drive	Temple	TX	76502	N/A	103463	Not Accredited
8	**Cedar Hills Senior Living**	**Assisted Living**	602 East Beltline Road	Cedar Hill	TX	75104	N/A	149182	Not Accredited
9	**The Citadel Assisted Living Facility**	**Assisted Living**	520 South Higley Rd.	Mesa	AZ	85206	N/A	AL9770C	Not Accredited
10	**Citadel Independent Living Facility**	**Assisted Living**	444 S. Higley Rd.	Mesa	AZ	85206	N/A	AL9770C	Not Accredited
11	**Citrus Hills Assisted Living**	**Assisted Living**	142 South Prospect Street	Orange	CA	92869-3842	N/A	306004783	Not Accredited
12	**Cottonwood Manor Assisted Living**	**Assisted Living**	1450 South Military Avenue	Green Bay	WI	54304	N/A	0015625	Not Accredited
13	**Cranberry Court Assisted Living I**	**Assisted Living**	2230 14th Street	Wisconsin Rapids	WI	54494	N/A	0015632	Not Accredited
14	**Cranberry Court Assisted Living II**	**Assisted Living**	2230 James Court	Wisconsin Rapids	WI	54494	N/A	0015631	Not Accredited
15	**Deer Creek Senior Living**	**Assisted Living**	747 West Pleasant Run Road	DeSoto	TX	75115	N/A	000814	Not Accredited
16	**Desert Springs Senior Living**	**Assisted Living**	6650 W. Flamingo Road	Las Vegas	NV	89103	N/A	410-AGC-42	Not Accredited
17	**Desert View Senior Living**	**Assisted Living**	3890 N. Buffalo Drive	Las Vegas	NV	89129	N/A	8809-AGC-2	Not Accredited
18	**Grand Court of Mesa**	**Assisted Living**	262 East Brown Road	Mesa	AZ	85201	N/A	AL4168C	Not Accredited
19	**Harbor View Assisted Living**	**Assisted Living**	2115 Cappaert Road	Manitowoc	WI	54220	N/A	0015630	Not Accredited
20	**Heritage Assisted Living of Twin Falls**	**Assisted Living**	622 Filer Avenue West	Twin Falls	ID	83301	N/A	RC-1091	Not Accredited
21	**Kenosha Senior Living**	**Assisted Living**	3109 30th Avenue	Kenosha	WI	53140	N/A	0015616	Not Accredited
22	**Lake Pointe Villa Assisted Living**	**Assisted Living**	190 Lake Pointe Drive	Oshkosh	WI	54904	N/A	0016733	Not Accredited
23	**Lakeshore Assisted Living and Memory Care**	**Assisted Living**	5250 Medical Drive	Rockwall	TX	75032	N/A	103958	Not Accredited
24	**Las Fuentes Resort Village**	**Assisted Living**	262 East Brown Road	Prescott	AZ	86301	N/A	AL9771C	Not Accredited
25	**Lexington Assisted Living**	**Assisted Living**	5440 Ralston Street	Ventura	CA	93003-6002	N/A	565801737	Not Accredited
26	**Lo-Har Senior Living**	**Assisted Living**	768 Dorothy Street	El Cajon	CA	92019-3101	N/A	374603673	Not Accredited
27	**Madison Pointe Senior Living**	**Assisted Living**	705 Ziegler Road	Madison	WI	53714	N/A	0015621	Not Accredited
28	**Mainplace Senior Living**	**Assisted Living**	1800 & 1832 W. Culver Avenue	Orange	CA	92868	N/A	306005636	Not Accredited
29	**Maple Meadows Assisted Living**	**Assisted Living**	1001 Primrose Lane	Fond du Lac	WI	54935	N/A	0016731	Not Accredited
30	**McFarland Villa Assisted Living**	**Assisted Living**	5206 Paulson Court	McFarland	WI	53558	N/A	0015622	Not Accredited
31	**Meadow View Assisted Living**	**Assisted Living**	4606 Mishicot Road	Two Rivers	WI	54241	N/A	0015626	Not Accredited
32	**Meadowcreek Senior Living**	**Assisted Living**	2400 West Pleasant Run Road	Lancaster	TX	75146	N/A	000695	Not Accredited
33	**Mesa Springs Independent Living**	**Independent Living**	7171 Buffalo Gap Road	Abilene	TX	79606	N/A	N/A	Not Accredited
34	**Mountain Terrace Senior Living CBRF**	**Assisted Living**	3402 Terrace Court	Wausau	WI	54401	N/A	0015628	Not Accredited
35	**Mountain Terrace Senior Living RCAC**	**Assisted Living**	3312 Terrace Court	Wausau	WI	54401	N/A	0015634	Not Accredited
36	**Mountain View Retirement Village**	**Assisted Living**	7900 North La Canada Drive	Tucson	AZ	85704	N/A	AL9760C	Not Accredited
37	**North Point Senior Living**	**Assisted Living**	3109 12th Street	Kenosha	WI	53144	N/A	0016740	Not Accredited
38	**Paris Chalet Senior Living**	**Assisted Living**	2410 Stillhouse Road	Paris	TX	75462	N/A	147909	Not Accredited
39	**Park Place Assisted Living**	**Assisted Living**	2305 Ives Court	Reno	NV	89503	N/A	333-AGC-27	Not Accredited
40	**Parkside Senior Living**	**Assisted Living**	2330 Bruce Street	Neenah	WI	54956	N/A	0016732	Not Accredited
41	**Pleasant Point Senior Living (CBRF)**	**Assisted Living**	8600 Corporate Drive	Racine	WI	53406	N/A	0015617	Not Accredited
42	**Pleasant Point Senior Living (RCAC)**	**Assisted Living**	8500 Corporate Drive	Racine	WI	53406	N/A	0015617	Not Accredited
43	**Redmond Heights Senior Living**	**Assisted Living**	7950 Willows Road NE	Redmond	WA	98052-6813	N/A	2522	Not Accredited
44	**Riverview Village Senior Living**	**Assisted Living**	W176 N9430 Rivercrest Drive	Menomonee Falls	WI	53051	N/A	0015619	Not Accredited
45	**Rockbrook Assisted Living and Memory Care**	**Assisted Living**	2215 Rockbrook Drive	Lewisville	TX	75067	N/A	103138	Not Accredited
46	**Rose Court Senior Living**	**Assisted Living**	2935 North 18th Place	Phoenix	AZ	85016	N/A	AL8634C	Not Accredited
47	**Santa Maria Terrace**	**Assisted Living**	1405 E. Main St.	Santa Maria	CA	93454	N/A	425801863	Not Accredited
48	**Scandinavian Court Assisted Living**	**Assisted Living**	346 Scandinavian Court	Denmark	WI	54208	N/A	0015623	Not Accredited
49	**Sea Cliff Assisted Living**	**Assisted Living**	18851 Florida Street	Huntington Beach	CA	92648	N/A	060000123	Not Accredited
50	**Sherwood Village Assisted Living and Memory Care**	**Assisted Living**	102 South Sherwood Village Drive	Tucson	AZ	85710	N/A	AL9495C	Not Accredited
51	**Stoughton Meadows Senior Living**	**Assisted Living**	2321 Jackson St.	Stoughton	WI	53589	N/A	0015620	Not Accredited
52	**The Grove Assisted Living**	**Assisted Living**	3401 Lemon Street	Riverside	CA	92501	N/A	336424161	Not Accredited
53	**The Shores of Sheboygan Assisted Living I**	**Assisted Living**	3315 Superior Ave.	Sheboygan	WI	53081	N/A	0015629	Not Accredited
54	**The Shores of Sheboygan Assisted Living II**	**Assisted Living**	3319 Superior Ave.	Sheboygan	WI	53081	N/A	0015627	Not Accredited
55	**Twin Falls Manor Senior Living**	**Independent Living**	491 Caswell Avenue West	Twin Falls	ID	83301	N/A	N/A	Not Accredited
56	**Villa Court Assisted Living and Memory Care**	**Assisted Living**	3985 S. Pearl Street	Las Vegas	NV	89121	N/A	9444-AGC-0	Not Accredited
57	**Villa Court Assisted Living and Memory Care**	**Assisted Living**	4025 S. Pearl Street	Las Vegas	NV	89121	N/A	9454-AGC-0	Not Accredited
58	**Whittier Glen Assisted Living**	**Assisted Living**	10615 Jordan Road	Whittier	CA	90603-2932	N/A	198602088	Not Accredited
59	**Willow Brooke Point Senior Living CBRF**	**Assisted Living**	1800 Bluebell Lane	Stevens Point	WI	54481	N/A	0015624	Not Accredited
60	**Willow Brooke Point Senior Living RCAC**	**Assisted Living**	1801 Lilac Lane	Stevens Point	WI	54481	N/A	0015633	Not Accredited
61	**Windsor Court Senior Living**	**Assisted Living**	1101 Jameson Street	Weatherford	TX	76086	N/A	030057	Not Accredited
62	**Wisteria Place Assisted Living**	**Assisted Living**	3202 South Willis Street	Abilene	TX	79605	N/A	307578	Not Accredited

HOSPICE
MEDICAL DIRECTOR SERVICE AGREEMENT

AGREEMENT EFFECTIVE DATE:	_____12/21/20_____
AGENCY:	**SYMBOL HEALTHCARE, INC.** **Address:** 4002 Tacoma Mall Blvd., Suite 204A, Tacoma, WA 98409
MEDICAL DIRECTOR:	**WILLIAM ELLEDGE, M.D.** **Address:** 1916 Berry Street N.E., Olympia, WA 98506

THIS HOSPICE MEDICAL DIRECTOR SERVICE AGREEMENT ("Agreement") is made and entered into as of the above-listed Agreement Effective Date ("Effective Date") by and between the above-listed Agency and Medical Director, (each a "Party" and collectively the "Parties").

R E C I T A L S

WHEREAS, Agency is engaged in the provision of a comprehensive set of services, identified and coordinated by an interdisciplinary group, for the palliation and management of the terminal illness and related conditions of its patients;

WHEREAS, Medical Director is a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he or she performs that function or action; and

WHEREAS, Agency desires to engage the services of Medical Director to serve as Medical Director for its Hospice Agency services.

NOW THEREFORE, IN CONSIDERATION OF THE PREMISES and for other good and valuable consideration, the receipt and sufficiency of which the parties hereby mutually acknowledge, the parties agree:

T E R M S A N D C O N D I T I O N S

Section 1. Medical Director's Duties

The Medical Director agrees to serve as the Medical Director for the Agency during the term of this Agreement, and to perform the duties set forth in **Exhibit A** in a good, professional and workmanlike manner.

Section 2. Agency's Duties

Agency shall:

2.1 Organize, manage, and administer its resources to provide the hospice care and services to patients, caregivers and families necessary for the palliation and management of the terminal illness and related condition. Agency shall provide hospice care that (a) optimizes comfort and dignity; and (b) is consistent with patient and family needs and goals, with patient needs and goals as priority.

2.2 Assume and maintain full legal authority and responsibility for the management of the Agency, the provision of all hospice services, its fiscal operations, and continuous quality assessment and performance improvement. Agency shall be responsible for the day-to-day operation of the Agency.

2.3 Not restrict or limit the Medical Director's right to exercise his or her independent professional judgment, including his or her right to recommend services to be rendered and the manner to be used in performing those services.

2.4 Furnish the Medical Director with such supplies and materials as might ordinarily be expected for the preparation of reports, remarks and consultations.

2.5 Indemnify and hold harmless Medical Director from any claims arising out of the acts or omissions of Agency or its employees; provided, however, that Agency shall have no obligation to indemnify or hold harmless Medical Director for any claims alleging medical malpractice.

Section 3. Compensation

For and in consideration for all Services to be provided under this Agreement, Agency shall compensate Medical Director as follows:

3.1 Agency shall pay Medical Director an all-inclusive hourly rate of **One Hundred Ninety Dollars ($190.00)**, which the Parties agree will apply to and cover all administrative and operational functions required by Agency, all face-to-face services, and all travel time necessary to perform Medical Director's required duties ("Administrative Services").

3.2 For each month during the Term of this Agreement, Medical Director shall keep an accurate record of all time spent performing Administrative Services for Agency by completing a copy of **Exhibit B** ("Physician Services Log/Invoice"), attached hereto. Medical Director shall submit a completed copy of **Exhibit B** to the Agency by the fifth (5th) day of the month following the month of service. All amounts due under this contract for Administrative Services will be due and payable by the fifteenth (15th) day of the month following the month of service by the Medical Director.

3.3 *Direct Patient Care Services*. In the event Medical Director renders direct patient care services ("Direct Patient Care Services") in his or her capacity as an Agency Patient's attending physician, Medical Director shall keep accurate record of all time spent performing Direct Patient Care Services and shall complete the "Direct Patient Care Services Worksheet" or other form provided by the Agency Administrator to receive reimbursement according to the terms of this Agreement. Agency shall reimburse Medical Director at a rate equal to ninety-two percent 92% of the Medicare or Medicaid rate received by the Agency for all Direct Patient Care Services. Medical Director shall submit a completed copy of Direct Patient Care Services Worksheet to the Agency by the fifth (5th) day of the month following the month of service. All amounts due under this contract for Direct Patient Care Services will be due and payable by the fifteenth (15th) day of the month following the month of service by the Medical Director.

Section 4. Insurance

4.1 Agency agrees that during the term of this Agreement, Physician, while acting within the scope of his duties as outlined herein, is covered under the Agency's general and professional liability (errors and omissions) insurance, which includes tail coverage for two years.

4.2 Agency agrees to maintain general and professional liability insurance or a plan of self-insurance in an amount not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in the aggregate.

Section 5. Term and Termination

5.1 The Term of this Agreement shall commence on the date referenced in the first paragraph of this Agreement and continue thereafter for a period of one (1) year (the "Initial Term"). Upon expiration of the Initial Term and each extension term thereafter, this Agreement shall automatically extend for an additional term of one (1) year unless, not less than thirty (30) days prior to the end of the term, either party gives written notice of termination to the other, in which case this Agreement shall terminate as of the end of the term.

5.2 Notwithstanding anything herein to the contrary, either party may cancel this Agreement for any reason or no reason, and without penalty, upon thirty (30) days written notice to the other party.

5.3 The Agency shall have the right to summarily and immediately terminate this Agreement for cause upon Medical Director's receipt of written notice documenting the breach and decision. For purposes of this Section, "for cause" shall include the following: (i) Medical Director's breach of any material term or condition of this Agreement; (ii) limitation, suspension or revocation of Medical Director's license to practice medicine or to prescribe controlled substances; (iii) Medical Director's violation of the eligibility requirements for reimbursement under any government program; (iv) the occurrence or existence of any condition, practice, procedure, action, inaction or omission of, by, or involving, Medical Director which, in the reasonable opinion of Agency constitutes a threat to the health, safety and welfare of any patient, Agency, or Agency employee; or (v) violation of any law, regulation, requirement, license, eligibility or material agreement governing Agency's operation or Medical Director's ability to practice medicine.

5.4 The Medical Director shall have the right to summarily and immediately terminate this Agreement for cause upon Agency's receipt of written notice documenting the breach and decision. Termination by the Medical Director shall be considered "for cause" under either of the following circumstances: (i) breach of any material term or condition of this Agreement by the Agency; or (ii) loss of the Agency's licensure to operate as a Home Health and Hospice Agency.

Section 6. Regulatory Changes

Agency and Medical Director mutually agree that in the event local, state or federal government agencies promulgate regulations which materially affect the terms of this Agreement, this Agreement shall be immediately subject to renegotiation upon the initiative of either Party.

Section 7. Licensure, Eligibility and Compliance

7.1 Medical Director and any employee of Medical Director rendering services hereunder shall at all times during the term of this Agreement be duly licensed to practice medicine in the state in which the Medical Director will perform the services contemplated herein, and shall provide satisfactory evidence of continuing licensure to the Agency upon the execution of this Agreement and thereafter upon request by Agency from time to time.

7.2 Medical Director acknowledges that its activities under this Agreement are governed by, *inter alia*, the United States Department of Health and Human Services' Office of the Inspector General's Compliance Program Guidelines for Home Health and Hospice Agencies. Upon request, Medical Director shall provide documentation that Medical Director is not and at no time has been an excluded party on the Office of Inspector General's List of Excluded Individuals/Entities or otherwise excluded from participating in any federally funded healthcare program including Medicare and Medicaid, with printed search results to be maintained on file and conducted annually. Medical Director represents and warrants that neither Medical Director nor any individual or entity with a direct or indirect ownership or control interest of five percent (5%) or more in Medical Director, nor any director, officer, agent or employee of such party, is debarred, suspended or excluded under any state or federal healthcare program it is currently eligible to participate in

Medicare, Medicaid, and all other federally funded health care programs and is not subject to any sanction or exclusion by any of those programs.

7.3 Medical Director agrees to immediately disclose to Agency any actual or threatened federal, state or local investigations or imposed sanctions of any kind, in progress or initiated subsequent to the date of entering into this Agreement. Medical Director further represents and warrants that it is not currently sanctioned under any applicable state or federal fraud and abuse statutes, including exclusion from any state or federal health care program.

7.4 If, during the term of this Agreement, Medical Director, its parent, or any officer, director or owner receives such a sanction, or notice of proposed sanction, Medical Director shall provide notice of and a full explanation of such sanction or proposed sanction and the period of its duration within ten (10) days of receipt. Agency reserves the right to terminate the Agreement immediately upon receipt of notice that Medical Director has been sanctioned under fraud and abuse statutes and/or any other federal, state or local regulation.

7.5 Medical Director acknowledges that it has received and reviewed a copy of Agency's Code of Conduct, available online at www.ensigngroup.net or upon request to Agency, and agrees to abide by the provisions thereof.

7.6 Medical Director shall participate in PennantU/compliance training and activities as required by Agency or Agency's compliance partners.

Section 8. Medical Director's Schedule and Availability

8.1 Nothing in this Agreement shall be construed as limiting or restricting in any manner Medical Director's right to render the same or similar services to other individuals or entities, including but not limited to, nursing homes and acute care facilities or home health and hospice agencies during or subsequent to the Term of this Agreement.

8.2 The Agency recognizes that Medical Director is a licensed and actively practicing physician who will continue the active practice of medicine. Nothing in the Agreement shall be construed to prevent or limit that practice.

8.3 Medical Director is entitled to be reasonably absent for annual vacations, sick leave, continuing education, and personal reasons; provided that in the event of any absence Medical Director shall make reasonable efforts to first consult with the Agency concerning the impending absence and cooperate with the Agency in providing a qualified physician acceptable to Agency to temporarily serve as acting Medical Director of the Agency during the period of absence.

Section 9. Contractual Relationship

9.1 *Independent Contractor*. It is expressly acknowledged by both parties that Medical Director is an independent contractor. Nothing herein is intended to be construed to create an employer-employee, partnership, joint-venture or other relationship between Medical Director and the Agency. No provision of this Agreement shall create any right in Agency to exercise control or direction over the manner or method by which Medical Director performs its duties, renders services or practices medicine in the Agency as the Medical Director hereunder; provided always, that those services shall be provided in a manner consistent with all applicable laws, rules and regulations of all governmental authorities, and Agency's Corporate Compliance Program. Agency will not withhold from compensation payable to Medical Director hereunder, or be in any way responsible for, any sums for income tax, employment insurance, Social Security, or any other agency, and Medical Director agrees that the payment of all such amounts as may be required by law are and shall be the sole responsibility of Medical Director.

9.2 *Fair Market Value*. The amounts to be paid to Medical Director hereunder have been determined by the parties through good faith and arms-length bargaining to be the fair market value of the services to be rendered hereunder. No amount paid or to be paid hereunder is intended to be, nor will it be construed as, an offer, inducement or payment, whether directly or indirectly, overtly or covertly, for the referral of patients by Medical Director to Agency, or by Agency to Medical Director, or for the recommending or arranging of the purchase, lease or order of any item or service or any other business generated between the parties. The services contracted for in this Agreement do not exceed what is reasonable and necessary to carry out the legitimate business purpose of the Agency. For purposes of this section, Medical Director and Agency will include each such person or entity and any affiliate thereof. No referrals are required under this Agreement.

Section 10. Indemnification.

10.1 Except as set forth in Subsection 2.5 above with regard to Medical Director's acts and omissions, Agency agrees to defend, indemnify, and hold Medical Director, its corporate parent, subsidiaries, affiliated and related companies, directors, officers, employees, and agents, wholly harmless for, from and against any and all costs (including reasonable attorney's fees) liabilities, claims, losses, lawsuits, settlements, demands, causes, judgments and expenses arising from or connected with the performance of this Agreement to the extent that such costs and liabilities are alleged to result from the negligence or willful misconduct of Agency.

10.2 Medical Director agrees to defend, indemnify, and hold Agency, its corporate parent, subsidiaries, affiliated and related companies, directors, officers, employees, and agents, wholly harmless for, from and against any and all costs (including reasonable attorney's fees), liabilities, claims, losses, lawsuits, settlements, demands, causes, judgments and expenses arising from or connected with the performance of this Agreement, to the extent that such costs and liabilities are alleged to result from the negligence or willful misconduct of Medical Director.

10.3 A party receiving notice of a claim or potential claim shall send written notice to the other within ten (10) business days, and shall fully cooperate in the defense thereof by counsel mutually acceptable to the parties. The parties' rights to indemnification set forth in this Article are non-exclusive and are not intended to affect in any way any other rights of the parties to indemnification under applicable federal, state or local laws and regulations.

Section 11. Access to Books and Records

Pursuant to 42 U.S.C. 1395x(V)(1)(I), during the four (4) year period after completion of services hereunder, Agency and Medical Director will, upon written request, make available to the Secretary of Health and Human Services or to the Comptroller General, or their duly authorized representatives, this Agreement and any books, documents, and records that are necessary to certify the nature and extent of costs incurred by the Agency under the provisions of this Agreement. This provision shall be in force for any twelve (12) month period during which the total value of services provided or goods delivered hereunder is ten thousand dollars ($10,000) or more. This paragraph shall have no effect unless Medical Director is deemed a "subcontractor" under any regulation adopted under the provision of the United States Code cited above.

Section 12. Privacy

12.1 *HIPAA Applicability and Compliance.* Agency may be a "Covered Entity" under, and may be required to comply with, the applicable provisions of the Health Insurance Portability and Accountability Act of 1996 as amended ("HIPAA") and the regulations and guidelines pertaining thereto (collectively with HIPAA the "HIPAA Rules"), and to obtain sufficient assurances that its contracting parties will appropriately safeguard patients' Protected Health Information ("PHI") as defined in the HIPAA Rules. Medical Director acknowledges that in the course of performing Medical Director's services, duties and obligations herein, Medical Director may receive, create or obtain access to PHI. Medical Director agrees to maintain the security and confidentiality of all PHI, as required of Agency under the HIPAA Rules and other applicable laws and regulations.

12.2 *Additional Documentation and Assurances*. Medical Director agrees that, upon Agency's request from time to time as deemed necessary by Agency in order to ensure Agency's full and continuing compliance with HIPAA Rules and other legal and contractual requirements, Medical Director will execute and deliver to Agency information, documentation or agreements as may be necessary to maintain compliance with the HIPAA Rules and all laws, statutes, ordinances, regulations and orders now or hereafter applicable to Agency or Medical Director.

12.3 *Correlation of Record Handling Requirements.* In the event of any conflict between the requirements of this Article 12 and/or between the various laws, statutes, ordinances and regulations relating to or otherwise affecting the subject matter thereof, the requirement or applicable law that that presents the most stringent standard for compliance, as reasonably determined by Agency, shall be followed, such that compliance is achieved or maximized in all cases.

12.4 *Confidential Information*. Medical Director shall preserve the confidentiality of all private, confidential and/or proprietary information disclosed to or discovered by Medical Director in connection with this Agreement, including, without limitation, nonpublic financial information, manuals, protocols, policies, procedures, marketing, and strategic information, Agency lists, computer software, training materials, resident/patient health information, resident/patient records, and resident/patient care and outcomes data ("Confidential Information") as required by law. Medical Director shall not use for its own benefit or disclose or otherwise disseminate to third parties, directly or indirectly, any Confidential Information without prior written consent from Agency. Upon termination of this Agreement, all Confidential Information and copies thereof shall be returned to Agency. Medical Director and Agency shall comply with applicable federal, state and local laws and regulations with respect to all Confidential Information, including, but not limited to, any disclosures thereof pursuant to this paragraph.

Section 13. Notices

All notices required or which may be given pursuant to this Agreement shall be in writing and shall be sufficient in all respects, if given in writing and delivered personally or by registered or certified United States mail, or by a comparable commercial delivery system, return receipt requested, and notice shall be deemed given on the date hand-delivered or on the date which is three (3) business days after the date deposited in the United States mail, or with a comparable commercial delivery system, with postage or other delivery charges thereon prepaid, at the addresses first set forth hereinabove or such other address as the Agency or Medical Director may designate by written notice to the other pursuant to this Section. For a notice from the Medical Director to the Agency to be effective, a true and complete copy of such notice shall be simultaneously delivered by the Medical Director to Cornerstone Service Center, Inc., Attn: General Counsel, 1675 E. Riverside Drive, Suite 200, Eagle, ID 83616.

Section 14. Dispute Resolution/Arbitration

14.1 The Parties agree to meet and confer in good faith to resolve any dispute(s) that may arise out of and/or relate to this Agreement. If such dispute(s) remain unresolved, the Parties mutually agree that such disputes shall be resolved exclusively by arbitration in accordance with the provisions of this Section.

14.1.1 Either Party may commence arbitration by sending a written demand for arbitration to the other Party, setting forth the nature of the controversy, the dollar amount involved, if any, the remedies sought, and attaching to such demand a copy of this fully executed Agreement.

14.1.2 The Parties agree to utilize a single mutually agreed upon arbitrator and/or arbitration service sitting in the county and state where Agency's principle office is located. If the Parties fail to select a mutually acceptable arbitrator within thirty (30) days after the demand for arbitration is mailed, then the parties stipulate to confidential arbitration in accordance with the then current American Health Lawyers Association dispute resolution

rules ("AHLA"), by a sole arbitrator selected from among the AHLA panel of certified arbitrators; provided, however, that if AHLA (or any successor organization thereto) no longer exists, then such arbitration shall be administered by the American Arbitration Association ("AAA") in accordance with its then-existing Commercial Arbitration Rules, and the sole arbitrator shall be selected in accordance with such AAA rules.

14.1.3 The Parties shall share all costs of arbitration evenly. The prevailing Party shall be entitled to reimbursement by the other Party of such Party's attorneys' fees and reasonable costs and any arbitration fees and expenses incurred in connection with the arbitration hereunder.

14.1.4 The substantive, evidentiary, and procedural law of the State where Agency's principal office is located shall be applied by the arbitrator. Arbitration shall take place in city where Agency's principle office is located, unless the Parties otherwise agree in writing. As soon as reasonably practicable, a hearing with respect to the dispute or matter to be resolved shall be conducted by the arbitrator. As soon as reasonably practicable thereafter, the arbitrator shall arrive at a final decision, which shall be reduced to writing, signed by the arbitrator and mailed to each of the Parties and their legal counsel. All decisions of the arbitrator shall be final, binding and conclusive on the Parties and shall constitute the only method of resolving disputes or matters subject to arbitration pursuant to this Agreement. The arbitrator or any court of competent jurisdiction may issue a writ of execution to enforce the arbitrator's judgment. Judgment may be entered upon such a decision in accordance with applicable law in any court having jurisdiction thereof.

14.1.5 Notwithstanding the foregoing, because time is of the essence in this Agreement, (i) the Parties specifically reserve the right to seek a judicial temporary restraining order, preliminary injunction, or other similar short term equitable relief, and grant the arbitrator the right to make a final determination of the Parties' rights, including whether to make permanent or dissolve such court order; (ii) any and all arbitration proceedings are conditional upon such proceedings being covered within the Parties' respective risk insurance policies; and (iii) the Parties shall not be required to arbitrate malpractice or any third party claims.

Section 15. Miscellaneous

15.1 This Agreement has been negotiated by and between Medical Director and Agency in arms-length negotiations, and both parties are responsible for its drafting. Both parties have reviewed this Agreement with appropriate counsel, or have waived their right to do so, and the parties hereby mutually and irrevocably agree that this Agreement shall be construed neither for nor against either party, but in accordance with the plain language and intent hereof. The invalidity or unenforceability of any provision of this Agreement shall not affect the other provision hereto, and this Agreement shall be construed in all respects as if such invalid or unenforceable provisions were omitted. Headings are used herein for convenience only, and shall play no part in the construction of any provision of this Agreement.

15.2 Medical Director and Agency hereby covenant that in performing their respective obligations under this Agreement, they will comply in all material respects with all applicable statutes, regulations, rules, orders, ordinances and other laws of any governmental entity to which this Agreement and the parties' obligations under this Agreement, are subject with respect to healthcare regulatory matters (including, without limitation, The Social Security Act, as amended, Sections 1128, 1128A and 1128B, 42 U.S.C. Sections 1320a-7, 7(a) and 7(b) including criminal penalties involving Medicare or state health care programs, commonly referred to as the "Federal Anti-Kickback Statute," and if applicable, the statute commonly referred to as the "Federal False Claims Act" and all statutes and regulations related to the possession, distribution, maintenance and documentation of controlled substances) ("Healthcare Laws"). Medical Director and Agency hereby represent and warrant that, to their best knowledge, no circumstances currently exist which can reasonably be

expected to result in material violations of any Healthcare Laws by Medical Director or Agency in connection with, or which can reasonably be expected to affect, their respective performance under this Agreement.

15.3 Time is of the essence of this Agreement and every term and condition hereof.

15.4 The waiver by any party hereto of breach of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach by any party.

15.5 This Agreement shall binding upon the parties hereto, their heirs, successors and assigns. Notwithstanding the foregoing, Medical Director acknowledges that a material and substantial consideration in Agency's execution of this Agreement is the identity and reputation of Medical Director, and Agency's subjective perception of Medical Director's value to and compatibility with Agency and its officers, employees, facilities and patients. As such, notwithstanding anything contained herein to the contrary, this Agreement and the rights of Medical Director hereunder are personal to Medical Director and may not be assigned or subcontracted to, nor shall the duties and responsibilities of Medical Director hereunder be delegated to or rendered by, any other person or entity without the express prior written consent of Agency, which consent may be granted or denied, conditionally or unconditionally, by Agency in its sole, absolute and unfettered discretion.

15.6 *Notice Regarding the Elder Justice Act.* All individuals who are agents or contractors of the Agency are required to report suspicion of a crime against any individual who is a resident of, or is receiving care from, the Agency to the Secretary of the U.S. Department of Health and Human Services and one or more law enforcement entities for the political subdivision in which the Agency is located. If the events that cause the suspicion result in serious bodily injury, the report shall be made no later than two hours after forming the suspicion. If the events that cause the suspicion do not result in serious bodily injury, the report shall be made no later than twenty-four (24) hours after forming the suspicions.

15.7 This Agreement represents the entire agreement and understanding of the parties with respect to the subject matter hereof, and supersedes and negates any previous contracts between Agency and Medical Director. Agency and Medical Director mutually agree that this Agreement may not be modified unless such modification is in writing and signed by both parties.

[Signature Page to follow]

IN WITNESS WHEREOF, the parties have affixed their signatures hereto as of the dates set forth below.

_____	_____
MEDICAL DIRECTOR SIGNATURE	**AGENCY SIGNATURE**
Name: _____	By: _____ Administrator/Authorized Agent
Date: _____	Date: _____

EXHIBIT A

MEDICAL DIRECTOR RESPONSIBILITIES:

ADMINISTRATIVE

a. Meets regularly with the Executive Director, Administrator, the Director of Nursing Services, and other decision makers in the Agency and provides leadership and direction in an effort to continuously improve the care delivered by the team to Agency patients.
b. Participates in, and helps respond to, regulatory surveys and interacts with outside regulatory bodies.
c. Participates in disciplinary actions of Agency employees and facilitates performance review of practitioners performing services for Agency, when appropriate.

PROFESSIONAL SERVICES

a. Reviews the clinical information for each hospice patient and provides written Certification of Terminal Illness, considering all facts and circumstances of the patient's condition, including: (a) diagnosis of the terminal condition of the patient; (b) other health conditions, whether related or unrelated to the terminal condition; and (c) current clinically relevant information supporting all diagnoses.
b. Ensures the adequacy and appropriateness of the medical services provided to Agency patients, including being responsible for (in conjunction with patient's attending physician) the palliation and management of Agency patients' terminal illness and conditions related to the terminal illness.
c. Works in concert with attending physician and interdisciplinary team (IDT) to establish and periodically review a plan of care for each patient to address the physical, medical, psychosocial, emotional, and spiritual needs of the hospice patients and families facing terminal illness and bereavement.
d. Regularly attends and helps lead IDT meetings, enters reports into Agency's electronic medical records system (if applicable), prepares orders for patient care, and reviews recertification and admission reports.
e. Performs and documents face-to-face evaluations, in accordance with hospice conditions of participation and other Federal and state requirements.
f. Serves as consulting physician on patient care issues and questions, including: (a) being on-call to field telephone calls from Agency nursing staff, as agreed upon with Agency and (b) responding to facsimile transmissions, telephone calls, and other communication relating to Agency patient care. Takes responsibility for the medical component of the Agency's patient care program and oversees the planning and rendering of care, including supervising all work conducted on behalf of the Agency by other Agency physicians (either contracted or employee).
g. Acts as liaison with attending physicians to oversee the rendition, and ensure the quality, of the collective professional services rendered within the Agency.
h. Ensures that proper orders are written and submitted promptly.
i. Helps develop, review, and updates, as necessary, written policies and procedures to guide Agency physicians in admitting and caring for their patients (including delineation of responsibility) at the Agency.
j. Evaluates and ensures the medical services rendered from or within the Agency are compliant with the Agency's current policies and procedures, including without limitation, the Agency's Code of Conduct and applicable state and Federal law.
k. Renders necessary medical care to Agency patients when the attending physician is not immediately available.
l. Assists Agency staff in addressing medical emergencies within the Agency.
m. Participates in the periodic evaluation of the adequacy and appropriateness of Agency professional and support staff services.
n. Assures medical coverage during emergencies, and helps develop policies and procedures relating thereto.
o. Organizes, coordinates, and monitors the activities of the physicians delivering care at the Agency, and ensures that the quality and appropriateness of services meets community and regulatory standards.

QUALITY ASSURANCE

a. Participates in the monitoring of care within the Agency, serves as a member of the Agency's Quality Assurance Committee, and attends and participates in Quality Assurance Committee meetings.
b. Maintains knowledge of state and national standards for and regulations applicable to the rendering of hospice services, and ensures that the Agency meets the existing standards of care and conditions of participation.
c. Attends in QAPI meetings and participates in developing and reviewing Agency's QAPI Program in an effort to ensure Agency's policies, procedures, and practices regarding patient care comply with all applicable federal and state requirements.

EDUCATION

a. Participates in the education and training activities of hospice staff members, and identifies and suggests topics for in-service training through observation and evaluation of patient care.
b. Participates in the development, organization, and delivery of education programs for staff, patients, patient families, board members, and the community at large.
c. At the direction of Administrator, completes any required Agency education and training courses within the timeframe established by the Administrator.

COMMUNITY

a. Acts as an advocate for the Agency, encourages and facilitates community involvement in the activities of the Agency, and assists the community in understanding the Agency's capabilities and services.
b. Serves as a liaison on behalf of the Agency in the community, including, helping to create positive relationships between the Agency and other health care providers in the community.

SOCIAL, REGULATORY, AND FINANCIAL

a. Understands the mechanisms for hospice care reimbursement, and establishes relationship with other organizations involved in hospice care to assure that patients' needs are met across the continuum of care.

EXHIBIT B
PHYSICIAN SERVICES LOG/INVOICE

Physician Name: _____

Instructions:

1. Complete Service Log/Invoice, accounting for all time spent providing services pursuant to the terms of your Hospice Physician Services Agreement and Exhibit A.
2. Do not submit Service Log/Invoice for payment for direct patient care services rendered in your capacity as an Agency patient's attending physician. In the event you perform such services, you will complete the "Direct Patient Care Services Worksheet" provided by the Agency Administrator and receive reimbursement according to the terms of your Medical Director Services Agreement.
3. Submit the completed, signed and dated Service Log/Invoice to the Agency Administrator for their approval and payment pursuant to the terms and conditions of your Hospice Physician Services Agreement.

Please fill out the table below, filling in the month and year of the services performed. Then, mark an "X" next to those services performed, enter the date those services were performed, and the hours worked.

MONTH & YEAR:			
MARK X	Specific Activities Performed	Date	Hours
	Attendance at IDT. Including, facilitating the establishment/review of patient plans of care with other members of the IDT.		
	Providing on-call consultation. Including providing on-call consultation to Agency, caregiver, and/or facility staff regarding questions about patient care services for Agency's patient(s).		
	Face-to-face. Performed face-to-face evaluations of patients, in accordance with the hospice conditions of participation and other applicable State or Federal requirements.		
	Attendance at Management Meetings. Including meeting with Agency's Administrator, Director of Nursing, Operations Manager, and/or other Agency personnel at the direction of Administrator.		
	Reviewing reports. Including reviewing admission and/or recertification reports, prepping for IDT, and/or entering information into Homecare Homebase (HCHB).		
	On-call services. Including the time spent being available for on-call consultative support on weekends, nighttime, and/or holidays.		
	Other. *(please provide a detailed description of the Medical Directorship duties performed)*		

ATTESTATION

HOSPICE PHYSICIAN

I affirm this service log reflects accurate and complete services and hours performed in accordance with the requirements of my Medical Director Service Agreement. I affirm these activities do not constitute the provision of professional services to individuals that have been billed to the patient or any third party payor. I confirm that no compensation has been solicited, offered, or received for the referral of any patient or the ordering of any goods or services in connection with these activities. I affirm this service log does not include any activities excluded from compensation under my Medical Director Service Agreement.

_____ _____

Physician Signature Date

ADMINISTRATOR

I have reviewed this service log and attest to its completeness, accuracy and adherence to the documentation and verification standards. I confirm the activities as listed above were reasonable and necessary for legitimate and commercially reasonable purposes of the Program. I confirm that no compensation has been solicited, offered, or received for the referral of any patient or the ordering of any goods or services in connection with these activities. I affirm this service log does not include any activities excluded from compensation under the Medical Director Service Agreement.

_____ _____

Administrator Signature Date

IN WITNESS WHEREOF, the parties have affixed their signatures hereto as of the dates set forth below.

MEDICAL DIRECTOR SIGNATURE

Name: William N. Eggleston MD

Date: 12/19/2020

AGENCY SIGNATURE

By: Devin Rothwell
Administrator/Authorized Agent

Date: 12/21/2020

EXHIBIT 4

THIRD ADDENDUM TO LEASE AGREEMENT

AMENDMENT EFFECTIVE DATE:	12/27, 2021
TENANT:	**SYMBOL HEALTHCARE, INC.** **Address**: 4002 Tacoma Mall Blvd., Suite 204, Tacoma, WA 98049
LANDLORD:	**JANKELSON LACEY PARTNERSHIP, LP** **Address:** c/o Targa Real Estate, P.O. Box 4508, Federal Way, WA 98063

THIS THIRD ADDENDUM TO LEASE AGREEMENT ("Third Addendum") is made and entered into as of the Effective Date above ("Effective Date") by and between Symbol Healthcare, Inc. ("Tenant"), and Jankelson Lacey Partnership, LP ("Landlord"), each a ("Party") and collectively the ("Parties").

RECITALS

A. Tenant and Landlord previously entered into a Lease Agreement, entitled Lease—Commercial/Industrial Premises on October 15, 2015, including a First Addendum To Lease Agreement on March 13, 2019, and Second Addendum To Lease Agreement on March 30, 2021, (collectively referred to herein as the "Lease") in regard to the Leased Premises located at 4002 Tacoma Mall Blvd., Suite 204, Tacoma, WA;

B. Pursuant to the Lease, the Term of the Lease expires December 31, 2025;

C. The Parties acknowledge that Tenant is in the process of preparing and submitting a Certificate of Need application to the Washington State Department of Health (WSDH) for authorization to provide home health and hospice services in _____, and the surrounding area. It is anticipated that the WSDH will make a determination on Tenant's Certificate of Need application during the last calendar quarter of 2022.

D. The Parties acknowledge that in order for Tenant to submit a complete application Tenant must have office space in the Tacoma area available through December 2026 for conducting home health and hospice services. Such office space can be available to Tenant by ownership of lease.

E. The Parties desire to extend the Term of the Lease for an additional year, through December 2026 contingent upon Tenant obtaining the aforementioned Certificate of Need;

F. The Parties desire that this Addendum will not become effective and Tenant will not obtain possession of the Leased Premises in the event Tenant's Certificate of Need application is denied by the WSDH.

G. Tenant and Landlord mutually desire that upon execution, this Third Addendum hereby amends the Lease under the terms and conditions hereinafter set forth.

NOW THEREFORE, IN CONSIDERATION OF THE PREMISES and for other good and valuable consideration, the receipt and sufficiency of which the parties hereby mutually acknowledge, the parties agree as follows:

1. **Section 3. Term**. Section 3 of the Lease shall be amended by deleting the first full paragraph in Section 3 and replacing said paragraph with the following:

   "Term: (See Exhibit "B" attached hereto and made a part hereof) The Term of this Lease shall be for a period of One Hundred Thirty-Three (133) months, commencing on December 1, 2015, and terminating on December 31, 2026. Rent under the Lease commences on December 1, 2015. Lessor's acceptance of rent for a period after the end of the Term hereof shall not extend the Term but shall evidence a month-to-month tenancy."

2. **Exhibit "B", Section 1:** Section 1 of Exhibit "B" of the Lease shall be amended by adding to and including the following in the list of annual periods and rents:

   "For the months of January 2026 through December 2026, the monthly rent of $_9,181.42_.

3. In the event that on or before December 31, 2022, Tenant's Certificate of Need application is granted by the WSDH, then all rights, obligations, responsibilities and duties under this Addendum shall be in full force and Tenant shall have the right to possession of the Leased Premises beginning for the lease term stated above.

4. In the event that on or before December 31, 2022, Tenant's Certificate of Need application is denied by WSDH then, within five (5) days of receiving WSDH's determination, Tenant shall notify Landlord of the WSDH determination. This Addendum shall terminate and be of no effect on the date notice of WSDH's determination is provided by Tenant to Landlord.

5. In the event Tenant does not receive notification of a WSDH determination on or before December 31, 2022, then this Addendum shall terminate and be of no effect as of December 31, 2022.

6. **No Further Modification**. All other terms conditions, rights, and obligations in the Lease shall remain unchanged by this Third Addendum.

IN WITNESS WHEREOF, the parties have affixed their signatures hereto as of the dates set forth below.

Signature: Devin Rothwell	Signature: Kimberly Jankelson
SYMBOL HEALTHCARE, INC., D/B/A PUGET SOUND HOME HEALTH AND HOSPICE	**JANKELSON LACEY PARTNERSHIP, LP**
Name: Devin Rothwell	Name: Kimberly Jankelson
Title: Executive Director	Title: Partner
Date: 12/27/2021	Date: 12/27/2021

EXHIBIT 4

SECOND AMENDMENT TO LEASE AGREEMENT

AMENDMENT EFFECTIVE DATE:	March 30, 2021
TENANT:	**SYMBOL HEALTHCARE, INC.** **Address**: 4002 Tacoma Mall Blvd., Suite 204, Tacoma, WA 98409
LANDLORD:	**JANKELSON LACEY PARTNERSHIP, LP** **Address:** c/o Targa Real Estate, P. O. 4508, Federal Way, WA 98068

THIS SECOND AMENDMENT TO LEASE AGREEMENT ("Second Amendment") is made and entered into as of the Effective Date above ("Effective Date") by and between Symbol Healthcare, Inc. ("Tenant"), and Jankelson Lacey Partnership, LP ("Landlord"), each a ("Party") and collectively the ("Parties").

R E C I T A L S

A. Tenant and Landlord previously entered into a Lease Agreement dated October 15, 2015, including a First Amendment To Lease Agreement dated March 13, 2019, (collectively referred to herein as "Lease") for the for the leased premises located as 4002 Tacoma Mall Blvd., Suite 204, Tacoma, WA 98409;

B. Tenant and Landlord desire to extend the Term of the Lease through December 31, 2025;

C. Tenant and Landlord desire that upon execution, this Second Amendment hereby mutually amends the Lease under the terms and conditions hereinafter set forth.

NOW THEREFORE, IN CONSIDERATION OF THE PREMISES and for other good and valuable consideration, the receipt and sufficiency of which the parties hereby mutually acknowledge, the parties agree to amend the Lease as follows:

1. **Section 3. Term:** Section 3 of the Lease shall be amended by deleting the first full paragraph in Section 3 and replacing said paragraph with the following:

> "Term: (See EXHIBIT "B" attached hereto and made a part hereof) The Term of this Lease shall be for a period of one hundred twenty-one (121) months, commencing on December 1, 2015, and terminating on December 31, 2025. Rent under this Lease commences on December 1, 2015. Lessor's acceptance of rent for a period after the end of the term hereof shall not extend the term but shall evidence a month-to-month tenancy."

2. **Exhibit "B", Section 1:** Section 1 of Exhibit "B" of the Lease shall be amended by adding to and including the following in the list of annual periods and rents:

"For the months of January 2024 through December 2024, monthly rent of $8,697.00

For the months of January 2025 through December 2025, monthly rent of $8,914.00”

3. **New Section to Lease:** The Lease shall be amended by adding following Section 29 to the Lease:

“**29. Name of Tenant**. Landlord recognizes that the Premises will be used by Tenant doing business as Puget Sound Home Health and as Puget Sound Hospice of Pierce County.”

4. **No Further Modification**. All other terms conditions, rights, and obligations in the Lease shall remain unchanged by this First Amendment.

5. **IN WITNESS WHEREOF**, the parties have affixed their signatures hereto as of the dates set forth below.

Signature:	Signature:
SYMBOL HEALTHCARE, INC.	**JANKELSON LACEY PARTNERSHIP, LP**
Name: Devin Rothwell	Name: Kimberly M Jankelson
Title: Executive Director	Title: Partner
Date: 03/30/2021	Date: March 30, 2021

FIRST ADDENDUM TO LEASE AGREEMENT

AMENDMENT EFFECTIVE DATE:	March 13, 2019
TENANT:	**SYMBOL HEALTHCARE, INC., D/B/A PUGET SOUND HOME HEALTH** **Address:** 4002 Tacoma Mall Blvd., Suite 204, Tacoma, WA 98049
LANDLORD:	**JANKELSON LACEY PARTNERSHIP, LP** **Address:** c/o Targa Real Estate, P.O. Box 4508, Federal Way, WA 98063

THIS FIRST ADDENDUM TO LEASE AGREEMENT ("First Addendum") is made and entered into as of the Effective Date above ("Effective Date") by and between Symbol Healthcare, Inc., d/b/a Puget Sound Home Health ("Tenant"), and Jankelson Lacey Partnership, LP ("Landlord"), each a ("Party") and collectively the ("Parties").

RECITALS

A. Tenant and Landlord previously entered into a Lease Agreement, entitled Lease—Commercial/Industrial Premises, ("Lease"), on October 15, 2015, in regard to the Leased Premises located at 4002 Tacoma Mall Blvd., Suite 204, Tacoma, WA;

B. Pursuant to the Lease, the Term of the Lease expires December 31, 2020;

C. The Parties desire to extend the Term of the Lease for an additional three years;

D. Tenant and Landlord mutually desire that upon execution, this First Addendum hereby amends the Lease under the terms and conditions hereinafter set forth.

NOW THEREFORE, IN CONSIDERATION OF THE PREMISES and for other good and valuable consideration, the receipt and sufficiency of which the parties hereby mutually acknowledge, the parties agree as follows:

1. **Section 3. Term:** Section 3 of the Lease shall be amended by deleting the first full paragraph in Section 3 and replacing said paragraph with the following:

> "Term: (See EXHIBIT "B" attached hereto and made a part hereof) The Term of this Lease shall be for a period of ninety seven (97) months, commencing on December 1, 2015, and terminating on December 31, 2023. Rent under this Lease commences on December 1, 2015. Lessor's acceptance of rent for a period after the end of the term hereof shall not extend the term, but shall evidence a month-to-month tenancy."

2. **Section 19. Notices:** Section 19 of the Lease shall be amended by deleting Tenant's address for delivery of notices set forth therein and replacing it with the following:

"Symbol Healthcare, Inc., d/b/a

Puget Sound Home Health
4002 Tacoma Mall Blvd., Suite 204,
Tacoma, WA 98049

With Copy to:

Cornerstone Service Center
Attn: General Counsel
1675 E. Riverside Drive, Suite 200
Eagle, ID 83616"

3. **Exhibit "B", Section 1:** Section 1 of Exhibit "B" of the Lease shall be amended by deleting Section 1 in its entirety and replacing said Section 1 with the following:

"1. Rent: Rent Commencement shall be December 1, 2015. Rent is due on the first of each month without deduction or right of offset. Any late rent payments shall be subject to an additional charge of five percent (5%) of said month's rent amount, and shall become immediately due upon the tenth (10th) day of the month. Minimum monthly rent as follows:

For the months December 2015 through December 2016, monthly rent of	$7,000.00
For the months January 2017 through December 2017, monthly rent of	$7,210.00
For the months January 2018 through December 2018, monthly rent of	$7,426.00
For the months January 2019 through December 2019, monthly rent of	$7,649.00
For the months January 2020 through December 2020, monthly rent of	$7,879.00
For the months January 2021 through December 2021, monthly rent of	$8,076.00
For the months January 2022 through December 2022, monthly rent of	$8,278.00
For the months January 2023 through December 2023, monthly rent of	$8,485.00

Monthly rent for the Option Term shall be the then current fair market rate for the Premises as mutually agreed upon by the Lessor and Lessee.

4. **No Further Modification**. All other terms conditions, rights, and obligations in the Lease shall remain unchanged by this First Addendum.

5. **IN WITNESS WHEREOF**, the parties have affixed their signatures hereto as of the dates set forth below.

Signature:	Signature:
SYMBOL HEALTHCARE INC., D/B/A PUGET SOUND HOME HEALTH AND HOSPICE	**JANKELSON LACEY PARTNERSHIP, LP**
Name: Patricia Seagle-Santander	Name: Kimberly Jankelson
Title: Executive Director	Title: Partner
Date: 03/13/2019	Date: 3/13/2019

LEASE -- COMMERCIAL / INDUSTRIAL PREMISES

THIS LEASE made and entered into this 15th day of October, 2015, by and between Symbol Healthcare, Inc., d/b/a Puget Sound Home Health, hereinafter referred to as "Lessee", and Jankelson Lacey Partnership, LP, hereinafter referred to as "Lessor".

WITNESSETH:

1. Leased Premises: The Lessors are owners of the real property described in Exhibit "A", attached hereto and by this reference incorporated herein. This Lease is for a portion of the Building described in Exhibit "A", more specifically by unit and square footage: 4002 Tacoma Mall Blvd, Suite 204, Tacoma, WA 98409, approximately 4,278 rentable square feet (square footage is approximate, and for identification purposes only). Lessor does hereby lease to Lessee and Lessee does hereby lease from Lessor the "Premises".

2. Business Purpose: The Premises are to be used for the purpose of conducting therein administrative support for in-home health care providers, and related business, and for no other business or purpose without the written consent of Lessor, which consent shall not be unreasonably withheld. Lessee shall at all times, at its expense, have obtained all licenses, permits, and any other governmental approvals required to lawfully conduct its business and activities on said Premises.

3. Term: (See EXHIBIT "B" attached hereto and made a part hereof) The Term of this Lease shall be for a period of sixty one (61) months, commencing on December 1, 2015 and terminating on December 31, 2020. Rent under this Lease commences on December 1, 2015. Lessor's acceptance of rent for a period after the end of the term hereof shall not extend the term, but shall simply evidence a month-to-month tenancy.

Option Term: Provided Lessee has complied with all terms and conditions of the Lease during the primary Lease Term, Lessee shall have the right to extend this Lease for one additional five-year term, hereinafter referred to as the "Option Term". In order for Lessee to so extend the Lease for the Option Term, Lessee shall notify Lessor in writing no less than one hundred twenty (120) days prior to the end of the Primary Term of its election to renew the Lease for the Option Term. Rent for the Option Term shall be as set forth in Exhibit "B" attached.

Lessee shall have a one-time option to terminate this Lease at the end of the thirty-seventh (37th) month following the Commencement Date by providing six (6) months' written notice. Termination Fees shall be Lessor's unamortized Tenant Improvements costs and commission costs at an annual rate of seven percent (7%), plus two (2) months of Minimum Monthly Rent and Additional Rent. Termination Fee will be paid at the time of notice.

4. Lease Consideration: As partial consideration for the execution of this Lease, Lessee shall pay to Lessor the sum of $14,000.00 on or before signing of the Lease. $7,000.00 of this shall be a security deposit pending Lessor's review of Lessee's financial statements, and $7,000.000 shall be applied to the first month's minimum monthly rent payment. If Lessor, in its sole discretion, is satisfied following its review of Lessee's financial statements, Lessor shall return the security deposit to Lessee within thirty (30) days of receiving said financial statements. In the event that Lessor is not satisfied following its review of Lessee's financial statements, and provided Lessee has fulfilled all of its obligations under this Lease at the time of the expiration of this Lease or any Option Term thereto, Lessor shall return the security deposit to Lessee within thirty (30) days following the expiration of this Lease or any Option Term thereto.

5. Rent: Lessee shall, and agrees to pay at such place or places as Lessor may designate from time to time, in writing, the minimum monthly rent as described in Exhibit "B"

The minimum monthly rent shall be due and payable in advance, without right of offset, on the first day of each month.

If any rents or other payments due herein remain unpaid for a period of ten (10) days from date due, a late penalty in the amount equal to five (5) percent of the amount due will be paid by Lessee.

6. Insurance: See Exhibit "B" attached hereto and made a part hereof.

7. Utilities: Lessee shall pay promptly when due, all charges for electricity or other utility services rendered to or for the account of Lessee. Lessee shall separately contract for electrical and natural gas.

8. Signs or Advertising: See Exhibit "C" Signs which is attached hereto and made a part hereof.

9. Repairs and Maintenance: Lessee agrees at all times, from and after delivery of possession of the Premises to Lessee, at its own cost and expense, to repair and maintain in good and tenantable condition the Premises and every part thereof, excluding the roof, exterior walls, structural parts of the Premises and structural floor (floor covering, including carpeting, or other special flooring installed by, or for Lessee, to be maintained by Lessee), and including without limitation, all fixtures and other equipment therein, the store fronts, all Lessee's signs, locks and closing devices, and all window sashes, casements or frames, door frames, and all such items of repair, maintenance and improvement. Provided, however, that Lessee shall not be required to make repairs necessitated by reason of the acts of Lessor or any of Lessor's agents, employees, or contractors, or by reason of the failure of Lessor to perform or observe any conditions or agreement contained in this Lease. All glass, both exterior and interior, is at the sole risk of Lessee, and any glass broken shall be promptly replaced by Lessee with glass of the same kind, size, and quality, unless such glass is broken or damaged as a result of the acts of Lessor or Lessor's agents, employees, or contractors.

Subject to the foregoing provisions, Lessor shall keep and maintain in good and tenantable condition and repair, at its sole expense, the roof, exterior walls, structural parts of the Premises and structural floor, pipes and conduit outside the Premises for the furnishing to the Premises of various utilities (except to the extent that the same are the obligation of the appropriate public utility company).

PROVIDED, however, that Lessor shall not be required to make repairs necessitated by reason of the negligence of Lessee or any one claiming under Lessee, or by reason of the failure of Lessee to perform or observe any conditions or agreement contained in this Lease, or caused by alteration, additions, or improvements made by Lessee, or any one claiming under Lessee.

If Lessee refuses or neglects to make repairs and/or maintain the Premises, or any part thereof, in a manner reasonably satisfactory to Lessor, Lessor shall have the right, upon giving Lessee reasonable advance written notice of its election to do so, to make such repairs or perform such maintenance on behalf of and for the account of Lessee. In such event, such work shall be paid for by Lessee as additional rent promptly upon the receipt of a bill therefore.

Under any surrender of the Premises, Lessee shall redeliver the Premises to Lessor in good order, condition, and state of repair, ordinary wear and tear excepted, and excepting such items or repairs as may be Lessor's obligation hereunder.

Lessee agrees to permit Lessor and its authorized representatives to enter the Premises at all times during usual business hours for the purpose of inspecting the same. Lessee further covenants and agrees that Lessor may go upon the Premises and make any necessary repairs to the Premises and perform any work therein which may be necessary to comply with any laws, ordinances, rules or regulations of any public authority, or that Lessor may deem necessary to prevent waste or deterioration in connection with the Premises. Lessor agrees, when it is reasonably able to, to provide Lessee with advanced notice of Lessor's intent to enter the Premises.

10. Alterations or Improvements: Lessee shall not make any alterations or improvements in or to the Premises without first obtaining the written consent of Lessor, which consent shall not be unreasonably withheld. All alterations, additions or improvements which shall be made, shall be at the sole cost and expense of Lessee, and those alterations, additions and improvements that become so attached to the building as to become fixtures, in the legal sense, shall become the property of Lessor, and shall remain in, and be surrendered with the Premises as a part thereof at the termination of the Lease. Lessee further agrees to hold Lessor free and harmless from damage, loss or expense arising out of said work.

11. Automobile Parking and Common Area: Lessee and its employees and invitees are, except as otherwise specifically provided for in this Lease, authorized, empowered and privileged to use the automobile parking and common areas in common with other persons during the Term (and Option Term, if applicable) of this Lease. However, NO outdoor storage is permitted, and Lessee agrees that any refuse from its operation will be placed in appropriate refuse containers at a location designated by Lessor. Lessor agrees, without cost or expense to Lessee, to provide the automobile parking and common areas, and to maintain and operate (except as hereinafter provided with reference to cost of maintenance) said common areas at all times for the benefit and use of the customers and patrons of Lessee, and of other tenants. Lessor may at any time, and from time to time, set rules and regulations for Lessee's use of the common areas, including but not limited to assigning parking spaces for Lessee and Lessee's employees at locations removed from the immediate proximity to Lessee's Premises.

12. Anti-Subrogation: Neither Lessor nor Lessee shall be liable to the other for damage to the property of the other which results from direct loss from fire, lightning, windstorm, hail, explosion, riot attending a strike, civil commotion, aircraft, vehicles, and smoke, and/or damage caused by removal from the Premises endangered by such perils, as such perils are defined in insurance policies then in force, even though such resulting damage may be due to the negligent act of Lessor or Lessee, their agent or employees.

13. Condemnation: In the event of the taking of the Premises by condemnation or otherwise by a governmental authority, federal, state, or local, which unreasonably interferes with Lessee's use of the Premises, this Lease shall be deemed canceled as of the time of the taking of possession by said authority and, if Lessee is not in default of any provisions of this Lease on said date, the Lease consideration herein receipted for and not theretofore applied against rentals, if any, shall be refunded to Lessee, as well as rental paid for any period beyond the date of cancellation. Lessee shall have no claim to, nor shall it be entitled to, any portion of any award for damages to the real property or building on the Premises.

14. Default: If Lessee shall fail to keep and perform any of the covenants and agreements contained herein, then Lessor may cancel the Lease by giving the notice required by law and re-enter said Premises; but notwithstanding such re-entry by Lessor, the liability of Lessee for the results provided for herein shall not be extinguished for the balance of the Term of this Lease (and Option Term if applicable); and Lessee covenants and agrees to make good to Lessor any deficiency arising from re-entry and re-letting of the Premises at a lesser rental than herein agreed to. Lessee shall pay such deficiency each month as the amount thereof is ascertained by Lessor.

15. Storage of Personal Property: In the event of any re-entry or re-taking of possession of the Premises as hereinabove provided, Lessor shall have the right, but not the obligation, to remove from the Premises all personal property located therein and may place the same in storage in a public warehouse at the expense and risk of the owners thereof.

16. Assignment: Lessee shall not, without written consent of Lessor, let or sublet the whole or any part of the Premises or assign this Lease. Lessor's consent shall not be unreasonably withheld. This Lease shall not be assignable by operation of law.

17. Consent to Subletting or Assignment: It is expressly agreed that if consent is once given by Lessor to the assignment of this Lease, or to any subletting of the Premises, then Lessor shall not be barred from afterward refusing to consent to any further assignment or subletting. Lessor's consent shall not be unreasonably withheld.

18. Destruction of Premises: If these Premises are destroyed or injured by fire, earthquake or other casualty, Lessor may at its option, proceed to rebuild and restore said Premises or such part thereof as may be injured, provided that within thirty (30) days after such destruction or injury, Lessor shall, in writing, notify Lessee of Lessor's intention to so rebuild or restore, and during the period of such rebuilding or restoration, rentals shall abate in the same ratio that the portion of the Premises rendered for the time being unfit for occupancy shall bear to the whole Premises. If Lessor shall fail to rebuild and restore the Premises and to notify Lessee thereof, as aforesaid, then this Lease shall, at the expiration of the time for providing the notice above referred to, be deemed terminated, and all rights and liabilities by and between the parties shall thereupon cease.

19. Notices: Any notices required or permitted to be made or given by one party to the other by the terms of this Lease shall be posted in the United States mail, postage prepaid and certified mail, return receipt requested, addressed to the party at the address shown below.

Jankelson Lacey Partnership, LP
% Targa Real Estate
P.O. Box 4508
Federal Way, Wa 98063
253-925-2242
Email: Targa@TargaRealEstate.com

Symbol Healthcare, Inc., d/b/a
Puget Sound Home Health
27101 Puerta Real, Suite 450
Mission Viejo, CA 92691

20. Attorney's Fees: If either Lessor or Lessee institutes a suit concerning this Lease, the prevailing party is entitled to reasonable attorneys' fees and expenses, and other related legal expenses, including expert witness' fees, and attorney's fees for services rendered in the appeal of any action. The venue of any suit shall be in Pierce County, Washington, and this Lease shall be governed by and construed in accordance with the laws of the State of Washington.

21. Binding on Heirs and Assigns: The covenants and agreements of this Lease shall be binding not only upon Lessee and Lessor, but also upon their heirs, executor, administrator, successors and assigns.

22. Modifications: It is understood and agreed that this Lease contains the entire agreement between the parties hereto and shall not be modified in any manner except by and instrument in writing executed by the parties hereto.

23. Quiet Possession: Provided Lessee has performed all of its obligations hereunder, Lessor shall ensure that Lessee may peaceably and quietly hold and enjoy the Premises for the duration of this Lease, without

hindrance from Lessor or any party claiming by, through or under Lessor, but not otherwise, subject to the terms and conditions of this Lease.

24. Unlawful Use: Lessee will not disturb other occupants of said Building by making any undue or unseemly noise, or otherwise, and will not do or permit to be done in or about the Premises anything which is illegal or unlawful, or which will be dangerous to life or limb, or will increase any insurance rate upon said Premises or said Building.

25. Estoppel Certificate: Lessee shall at any time upon not less than ten days prior written notice from Lessor, execute, acknowledge and deliver to Lessor a statement in writing (i) certifying that this Lease is unmodified and in full force and effect (or, if modified, stating the nature of such modification and certifying that this Lease, as so modified, is in full force and effect), and the date to which rent and other charges are paid in advance, if any, and (ii) acknowledging that there is not, to Lessee's knowledge, and uncured defaults on the part of Lessor hereunder, or specifying such default, if any are claimed. Any such statement may be conclusively relied upon by any prospective purchaser or encumbrancer of the property.

At Lessor's option, Lessee's failure to deliver such statement within such time shall be a material breach of this Lease; or, it shall be deemed conclusive upon the Lessee (i) that this Lease is in full force and effect, without modification except as may be represented by Lessor, (ii) that there are no uncured defaults in Lessor's performance, and (iii) that not more than one month's rent has been paid in advance.

26. Subordination: This Lease, at Lessor's option, shall be subordinate to any ground lease, mortgage, deed of trust, or any other hypothecation or security now or hereafter placed upon the Building, to any and all advances made on the security thereof, and to all renewals, modifications, consolidations, replacements and extensions thereof. Notwithstanding such subordination, Lessee's right to quiet possession of the Premises shall not be disturbed if Lessee is not in default, and so long as Lessee shall pay rent and observe and perform all provisions of this Lease, unless this Lease is otherwise terminated pursuant to its terms. If any mortgagee, trustee or ground lessor shall elect to have this Lease prior to the lien of its mortgage, deed of trust or ground lease, and shall give written notice thereof to Lessee, this Lease shall be deemed prior to such mortgage, deed of trust or ground lease, whether this Lease is dated prior or subsequent to the date of said mortgage, deed of trust or ground lease, or to the date of the recording thereof.

Lessee agrees to execute any documents required to effect an attornment, a subordination, or to make this Lease prior to the lien of any mortgage, deed of trust or ground lease, as the case may be. Lessee's failure to execute such documents within ten days after written demand shall constitute a material default by Lessee hereunder, or, at Lessor's option, Lessor shall execute such documents on behalf of Lessee as Lessee's attorney-in-fact. Lessee does hereby make, constitute and irrevocably appoint Lessor as Lessee's attorney-in-fact and in Lessee's name, place and stead, to execute such documents in accordance with this paragraph.

28. Sale of Premises by Landlord: In the event of any sale of the Premises by Lessor, Lessor shall be and is hereby entirely freed and relieved of all liability under any and all of its covenants and obligations contained in or derived from this Lease arising out of any act, occurrence, or omission occurring after the consummation of such sale; and the Purchaser, at such sale or any subsequent sale of the Premises shall be deemed, without any further agreement between the parties or their successors in interest, or between the parties and any such purchaser, to have assumed and agreed to carry out any and all of the covenants and obligations of the Lessor under this Lease.

IN WITNESS HEREOF we have hereto set our hand and seals the day of the year first above written.

LESSOR:
Jankelson Lacey Partnership, LP

by Kimberly Woods, Partner

DATE 10/27/2015

LESSEE:
Symbol Healthcare, Inc., d/b/a Puget Sound Home Health

BY DEVIN A. CHRISTENSEN
ITS EXECUTIVE DIRECTOR

DATE 10/23/15

LANDLORD ACKNOWLEDGEMENT

STATE OF WASHINGTON)
) ss.
COUNTY OF PIERCE)

On this 27th day of October, 2015, before me the undersigned notary public in and for the State of Washington duly commissioned and sworn personally appeared Kimberly Woods to me known to be the Partner of the Jamerson Lacey Partnership, described and who executed the foregoing instrument and acknowledged to me that he signed as his free and voluntary act and deed for the uses and purposes therein mentioned.

WITNESS my hand and official seal thereto affixed the day and year in this certificate above written.

GENEVIEVE L. MONTGOMERY
STATE OF WASHINGTON
NOTARY PUBLIC
MY COMMISSION EXPIRES
10-06-18

Notary Public in and for the State of Washington
residing at Tacoma, WA

TENANT ACKNOWLEDGEMENT

STATE OF WASHINGTON)
) ss.
COUNTY OF PIERCE)

On this 26 day of October, 2015, before me the undersigned notary public in and for the State of Washington duly commissioned and sworn personally appeared DEVIN CHRISTENSEN to me known to be the Executive Director of the corporation that executed the within said foregoing instrument, and acknowledged that said instrument to be the free and voluntary act and deed of said corporation for the uses and purposes therein mentioned, and on oath stated that _____ was authorized to executed said instrument.

WITNESS my hand and official seal thereto affixed the day and year in this certificate above written.

Notary Public in and for the State of Washington, residing at Lakewood, WA

JORDAN O GRAHAM
NOTARY PUBLIC
STATE OF WASHINGTON
COMMISSION EXPIRES 07-01-17

EXHIBIT "A"

4002 Tacoma Mall Blvd.
Tacoma, Washington 98409

Tax Description
Section 18 Township 20 Range 03 Quarter 41 HOUGHTONS: HOUGHTONS L 11 THRU 16 B 6 EXC POR L 16 TO CY OF TAC TOG/W VAC 23072

EXHIBIT "B"

This Exhibit shall serve as attachment to the Lease by and between Symbol Healthcare, Inc., d/b/a Puget Sound Home Health, referred to as Lessee, and Jankelson Lacey Partnership, LP, referred to as Lessor, for the Premises located at 4002 Tacoma Mall Blvd, Suite 204, Tacoma, WA 98409.

1. Rent: Rent Commencement shall be December 1, 2015. Rent is due on the first of each month without deduction or right of offset. Any late rent payments shall be subject to an additional charge of five (5%) percent of said month's rent amount, and shall become immediately due upon the tenth (10th) day of the month. Minimum monthly rent shall be as follows:

For the months December 2015 through December 2016, monthly rent of	$7,000.00
For the months January 2017 through December 2017, monthly rent of	$7,210.00
For the months January 2018 through December 2018, monthly rent of	$7,426.00
For the months January 2019 through December 2019, monthly rent of	$7,649.00
For the months January 2020 through December 2020, monthly rent of	**$7,879.00**

Monthly rent for the Option Term shall be the then current fair market rate for the Premises, as mutually agreed upon by Lessor and Lessee.

2. Additional Rent: Lessee shall pay as additional rent its pro rata share of any increase in building operating expenses over the base year of 2016, beginning in January, 2017. Building operating expenses include, but are not limited to, real estate taxes, common area maintenance. (including without limitation: general maintenance and repairs; gardening and landscaping; painting; re-striping; lighting; lamp replacement; sanitary control; public liability and property damage insurance; utilities, licenses, and fees for common area facilities; cleaning, sweeping, and janitorial service; garbage compaction and disposal; removal of snow, traffic regulation, and guard or police services), building insurance, common building costs (including operating, maintaining, repairing and replacing common mechanical, electrical, plumbing, automatic fire sprinkler and other utilities systems), and building utilities.

Lessee's pro rata share of such monthly adjustments shall be that percentage of the total charges that the premises to the total number of square feet of gross leasable floor area now or hereafter in the Building, or such portions thereof as determined by Lessor to be applicable to the premises. "Gross floor area" is ground floor area, measured from the outside of the exterior walls and from the center of interior separation partitions

3. Improvements Provided by Lessor: Lessee agrees that it has inspected said Premises, and takes same in an "as is" condition, except for the following work to be performed by Lessor:

(1) Expand the existing conference room by removing walls and constructing new walls as shown on the attached Exhibit D.
(2) Remove door and replace with double-glass panel as shown on the attached Exhibit D
(3) Install new cabinets, countertop, and flooring in the existing kitchen area.
(4) Construct a wall behind the reception window as shown on the attached Exhibit D.
(5) Install new floor covering throughout the Premises.
(6) Patch walls and paint.
(7) Replace broken / damaged ceiling tiles.
(8) Replace front door lock. ("difficult" according to Kim)
(9) Repair Cabinets in Copy area.

4. Insurance: Lessee shall carry its own contents insurance, and Lessor shall not be responsible for damage or injury to persons or property of the Lessee (including to Lessee's contents) from any water

source or cause whatsoever, including water leaks from roof, walls, floor, plumbing, or any other source whatsoever, or from dampness and any direct or indirect consequences of dampness..

Lessor or its agent shall not be liable for, and Lessee agree to defend and hold Lessor and its agent harmless from , any claim, action and/or judgment for damages to property or injury to persons suffered or alleged to be suffered on the Premises by any person, firm or corporation, unless caused by Lessor's negligence.

Lessee agrees to maintain public liability insurance on the Premises for property damage and for bodily injury and death in the form of combined single limit for bodily injury and death and property damage in a minimum amount of $1,000,000.00, and shall name Lessor as an additional insured. Lessee shall furnish Lessor a certificate indicating that the insurance policy is in full force and effect, the Lessor has been named as an additional insured, and that the policy may not be cancelled unless ten (10) days prior written notice of the proposed cancellation has been given to Lessor.

Lessee, and its agents, employees, directors, officers, affiliates, and contractors shall not be liable for, and Lessor agrees to defend and hold Lessee and its agents, employees, directors, officers, affiliates, and contractors harmless from, any claim, action and/or judgment for damages to property or injury to persons suffered or alleged to be suffered in the Building by any person, firm or corporation, unless caused by Lessee's negligence.

Lessor agrees to maintain liability insurance on the Building for property damage and for bodily injury and death in the form of combined single limit for bodily injury and death and property damage in a minimum amount of $1,000,000.00.

LESSOR:
Jankelson Lacey Partnership, LP

by Kimberly Woods, Partner

DATE 10/27/2015

LESSEE:
Symbol Healthcare, Inc., d/b/a Puget Sound Home Health

BY DEVIN A. CHRISTENSEN
ITS EXECUTIVE DIRECTOR

DATE 10/26/15

EXHIBIT D

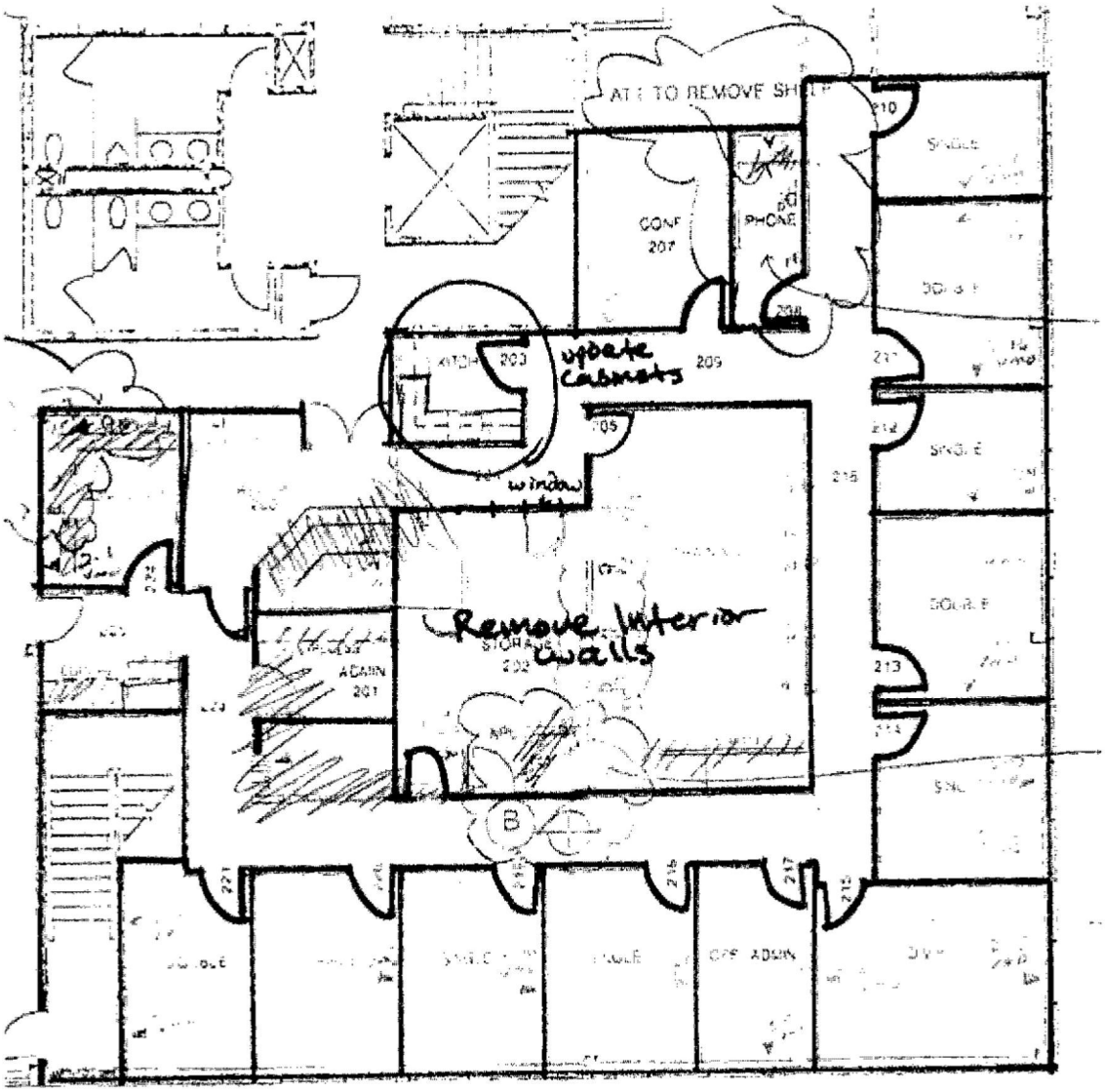
CONF
207
PHONE
update
cabinets
209
203
205
window
Remove interior
walls
ADMIN
201
B

EXHIBIT C

SIGNS

All signs or symbols placed by Lessee in the windows and doors of the Premises, or upon any exterior part of the building, shall be subject to Lessor's prior written approval, which approval shall not be unreasonably withheld. Lessor may demand the removal of signs which are not so approved, and Lessor's failure to comply with said written notice within forty-eight (48) hours will constitute a breach of this paragraph and will entitle Lessor to terminate this Lease or, in lieu thereof, to cause the sign to be removed and the Building to be repaired at the sole expense of Lessee. At the termination of this Lease, Lessee will remove all signs placed by it upon the Premises, and will repair any damage caused by such removal. All signs must comply with sign ordinances and be placed in accordance with required permits.

This Exhibit C is made a part of the Lease Agreement dated October 15, 2015, between Jankelson Lacey Partnership, LP, Lessor, and Puget Sound Home Health, Lessee.

LESSOR:
Jankelson Lacey Partnership, LP

by Kimberly Woods, Partner

DATE 10/27/2015

LESSEE:
Symbol Healthcare, Inc., d/b/a Puget Sound Home Health

BY DEVIN A. CHRISTENSEN
ITS EXECUTIVE DIRECTOR

DATE 10/23/15

Johnson, Lee

From: Johnson, Lee
Sent: Tuesday, November 16, 2021 5:32 PM
To: DOH HSQA CHS CON
Subject: King County Hospice Letter of Intent
Attachments: CN Letter of Intent - Symbol Healthcare, Inc.pdf

Dear Washington Certificate of Need Department,

Consistent with the requirements of WAC 246-310-290 (3),please accept the attached letter of intent for Cycle 1 (King County).

Please confirm receipt. Thank you!

Warm Regards,

Lee Johnson
Director of Licensing & Regulatory Services

1675 E. Riverside Dr., Ste 200, Eagle, Idaho 83616
Desk: 208.401.1369
Cell: 208.600.2519
Fax: 208.576.6909

PENNANT SERVICES
Servicing Cornerstone, Pinnacle, and Pennant

LEE L. JOHNSON
TREASURER
SYMBOL HEALTHCARE, INC.

direct line (208) 401-1369
direct fax (208) 576-6909
leejohnson@pennantservices.com

November 16, 2021

Via Email to FSLCON@doh.wa.gov

Eric Hernandez, Program Manager
Certificate of Need Program
Department of Health
111 Israel Road SE
Tumwater, WA 98501

Dear Mr. Hernandez:

In accordance with WAC 246-310-080, Symbol Healthcare, Inc., hereby submits a letter of intent proposing to establish a Medicare certified/Medicaid eligible hospice agency. In conformance with the requirements of WAC, the following information is provided:

1. A Description of the Extent of Services Proposed:
Symbol Healthcare, Inc., is proposing to establish a Medicare certified/Medicaid eligible hospice agency to needed palliative care to the terminally ill and bereavement care to families of King County. As necessary, other services will include health and medical services, personal care, respite and homemaker services.

2. Estimated Cost of the Proposed Project:

The capital expenditure associated with this project is estimated at $15,000.

3. Description of the Service Area:

The primary service area for the hospice agency will be King County.

Please do not hesitate to contact me if you have any questions or require additional information.

Sincerely,

Symbol Healthcare, Inc.
By:

Lee L. Johnson, Treasurer
Direct office line: (208) 401-1369

Pennant Group Affiliate

LANGUAGE ACCESS PLAN AND POLICY

2019

TABLE OF CONTENTS

Summary of Nondiscrimination in Health Programs and Activities

The Department of Health and Human Services (HHS) issued the Final Rule implementing the prohibition of discrimination under Section 1557 of the Affordable Care Act (ACA) of 2010. The Final Rule, Nondiscrimination in Health Programs and Activities, was issued to advance equity and reduce health disparities by protecting some of the populations that have been most vulnerable to discrimination in the health care context. The final rule provides consumers' rights under the law and provides covered entities important guidance about their obligations.

Section 1557 builds on long-standing and familiar Federal civil rights laws: Title VI of the Civil Rights Act of 1964 (Title VI), Title IX of the Education Amendments of 1972 (Title IX), Section 504 of the Rehabilitation Act of 1973 (Section 504), and the Age Discrimination Act of 1975 (Age Act). Most notably, Section 1557 is the first Federal civil rights law to prohibit discrimination on the basis of sex in all health programs and activities receiving Federal financial assistance.

The rule covers:

- Any health program or activity, any part of which receives funding from HHS (such as hospitals that accept Medicare or doctors who accept Medicaid);
- Any health program that HHS itself administers;
- Health Insurance Marketplaces and all plans offered by issuers that participate in those Marketplaces

Protections under the rule

Section 1557 builds on prior Federal civil rights laws to prohibit sex discrimination in health care. The final rule requires that women be treated equally with men in the health care they receive and also prohibits the denial of health care or health coverage based on an individual's sex, including discrimination based on pregnancy, gender identity, and sex stereotyping. The final rule also requires covered health programs and activities to treat individuals consistent with their gender identity.

For individuals with disabilities, the final rule requires covered entities to make all programs and activities provided through electronic and information technology accessible; to ensure the physical accessibility of newly constructed or altered facilities; and to provide appropriate auxiliary aids and services for individuals with disabilities. Covered entities are also prohibited from using marketing practices or benefit designs that discriminate on the basis of disability and other prohibited bases.

Covered entities must take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in their health programs and activities.

Enforcement

The existing enforcement mechanisms under Title VI, Title IX, Section 504 and the Age Act apply for redress of violations of Section 1557. These mechanisms include: requiring covered entities to keep records and submit compliance reports to OCR, conducting compliance reviews and complaint investigations, and providing technical assistance and guidance.

The U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR) enforces Section 1557. When OCR finds violations, a health care provider will need to take corrective actions, which may include revising policies and procedures, and/or implementing training and monitoring programs. Health care providers may also be required to pay monetary damages. Section 1557 also allows individuals to sue health care providers in court for discrimination.

Where noncompliance be corrected by informal means, available enforcement mechanisms include suspension of, termination of, or refusal to grant or continue Federal financial assistance; referral to the Department of Justice with a recommendation to bring proceedings to enforce any rights of the United States; and any other means authorized by law.

While Section 1557 pertains to operations receiving state or federal funds, it is recommended that 100% private pay communities initiate this plan as well.

LANGUAGE ACCESS POLICY

Purpose

The purpose of this policy is to describe and outline how Pennant-affiliated facilities and entities will provide individuals with meaningful access to healthcare and prohibit discrimination on the basis of race, color, national origin, sex, or disability.

The use of the term individual within this policy shall denote patient or resident.

Scope

The scope of this policy applies to all Pennant-affiliated facilities and entities (herein "operation") receiving funding from HHS.

Policy Statement

As recipients of Federal financial assistance, operations do not exclude, deny benefits to, or otherwise discriminate against any individual on the basis of race, color, national origin, sex, age, or disability. Operation will provide individuals with limited English proficiency (herein "LEP") and disabilities meaningful and equal access to health programs and activities in accordance with Section 1557 of The Patient Protection and Affordable Care Act.

Policy

Operation will;

1. Not deny or delay services based on an individual's race, color, national origin, disability, age, or sex.
2. Not aid or assist others in such discriminatory practices.
3. Develop a grievance procedure whereby individuals may file a complaint with regard to perceived discrimination.
4. Take reasonable steps to provide meaningful access to individuals with LEP and/or disabilities in a timely manner and at no cost.
5. Protect the privacy and independence of individuals with limited English proficiency
6. In conspicuous public spaces and on the operation's website home page post Notice of Nondiscrimination, in the two languages most widely used in the entity's state (likely English and Spanish).
7. In conspicuous public spaces and on the operation's website home page post taglines in the top 15 languages spoken in the State in which the operation is located.
8. Translate vital documents in the top 2 languages spoken in the State in which the operation is located.
    a. These documents may include; admission agreements, consents and complaint/grievance forms, intake forms with the potential for important

consequences, and written notices of eligibility criteria, rights, denial, loss, or decreases in benefits or services.

9. Provide, in a timely manner and free of charge, auxiliary aids and services (which may include video remote interpreting services) to individuals with impaired sensory, manual, or speaking skills.
10. Use only qualified interpreters for language access services (definition of qualified interpreter may be found in appendix A).
    a. Excludes bilingual/multilingual staff members with the exception of those taking and passing an assessment
11. Adopt practices to qualify staff as interpreters by meeting the qualifications of "qualified bilingual/multilingual staff," i.e., workforce who is designated by the operation to provide oral language assistance as part of the individual's current, assigned job responsibilities and who has demonstrated that he or she:
    a. Is proficient in speaking and understanding both spoken English and at least one other spoken language, including any necessary specialized vocabulary, terminology and phraseology, and
    b. Is able to effectively, accurately, and impartially communicate directly with individuals with limited English proficiency in their primary languages.
12. Report all grievances to Pennant Service's Section 1557 Coordinator; Erin Peterson.
13. Not require individuals to provide their own interpreters.
14. Not rely on minor children accompanying LEP patients/residents as interpreters except in the event of an emergency.
15. Not rely on adults accompanying LEP patients/residents as interpreters except in the event of an emergency, or if LEP patient/resident specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances.
16. Not rely on accompanying adults to interpret and relay medical information.
17. Document the accompanying adult's agreement to provide language assistance services and the circumstances
18. Document language needs and services provided in the patient's/resident's care plan.
19. No operate a health program that is limited to one gender unless there is an exceedingly persuasive justification to limit that program to one gender.

GRIEVANCE POLICY AND PROCEDURE

Purpose

The purpose is to outline Pennant-affiliated facilities and entities' internal grievance policy and procedures providing for prompt and equitable resolution of complaints alleging any discriminatory action prohibited by law.

The use of the term individual within this policy shall denote patient or resident.

Scope

The scope of this policy applies to all Pennant-affiliated facilities and entities (herein "operation") receiving funding from HHS.

Policy Statement

Any individual who believes he or she, or a third party, has been subject to discrimination on the basis of race, color, national origin, sex, age or disability may file a grievance with the operation.

Policy

Operation will;

1. Afford an individual the right to submit a discrimination complaint
2. Refrain from retaliating against any individual filing a discrimination complaint
3. Submit grievances to the compliance department within 2 business days for investigation
4. Compliance will conduct an investigation into the complaint, maintaining documentation related to all grievances, and will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.
5. Compliance will issue a written decision no later than 30 days of receipt of grievance. Written notice will include a notice to the individual of their right to pursue further administrative or legal remedies.

Procedure

Operation shall;

1. Implement a process for receiving complaints regarding perceived discrimination
2. Designate a point of contact to receive discrimination complaints
3. Document discrimination complaints using the *Discrimination Grievance Form*

Discrimination Grievance Form

Name	
Address	
City, State, ZIP	
Telephone Number	
Email address	

Information about the person, agency, or organization you believe discriminated against you

Name	
Address	
City, State, ZIP	
Telephone number	

Description of how, why, and when you believe your civil rights were violated

Description of the action you would like to see taken

Signature	
Date of Complaint	

The availability and use of this grievance procedure does not prevent you from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. Complaints must be filed within 180 days of the date of the alleged discrimination.

A person may file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201

<u>Information you may also include</u>:
Any special accommodations needed for us to communicate with you regarding your complaint
Whether you filed your complaint somewhere else and when you filed.

Notice of Non-discrimination

Pennant affiliates are committed to providing a surprising level of attention and service which includes delivery of care without discrimination based on race, color, national origin, sex, age or disability.

We take reasonable steps to provide meaningful access to each individual with limited English proficiency and/or disabilities. These steps include the provision of language assistance services such as oral language assistance, written information in alternate formats, or oral or written translation through a qualified interpreter and to provide appropriate auxiliary aids and services for persons with disabilities.

For access to these free services, please contact the staff of the agency or company from which you are receiving care.

If you believe we have discriminated against you or failed to provide these free services in a timely manner you may report your concern to:

Erin Peterson, Compliance Officer
Pennant Services, Inc.
1675 E. Riverside Dr. Suite #120, Eagle, Idaho 83616
Phone: 208-506-6063
Fax: 208-401-1401
Email: sec1557@pennantservices.com

You may also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail, email or phone:

Centralized Case Management Operations
U.S. Department of Health and Human Services/Office for Civil Rights
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201

Phone: 800-868-1019
TTD: 800-537-7697
Email: OCRcomplaint@hhs.gov

ELEMENTS AND PROCEDURES

Pennant Services' language access plan is defined in elements that are essential for any language access plan. The Language Access Plan identifies steps that Pennant-affiliated operations (herein "operation") should take to implement the policy and plan at the operation level. Operations have flexibility in how they apply the action steps to their programs and activities, and should provide increasing service levels as the importance of the relevant health care services increases.

ELEMENT 1: Assessment: Needs and Capacity

ELEMENT 2: Oral Language Assistance Services

ELEMENT 3: Written Translations

ELEMENT 4: Policies and Procedures

ELEMENT 5: Notification of the Availability of Language Assistance at No Cost

ELEMENT 6: Staff Training

ELEMENT 7: Assessment: Access and Quality

ELEMENT 8: Procurement of Language Assistance Services

ELEMENT 1: Assessment of Needs and Capacity

Operation shall have processes to regularly identify and assess the language assistance needs of its current and potential patients/residents, as well as processes to assess the capacity to meet these needs according to the elements of this plan.

Description

Operation shall assess the language assistance needs of their current and potential patients/residents in order to drive processes necessary to implement language assistance services that increase access to their respective programs and services for all populations. This assessment may include identifying the non-English languages spoken by the population likely to be accessing the operation's services, and whether barriers – including literacy barriers – exist that hinder effective oral and written communication with individuals with LEP and/or disabilities.

Operation shall also assess its capacity to meet the needs of its current and potential patients/residents in order to fulfill its commitment to provide competent language assistance at no cost and in a timely manner to individuals with LEP and/or disabilities.

Operation shall perform self-assessments to provide meaningful access to and an equal opportunity to participate fully in their services, activities, programs or other benefits. This includes effective communication between individuals with LEP and/or disabilities and staff members and contractors.

The following steps illustrate the actions operation shall take to implement Element 1. Operations have flexibility in how these steps are implemented.

PROCEDURE

Operation shall;

a. Consult internal experts, advocacy organizations, individuals with LEP and/or disabilities, subject matter experts, and applicable research to determine effective practices for assessing and implementing language assistance needs of current and projected patients/residents with respect to all public interface mechanisms, including but not limited to: marketing and outreach; technical assistance; face-to-face and over-the-phone customer service; ombudsman activities; websites; and multilingual survey and other patient/resident assessment instruments.

b. On admission or initiation of care, inquire as to the primary language of the individual and identify need for language assistance services.

c. Identify existing capacity to provide language assistance services, such as Qualified Bilingual/Multilingual Staff to serve as qualified interpreters/translators and the need and availability of contract interpreter and translation services.

d. Identify gaps where language assistance services are inadequate to meet needs of patients/residents and identify and take specific steps to enhance language assistance services.

e. Evaluate the extent of need for language assistance services in particular languages or dialects.

f. Modify existing satisfaction and other surveys of patients/residents and other means of obtaining feedback on services delivered, to include collection of data, including at point of entry, on preferred language, English proficiency.

g. Append language need assessments based on LEP/disability data from patient/resident satisfaction surveys and program reviews.

h. Determine specific circumstances in which an accompanying adult may provide language assistance services, which circumstances are typically limited to emergencies involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with LEP immediately available; or where the individual with LEP specifically requests that accompanying adult to interpret/facilitate communication, the accompanying adult agrees to do so and reliance on that adult for such assistance is appropriate under the circumstances.

ELEMENT 2: Oral Language Assistance Services

Operation shall provide oral language assistance (such as Qualified Interpreters or Qualified Bilingual/Multilingual Staff), in both face-to-face and telephone encounters, that addresses the needs of each patient/resident. Operation shall establish a point of contact for individuals with LEP and/or disabilities, such as a specific staff member.

Description

Operation shall provide oral language assistance services to provide meaningful access to and an equal opportunity to participate fully in the services, activities, programs or other benefits provided by the operation. Language assistance may be provided through a variety of means, including qualified bilingual and multilingual staff, staff or contract interpreters (including telephonic interpretation), and interpreters from community organizations or volunteer interpreter programs. Operation shall use qualified interpreters to provide the service and understand interpreter ethics and patient/resident confidentiality needs.

A single point of contact, such as a specific staff member should coordinate oral language assistance services at operation so that staff can refer any and all patients/residents to a designated person trained to obtain qualified interpreter services in a timely manner.

The following steps illustrate the actions operation shall take to implement Element 2. Operations have flexibility in how these steps are implemented.

PROCEDURE

Operation shall;

a. Develop a program that provides individuals with LEP and/or disabilities participating or attempting to participate in operation programs or activities oral language assistance services in accordance with this plan.

b. Provide points of contact to provide individuals with LEP and/or disabilities an interpreter at no cost.

c. Devise criteria for assessing bilingual staff to determine ability to provide services in languages other than English and to provide competent interpreter services.

d. Maintain a list of Qualified Bilingual/Multilingual Staff capable of providing competent interpreter services in languages other than English.

e. Establish and post notice of a list of all contacts and other resources available to the operation in providing direct, telephonic, or video oral language assistance to individuals with LEP and/or disabilities seeking information on or access to operation programs and activities.

f. Identify positions appropriate for making bilingual skill a selection criterion for employment, include such criterion in the position description and job announcement, and determine applicants' language skills before making hiring decisions.

ELEMENT 3: Written Translations

Operation will identify, translate (or use a qualified translator) and make accessible in various formats, including print and electronic media, vital documents in languages other than English in accordance with assessments of need and capacity of patients/residents.

Description

Operation shall provide written translations to provide meaningful access to and an equal opportunity to participate fully in the services, activities, programs or other benefits provided by the operation. All vital documents, regardless of language, should be easy to understand by target audiences. Matters of plain language and literacy should be considered for all documents, including vital documents before and after the translation process.

The following steps illustrate the actions operation shall take to implement Element 3. Operations have flexibility in how these steps are implemented.

PROCEDURE

Operation shall;

a. Provide points of contact to ensure staff and managers can arrange for document translation when necessary to improve access to operation's programs and activities.

b. Identify documents where the operation regularly encounters languages other than English in serving its patients/residents and take steps to provide translation in those non-English languages.

c. Use the services of qualified, professional translators.

ELEMENT 4: Policies and Procedures

Operation shall implement written policies and procedures that ensure individuals with LEP and/or disabilities have meaningful access to operation programs and activities.

Description

Operation shall implement and improve language assistance services within the operation. The results of the assessment from Element 1 should be used to in the development of procedures appropriate for the operation and the current and potential individuals with LEP and/or disabilities they serve.

The following steps illustrate the actions operation shall take to implement Element 4. Operations have flexibility in how these steps are implemented.

PROCEDURE

Operation shall;

a. Implement this Language Access Plan and policy.

b. Regularly monitor the efficacy of services provided.

c. Implement a procedure for receiving language assistance concerns or complaints from patients/customers with LEP and/or disabilities and establish procedures to improve services.

d. Direct concerns or complaints to Pennant Service's Section 1557 Coordinator; Erin Peterson, or the compliance hotline at 866-987-3715.

ELEMENT 5: Notification of the Availability of Language Assistance at No Cost

Operation, in accordance with its needs and capacity and in plain language, will proactively inform and post notices of nondiscrimination and taglines that alert individuals with limited English proficiency to the timely availability of language assistance services at no cost.

Description

Operations shall take steps to provide meaningful access to their programs, including notifying current and potential patients/residents with LEP and/or disabilities about the availability of language assistance in a timely manner and at no cost. Notification methods shall include multilingual posters, signs and brochures, as well as statements on application forms and informational material distributed to the public, including electronic forms such as websites, taglines in English and the top 15 non-English languages spoken in the State, written documents, etc.

The results from the Element 1 assessment should be used to inform the operation on the languages in which the notifications should be translated.

The following steps illustrate the actions operation shall take to implement Element 5. Operations have flexibility in how these steps are implemented.

PROCEDURE

Operation shall;

a. Implement a strategy for notifying individuals with LEP and/or disabilities who contact the operation or are being contacted by the operation, that language assistance is available to them in a timely manner and at no cost.

b. Distribute and make available resources.

c. Provide technical assistance necessary to assist those in need of language assistance services.

d. Prominently display Notice of Nondiscrimination, appropriate language taglines (translated into top 2 languages for small publications and top 15 languages for publications with larger surface areas), web pages currently available in English only, notifying that language assistance is available at no cost and how it can be obtained.

ELEMENT 6: Staff Training

Operation shall provide staff training so they may understand and can implement the policies and procedures of this plan. Training will help all employees understand the importance of and be capable of providing effective communication to individuals with LEP and/or disabilities in all their programs and activities.

Description

Operation shall determine which staff members should receive training in the related policies, procedures, and provision of language assistance services. All staff should be notified that the operation provides language assistance.

The following steps illustrate the actions operation shall take to implement Element 6. Operations have flexibility in how these steps are implemented.

PROCEDURE

Operation shall;

a. Develop, make available, and disseminate training materials that will assist management and staff in procuring and providing effective communication for individuals with limited English proficiency and/or disabilities.

b. Train management and staff on the policies and procedures of the operation-specific language assistance program to provide language assistance to persons with LEP and/or disabilities in a timely manner.

c. Train appropriate staff on when and how to access and utilize oral and written language assistance services, how to work with interpreters and translators, how to convey complex information using plain language, and how to communicate effectively and respectfully with individuals with limited English proficiency and/or disabilities

d. Train staff to competently identify LEP and/or disability contact situations and take the necessary steps to provide meaningful access.

e. When considering hiring criteria, assess the extent to which non-English language proficiency would be necessary for particular positions.

f. Provide ongoing training as needed.

g. Track existing and new staff by non-English languages spoken and level of oral and written proficiency.

h. Identify need for qualifying staff, assessing workload and productivity by taking into account time staff will spend on providing language assistance services.

ELEMENT 7: Assessment of Access and Quality

Operation shall regularly assess the accessibility and quality of language assistance activities for individuals with limited English proficiency and/or disabilities, maintain an accurate record of language assistance services, and implement or improve LEP/disability outreach programs and activities in accordance with patient/resident need and operation capacity.

Description

Operation shall assess and evaluate the language assistance services on an ongoing basis. Areas of evaluation should include patient/resident satisfaction, utilization of appropriate communication channels, and the accessibility and quality of language assistance services provided.

The following steps illustrate the actions operation shall take to implement Element 7. Operations have flexibility in how these steps are implemented.

PROCEDURE

Operation shall;

a. Regularly assess and take necessary steps to improve and ensure the quality and accuracy of language assistance services provided to individuals with LEP and/or disabilities.

b. Review and address complaints received from individuals with LEP and/or disabilities with respect to language assistance services and products or other services provided by the operation, in a timely manner.

c. Identify best practices for continuous quality improvement regarding operation language assistance activities.

d. Assess qualified staff for proficiency in and ability to communicate information accurately in both English and the other language.

e. Assess qualified staff's understanding and following of confidentiality, impartiality, and ethical rules.

f. Assess qualified staff's understanding and adherence to their roles as interpreters.

g. Document discussions surrounding language assistance services quality and improvement.

ELEMENT 8: Procurement of Language Assistance Services

When an operation elects to procure language assistance services, operation shall take reasonable efforts to ensure that any Request for Proposals or contract for language assistance services will specify responsibilities, assign liability, set pay rates, and provide for dispute resolution.

The following steps illustrate the actions operation shall take to implement Element 8. Operations have flexibility in how these steps are implemented.

PROCEDURE

Operation shall;

a. Review contract with Legal Department
b. Review contract for confidentiality and conflicts of interest
c. Verify vendor can meet the operation's demand for interpreters
d. Require qualified and competent interpreters with timely service delivery and emergency response plan
e. Identify with vendor effective complaint resolution when interpretation errors occur
f. Identify with vendor adequate quality control processes

Appendix A: Definitions

Auxiliary Aids and Services

Aids used to accommodate for a disability and may include, among other things; Qualified Interpreters, amplifiers, alternative formats, white boards, large print materials, closed captioning, video translation or video text displays, or equally effective telecommunications devices.

Disability

Physical or mental impairment that substantially limits on or more major life activities. Includes, without limitation, visual, speech, hearing impairments, mental health, diabetes, cancer, heart disease, HIV disease, drug addiction and alcoholism.

Effective Communication

Communication sufficient in providing individuals with LEP and/or disabilities with substantially the same level of access to services received by individuals without LEP and/or disabilities.

Qualified Bilingual/Multilingual Staff

A members of your staff designated by you who is (1) is proficient in speaking and understanding both spoken English and at least one other spoken language, including any necessary specialized vocabulary, terminology and phraseology, and (2) is able to effectively, accurately, and impartially communicate directly with individuals with limited English proficiency in their primary languages.

Qualified Interpreter

A Qualified Interpreter for an individual with a disability is an individual who has been assessed for relevant translation skills, is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, terminology and phraseology and who abides by a code of professional ethics (Code of Ethics for Interpreters in Health Care)

A Qualified Interpreter for an individual with a limited English is an individual who has been assessed for relevant translation skills, who demonstrates a high level of proficiency in at least two languages, and has the appropriate training and experience to render a message spoken or signed in one language into a second language and who abides by a code of professional ethics (Code of Ethics for Interpreters in Health Care).

Qualified Translator

A translator who: (1) Adheres to generally accepted translator ethics principles, including client confidentiality; (2) has demonstrated proficiency in writing and understanding both written English and at least one other written non-English language; and (3) is able to translate

effectively, accurately, and impartially to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology.

Language Access

Achieved when individuals with LEP and/or disabilities can communicate effectively with staff and contractors while participating in operation programs and activities.

Language Assistance Services

All oral and written language services needed to assist individuals with LEP and/or disabilities to communicate effectively with staff and contractors and gain meaningful access and an equal opportunity to participate in the services, activities, programs, or other benefits provided by operation.

Limited English Proficiency (LEP)

Individuals who do not speak English as their primary language and who have limited ability to read, write, speak, or understand English.

Meaningful Access

Language assistance that results in accurate, timely, and effective communication at no cost to an individual with LEP and/or disability. Denotes access that is not significantly restricted, delayed or inferior as compared to access provided to individuals without LEP and/or disability.

Plain Language

Plain language as defined as writing that is clear, concise and well organized.

Preferred Language

The language that an LEP individual identifies as the preferred language that he or she uses to communicate effectively.

Taglines

Brief messages that may be included in or attached to a document. Taglines in languages other than English can be used on documents written in English that describe how individuals with LEP can obtain translation of the document or an interpreter to read or explain the document.

Translation

Conveying meaning from written text in one language to written text in another language.

Translator

An individual who has been assessed for professional skills, demonstrates a high level of proficiency in at least two languages, and has the appropriate training and experience to render a written message into a second language and who abides by a code of professional ethics.

Vital Document

Paper or electronic written material that contains information critical for accessing healthcare services or is required by law. These documents may include, but are not limited to: critical records and notices as part of emergency preparedness and risk communications; online and paper applications; consent forms; complaint forms; waivers; letters or notices pertaining to eligibility for benefits; notices of individual rights; and letters or notices pertaining to the reduction, denial, or termination of services or benefits that require a response from an individual with LEP and/or disability.

Appendix B: Language Access Related Resources

LEP.gov

For more information about Section 1557, including factsheets on key provisions and frequently asked questions, visit http://www.hhs.gov/civil-rights/for-individuals/section-1557

https://www.hhs.gov/sites/default/files/2016-06-07-section-1557-final-rule-summary-508.pdf

https://www.hhs.gov/ocr/index.html

https://www.federalregister.gov/documents/2016/05/18/2016-11458/nondiscrimination-in-health-programs-and-activities

For translated materials, visit www.hhs.gov/civil-rights/forindividuals/section-1557/translated-resources/index.html.

The OCR website has materials on training for the final nondiscrimination rule at http://www.hhs.gov/civil-rights/for-individuals/section-1557/trainingmaterials/index.html.

YOUTUBE VIDEOS

Working with an interpreter: https://www.youtube.com/watch?v=pVm27HLLiiQ

Working with Interpreters in the Healthcare Setting: https://www.youtube.com/watch?v=D2fEgvQmx3s

How to use interpreters effectively: https://www.youtube.com/watch?v=flB3DLEOsmg

Understanding Section 1557's Final Rule: https://www.youtube.com/watch?v=65W7qvYlrGc

Serving Healthcare Patients with Limited-English Proficiency: https://www.youtube.com/watch?v=wxxD1uDugCg

ADMISSION CRITERIA AND PROCESS
Policy No. 4-021.1

PURPOSE

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

POLICY

Puget Sound Hospice will admit any patient with a life-limiting illness that meets the admission criteria.

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

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

While patients are accepted for services based on their hospice care needs, the patient's ability to pay for such services, whether through state or federal assistance programs, private insurance, or personal assets is a factor that will be considered.

The patient's life-limiting illness and prognosis of six (6) months or less will be determined by utilizing standard clinical prognosis criteria developed by the fiscal intermediary's Local Coverage Determinations (LCDs).

Puget Sound Hospice reserves the right not to accept any patient who does not meet the admission criteria.

A patient will be referred to other resources if Puget Sound Hospice cannot meet his/her needs.

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

Admission Criteria

1. The patient must be under the care of a physician. The patient's physician (or other authorized independent practitioner) must order and approve the provision of hospice care, be willing to sign or have a representative who is willing to sign the death certificate, and be willing to discuss the patient's resuscitation status with the patient and family/caregiver.

2. The patient must identify a family member/caregiver or legal representative who agrees to be a primary support care person if and when needed. Persons without such an identified individual and who are independent in their activities of daily living (ADLs) will require a specific plan to be developed at time of admission with the social worker.

3. The patient must have a life-limiting illness with a life expectancy of six (6) months or less, as determined by the attending physician and hospice Medical Director, utilizing standard clinical prognosis criteria developed by LCD.

4. The patient must desire hospice services, and be aware of the diagnosis and prognosis.

5. The focus of care desired must be palliative versus curative.

6. The patient and family/caregiver desire hospice care, agree to participate in the plan of care, and sign the consent form for hospice care.

7. The patient and family/caregiver agree that patient care will be provided primarily in the patient's residence, which could be his/her private home, a family member's home, a skilled nursing facility, or other living arrangements.

8. The physical facilities and equipment in the patient's home must be adequate for safe and effective care.

9. The patient must reside within the geographical area that the Puget Sound Hospice services.

10. Eligibility for participation will not be based on the patient's race, color, religion, age, gender, sexual orientation, disability (mental or physical), communicable disease, or place of national origin.

11. If applicable, the patient must meet the eligibility criteria for Medicare, Medicaid, or private insurance hospice benefit reimbursement.

12. Eligibility criteria will be continually reviewed on an ongoing basis by the interdisciplinary team to assure appropriateness of hospice care.

PROCEDURE

1. The organization will utilize referral information provided by family/caregiver, health care clinicians from acute care facilities, skilled or intermediate nursing facilities, other agencies, and physician offices in the determination of eligibility for admission to the program. If the request for service is not made by the patient's physician, he/she will be consulted prior to the evaluation visit/initiation of services.

2. The Clinical Supervisor will assign hospice personnel to conduct initial assessments of eligibility for services within the time frame requested by the referral source, or based on the information regarding the patient's condition or as ordered by the physician (or other authorized independent practitioner).

3. Assignment of appropriate hospice personnel to conduct the initial assessments of patient's eligibility for admission will be based on:

   A. Patient's geographical location

   B. Complexity of patient's hospice care needs/level of care required

   C. Hospice personnel's education and experience

   D. Hospice personnel's special training and/or competence to meet patient's needs

   E. Urgency of identified need for assessment

4. In the event that the time frame for assessment cannot be met, the patient's physician and the referral source, as well as the patient, will be notified for approval of the delay.

   A. Such notification and approval will be documented.

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

5. A hospice registered nurse will make an initial contact prior to the patient's hospital discharge, if possible or appropriate. The initial home visit will be made within the time frame requested by the referral source and according to organization policy, or as ordered by the physician (or other authorized independent practitioner). The purpose of the initial visit will be to:

   A. Explain the hospice philosophy of palliative care with the patient and family/caregiver as unit of care.

   B. Provide a written copy and explain (verbally) the patient's rights and responsibilities and grievance procedure. (See "Patient Bill of Rights" Policy No. 2-002.)

   C. Provide the patient with a copy of Puget Sound Hospice notice of privacy practices.

   D. Assess the family/caregiver's ability to provide care.

   E. Evaluate physical facilities and equipment in the patient's home to determine if they are safe and effective for care in the home.

   F. Allow the patient and family/caregiver to ask questions and facilitate a decision for hospice services especially provided under the Medicare/Medicaid hospice benefit.

G. Review appropriate forms and subsequently sign forms by patient and family/caregiver once agreement for the hospice program has been decided.

H. Provide services as needed and ordered by physician (or other authorized independent practitioner), and incorporate additional needs into the hospice plan of care.

I. Give patient information about durable power of attorney for health care, if the patient has not already done so.

6. During the initial assessment visit, the admitting clinician will assess the patient's eligibility for hospice services according to the admission criteria and standard prognosis criteria to determine/confirm further:

   A. Level of services required and frequency criteria

   B. Eligibility (according to organization admission criteria)

   C. Source of payment

7. If eligibility criteria is met the patient and family/caregiver will be provided with a hospice brochure and various educational materials providing sufficient information on:

   A. Nature and goals of care and/or service

   B. Hours during which care or service are available (physician, nursing, drugs and biological are available 24 hours/day. All other services are available to meet individual patient care needs)

   C. Access to care after hours

   D. Costs/charges to the patient, if any, for care, treatment or services

   E. Hospice mission, objectives, and scope of care provided directly and those provided through contractual agreement

   F. Safety information

   G. Infection control information

   H. Emergency preparedness plans

   I. Available community resources

   J. Complaint/grievance process

K. Advance Directives

L. Availability of spiritual counseling in accordance with religious preference

M. Hospice personnel to be involved in care

N. Mechanism for notifying the patient and family/caregiver of changes in care and any related liability for payment as a result of those changes

8. The hospice registered nurse will document that the above information has been furnished to the patient and family/caregiver and any information not understood by the patient and family/caregiver.

9. The patient and family/caregiver, after review, will be given the opportunity to either accept or refuse services.

10. The patient or his/her representative will sign the required forms indicating election of hospice care and receipt of patient rights and privacy information.

11. Refusal of services will be documented in the clinical record. Notification of the Clinical Supervisor, attending physician, and referral source will be completed and documented in the clinical record.

12. The hospice registered nurse will assist the family in understanding changes in the patient's status related to the progression of an end-stage disease.

13. The hospice registered nurse will educate the family in techniques for providing care.

14. The hospice registered nurse will contact the physician for clinical information in writing to certify patient for hospice care.

15. The hospice registered nurse will complete an initial assessment during this visit within 48 hours after the election of the hospice care (unless the physician, patient or representative requests that the initial assessment be completed in less than 48 hours.) (See "Initial Assessment" Policy No. 4-041.)

16. The hospice registered nurse will contact at least one (1) other member of the interdisciplinary group for input into the plan of care, prior to the delivery of care. The two (2) remaining core services must be contacted and provide input into the plan of care within two (2) days of start of care; this may be in person or by phone.

17. If the patient is accepted for hospice care, a comprehensive assessment of the patient will be performed no later than 5 calendar days after the election of hospice care. A plan of care will be developed by the attending hospice physician, the Medical Director or physician designee, and the hospice team. It will then be submitted to the attending physician for signature. The patient's wishes/desires will be considered and respected in the development of the plan of care. (See "Comprehensive Assessment" Policy No. 4-042.)

18. The time frames will apply for weekends and holidays, as well as weekday admissions.

19. A clinical record will be initiated for each patient admitted for hospice services.

20. If a patient does not meet the admission criteria or cannot be cared for by Puget Sound Hospice, the Clinical Supervisor should be notified and appropriate referrals to other sources of care made on behalf of the patient.

21. The following individuals should be notified of non-admits:

    A. Patient

    B. Physician

    C. Referral source (if not physician)

22. A record of non-admits will be kept for statistical purposes, with date of referral, date of assessment, patient name, services required, physician, reason for non-admit, referral to other hospice care facilities, etc.

23. In instances where patient does not meet the stated criteria for admission to the program, exceptions will be decided upon by the Executive Director/Administrator in consultation with the Medical Director, upon request of the referring party and/or the patient.

24. In instances where continued care to a patient contradicts the recommendations of an external or internal entity performing a utilization review, the Executive Director/Administrator will be notified. All care, service, and discharge decisions must be made in response to the care required by the patient, regardless of the external or internal organization's recommendation. The patient and family/caregiver, as appropriate, and physician will be involved in deliberations about the denial of care or conflict about care decisions.

25. A record of conflict of care issues and outcomes will be kept for statistical purposes, referencing the date of the conflict of care issue, the patient name, the external or internal organization recommendations and reasons, and complete documentation of organization decision and patient care needs.

CHARITY CARE
Policy No. 3-007.1

PURPOSE

To detail the process utilized for patients in need of hospice services under the charity care policy as required by the Washington State Department of Health.

POLICY

Patients without third-party payer coverage and who are unable to pay for medically necessary hospice care will be accepted for charity care admission, per established criteria set forth by Federal and Washington State Department of Health.

Alpha Hospice will establish objective criteria and financial screening procedures for determining eligibility for charity care.

Once Federal and State hospice clinical admission guidance, all patients in need of hospice will receive Alpha Hospice services expeditiously regardless of ability to pay, race, color, gender, gender identity, religion, age, or citizenship.

The organization will consistently apply the charity care policy.

PROCEDURE

1. When it is identified that the patient has no source for payment of services and requires medically necessary care/service, **a request will be made for the patient to provide** personal financial information upon which the determination of charity care will be made.

    - **A in person, or virtually, interview with the patient/family will take place to to determine hospice eligibility and need, financial hardship, and charity care needs.**

    - **The patient will be admitted as soon as reasonably possible, the determination of qualifying for charity care will not delay the start of hospice care and services.**

2. **The hospice social worker with meet in person or virtually, the patient and or patient representative to determine financial assistance or charity care eligibility for Federal and or state funding, insurance programs, and community financial assistance programs.**

    - **If the patient or family is able, the hospice social worker will the assist patient in completing a financial declaration.**

    - **The hospice social worker will assist the patient and family as needed in navigating available community resources and or financial aid.**

    Any patient without the ability to pay, who meets all established admission criteria will be admitted to Alpha Hospice services without charge.

3. The Executive Director/Administrator, with the appropriate program director, will review all applicable patient information, including financial declarations, physician (or other authorized licensed independent practitioner) orders, initial assessment information, and social work notes to determine acceptance for charity care.

    - **If it is determined the patient has a limited or any ability to pay for hospice services, a payment sliding scale based on income will be used.**

4. All documentation utilized in the determination for acceptance for charity care will be maintained in the patient's billing record.

5. **If at any time the financial declarations (or the patient) reveal the patient is able to make partial payment for services, the Executive Director/Administrator, with the appropriate program director, will determine the sliding scale payment amount (if any) to be paid.**

6. **A revised sliding-fee schedule will be reviewed with the patient or patient representative, a payment plan will be agreed upon based on patient ability to pay and the Federal Poverty Level Guidelines updated 8/23/2020.**

7. **The patient's ability to pay will be reassessed every 120 days (after first hospice certification period.**

8. **If at any time Alpha Hospice is unable to admit the patient to hospice or to continue hospice charity care, every effort will be made to refer and guide the patient to the appropriate care/service with an alternate provider. The patient will not be discharged from the hospice service until adequate arrangements for continued hospice care have been secured.**

9. The referral source will be advised of acceptance, non-acceptance, continuation, or discharge from charity care.

PASSION FOR LEARNING

NONDISCRIMINATION STATION

Section 1557 of the Affordable Care Act

Does Section 1557 and other nondiscrimination laws apply to my facility?

YES!

- ✓ These laws apply to <u>any provider</u> that receives federal financial assistance which includes Medicare and Medicaid

What should I know??

- ✓ You may not discriminate against an individual if they are appropriate for admission
- ✓ You may not delay or deny services to those with Limited English Proficiency (LEP) or disabilities including deafness
- ✓ You may not discriminate against any individual based on race, color, national origin, sex, age or disability
- ✓ You are required to provide every individual with equal access to their healthcare
- ✓ You are required to provide language assistance services FREE and in a TIMELY manner. You may NOT require an individual to provide their own language assistance services

What could happen if we are not in compliance?

- ❖ State survey citations
- ❖ Litigation with the potential for significant jury verdict awards
- ❖ Fines
- ❖ Office for Civil Rights (OCR) investigation
- ❖ Corrective Action Plan dictated by OCR
- ❖ Suspension or termination from participating in Medicare or Medicaid
- ❖ Reputational harm

WATCH YOUR EMAIL FOR MORE INFORMATION AND RESOURCES

Where do I go for more information?

Visit the Non-Discrimination section on Pennant University:
http://learning.pennantservices.com/moodle/course/view.php?id=43&section=4

Who do I contact with questions?

COMPLIANCE CONTACTS
Jennifer Bertino – (949) 426-4309
Erin Peterson – (208) 401-6063

NONDISCRIMINATION POLICY AND GRIEVANCE PROCESS
Policy No. 2-037.1

PURPOSE

To prevent organization personnel from discriminating against other personnel, patients, or other organizations on the basis of race, color, religion, age, sex (an individual's sex, gender identity, sex stereotyping, pregnancy, childbirth and related conditions), sexual orientation, disability (mental or physical), communicable disease, or national origin.

POLICY

In accordance with Title VI of the Civil Rights Act of 1964, Section 1557 of the Affordable Care Act (ACA) of 2010 and its implementing regulation, Puget Sound Hospice will, directly or through contractual or other arrangement, admit and treat all persons without regard to race, color, or place of national origin in its provision of services and benefits, including assignments or transfers within facilities.

In accordance with Section 504 of the Rehabilitation Act of 1973, Section 1557 of the Affordable Care Act (ACA) of 2010 and its implementing regulations, Puget Sound Hospice will not, directly or through contractual or other arrangements, discriminate on the basis of disability (mental or physical) in admissions, access, treatment or employment.

In accordance with the Age Discrimination Act of 1975, Section 1557 of the Affordable Care Act (ACA) of 2010 and its implementing regulation, Puget Sound Hospice will not, directly or through contractual or other arrangements, discriminate on the basis of age in the provision of services unless age is a factor necessary to the normal operation or the achievement of any statutory objective.

In accordance with Title II of the Americans with Disabilities Act of 1990, Puget Sound Hospice will not, on the basis of disability, exclude or deny a qualified individual with a disability from participation in, or benefits of, the services, programs or activities of the organization.

In accordance with other regulations the organization will not discriminate in admissions, access, treatment, or employment on the basis of gender, sexual orientation, religion, or communicable disease.

PROCEDURE

1. The Section 504/ADA Compliance Coordinator and Section 1557 Civil Rights Coordinator (can be same person) designated to coordinate the efforts of Puget Sound Hospice to comply with the regulations will be the Executive Director/Administrator. Contact the Executive Director/Administrator at _____ (insert telephone number.)

2. Puget Sound Hospice will identify an organization or person in their service area who can interpret or translate for persons with limited English proficiency and who can disseminate information to and communicate with sensory impaired persons. These contacts will be listed and kept in the policy manual. (See "Facilitating Communication" Policy No. 2-038.)

3. A copy of this policy will be posted in the reception area of Puget Sound Hospice, given to each organization staff member, and sent to each referral source.

4. A nondiscrimination statement (See #5) will be posted in a conspicuous place, such as the reception area of the organization and will be printed on brochures, other printed public materials and in a conspicuous location on the organization's web site accessible from the home page, in English and at least the top 15 non-English languages spoken in the state.

5. The nondiscrimination statement will read: *"Puget Sound Hospice complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Puget Sound Hospice does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Puget Sound Hospice provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written materials in other formats (e.g. large print, audio, accessible electronic formats). Puget Sound Hospice provides free language services to people whose primary language is not English such as qualified interpreters and information written in other languages. If you need these services, contact the Section 504/ADA Coordinator/Section 1557 Civil Rights Coordinator at _____ (insert phone number). If you believe that Puget Sound Hospice has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex you can file a grievance with _____ (insert name and title of ADA/Civil Rights Coordinator) _____ (insert mailing address) _____ (insert telephone number and TYY number if available) _____ (insert fax) _____ (insert email). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, _____ (insert name and title of ADA/Civil Rights Coordinator) is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office of Civil Rights Compliant Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 2020; 1-800-368-1019, 800-537-7697(TDD)"*

6. Any person who believes she or he has been subjected to discrimination or who believes he or she has witnessed discrimination, in contradiction of the policy stated above, may file a grievance under this procedure. It is against the law for Puget Sound Hospice to retaliate against anyone who files a grievance or cooperates in the investigation of a grievance.

7. Grievances must be submitted to the Section 504/ADA Compliance Coordinator/ Section 1557 Civil Rights Coordinator within 60 days of the date the person filing the grievance becomes aware of the alleged discriminatory action.

8. A complaint may be filed in writing, or verbally, containing the name and address of the person filing it ("the grievant"). The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought by the grievant.

9. The Section 504 Coordinator/Section 1557 Civil Rights Coordinator (or her/his representative) will conduct an investigation of the complaint to determine its validity. This investigation may be informal, but it must be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint.

10. The Section 504/ADA Compliance Coordinator/ Section 1557 Civil Rights Coordinator will issue a written decision on the grievance no later than 30 days after its filing.

11. The grievant may appeal the decision of the Section 504/ADA Compliance Coordinator/Section 1557 Civil Rights Coordinator by filing an appeal in writing to Puget Sound Hospice within 15 days of receiving the Section 504/ADA Compliance Coordinator/Section 1557 Civil Rights Coordinator's decision.

12. Puget Sound Hospice will issue a written decision in response to the appeal no later than 30 days after its filing.

13. The Section 504/ADA Compliance Coordinator/Section 1557 Civil Rights Coordinator will maintain the files and records of Puget Sound Hospice relating to such grievances.

14. The availability and use of this grievance procedure does not preclude a person from filing a complaint of discrimination on the basis of handicap with the regional office for Civil Rights of the U.S. Department of Health and Human Services.

15. All organization personnel will be informed of this process during their orientation process.

16. Puget Sound Hospice will make appropriate arrangements to assure that persons with disabilities can participate in or make use of this grievance process on the same basis as the nondisabled. Such arrangements may include, but will not be limited to, the providing interpreters for the deaf, providing taped cassettes of material for the blind, or assuring a barrier-free location for the proceedings. The Section 504 Coordinator will be responsible for providing such arrangements.

Section 1557 Checklist

BASICS

- ❖ The patient's/resident's access to their healthcare must be equal, meaningful and effective
- ❖ Services may not be denied or delayed on the basis of race, color, national origin, disability, age, or sex
- ❖ Language and auxiliary services must be provided in a timely manner and FREE of charge
- ❖ We may not rely on family members or others to interpret with the exception of emergency situations
- ❖ We may not rely on bilingual/multilingual staff to interpret with the exception of those assessed and deemed qualified

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CHECKLIST

POLICY

- ☐ Review Language Access Plan and Policy
- ☐ Make Language Access Plan and Policy available to all staff
- ☐ Host an in-service to educate staff on process for interpretation and ancillary services

NOTICE OF NONDISCRIMATION AND TAGLINES

- ☐ Post in common areas, accessible to patients and residents, and link on website, with taglines in top 15 languages spoken in the state
- ☐ Make available on request

TRANSLATED DOCUMENTS

- ☐ Include translated admission agreement, arbitration agreement, and Notice of Privacy Practices in admission packet, in top 2 languages spoken in the state
- ☐ Interpret verbally using an interpreter service or a qualified staff member for all other admission documents (admission packet/financial information)

VENDORS

- ☐ Review vendor and resource list. Select a vendor to provide on demand telephonic interpretive services and auxiliary services as needed
- ☐ Send contract to Ensign Services' Legal department for review
- ☐ Complete the Bilingual Resources and Sign Language Interpreters documents to include with your Language Access Plan and Policy

PRE-ADMIT PROCESS

- ☐ Implement a process for identifying language access and/or ancillary service needs prior to admission

ADMISSION PROCESS

- ☐ Provide Notice of nondiscrimination (in top 2 languages) along with taglines (in top 15 languages) to all LEP patients/residents to determine primary language and need for interpretation services during admission process
- ☐ Provide interpretation and/or auxiliary services during the admission process
- ☐ Provide translated admission documents

- ☐ Designate a point of contact to coordinate oral language assistance services so that staff can refer any and all patients/residents to a designated person trained to obtain qualified interpreter services in a timely manner and arrange for document translation when necessary

STAFF QUALIFICATION

Type of qualification dependent on type of interpreting; clinical vs. non-clinical

A qualified staff member is one who has passed an assessment demonstrating;

a. Proficiency in speaking and understanding both spoken English and at least one other spoken language, including any necessary specialized vocabulary, terminology and phraseology, and
b. Ability to effectively, accurately, and impartially communicate directly with individuals with limited English proficiency in their primary languages.

A qualified staff member is one who has had;

a. Relevant training
b. Proficiency testing to interpret
c. And who follows the Code of Ethics for Interpreters in Health Care

- ☐ Identify existing capacity to provide language assistance services, such as bilingual and multilingual staff to serve as qualified interpreters and the need and availability of contract interpreter and translation services
- ☐ Contact CyraCom to arrange for testing
  - assessmentsteam@cyracom.com
  - Approximately $150-$175 per assessment
- ☐ Include interpretation as a job responsibility as part of the staff member's job description

CARE DELIVERY

- ☐ Offer/provide interpretation and/or auxiliary services during care
- ☐ Identify emergency circumstances warranting interpretation by an adult family member

DOCUMENTATION

- ☐ Identify and document specific language and/or auxiliary aid needs during the preadmission process
- ☐ Add language assistance and auxiliary aid needs to the admission care plan
- ☐ Discuss and document ongoing needs during care plan meetings and make modifications where needed
- ☐ As part of the QAPI process, assess services offered and provided. Document patient/resident satisfaction, accessibility of language assistance and auxiliary aids, modifications to program based on areas of deficiency, quality of vendor services, etc.
- ☐ Document emergency situations resulting in the need to rely on a family member or friend to interpret initially when there is a threat to the patient/resident and no other interpreter is available
- ☐ Document in the care plan and nurse's note when a patient/resident requests a specific interpreter and refuses an external interpreter
- ☐ Document any concerns with competency or confidentiality of the preferred interpreter and make arrangements for a qualified interpreter

- ☐ Document patient/resident refusals to use auxiliary aids
- ☐ Document language and/or disabilities as barriers and how barriers are managed

GRIEVANCES

- ☐ Implement a process for receiving complaints regarding perceived discrimination
- ☐ Use the ***Discrimination Grievance Form*** to document all complaints of discrimination
- ☐ Forward all ***Discrimination Grievance Forms*** to compliance within 2 business days

QUALITY IMPROVEMENT

- ☐ Assess and evaluate the language assistance services on an ongoing basis. Areas of evaluation should include patient/resident satisfaction, utilization of appropriate communication channels, and the accessibility and quality of language assistance services provided

RESOURCES

Resource Materials: Compliance section on Pennant U
http://learning.pennantservices.com/moodle/course/view.php?id=43&section=4

Office for Civil Rights: https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html

CONTACTS

Erin Peterson, Chief Compliance Officer/Section 1557 Coordinator
208-506-6063
Email: sec1557@pennantservices.net
*Complaints
*Order additional posters
*Notice of Privacy Practices
*General questions

REFERRAL DISCLOSURE AND CARE DECISIONS
Policy No. 1-004.1

PURPOSE

To ensure that all patients are informed about the relationship between the use of services and financial incentives between the organization and other service providers. To ensure that the integrity of clinical decision-making is not compromised by financial incentives offered to leaders, managers, clinical personnel, or physicians.

POLICY

When a patient is referred to another service organization, the patient will be informed of any financial benefit to Puget Sound Hospice. To promote efficient quality patient care, clinical care decisions will be based on identified patient health care needs.

[Cross-reference "Admission Criteria and Process" Policy No. 4-021, "Initial Assessment" Policy No. 4-041, "Comprehensive Assessment" Policy No. 4-042, "Ongoing Assessments" Policy No. 4-043, "The Plan of Care" Policy No. 4-027, "Interdisciplinary Group Plan of Care" Policy No. 4-031, "Change of Designated Hospice" Policy No. 4-073, and "Verification of Physician Orders" Policy No. 4-028]

PROCEDURE

1. The Program Director will be responsible to inform the patient or family/caregiver of any affiliation or financial incentives between Puget Sound Hospice and other service providers.

2. The patient may choose referral of services to other organizations.

3. All referrals will be documented and include name, date, time, and reason for referral.

4. The referrals will be monitored, reviewed, and reported each month by the Program Director. Any areas of concern identified, will be reviewed by the Program Director and Executive Director/Administrator as part of the organization's QAPI process.

5. All clinical decisions will be based on identified patient health care needs. Decisions will not be based on organizational compensation or financial risk shared with leaders, managers, clinical personnel, or physicians. All personnel are educated and understand this.

6. The organization will accept only those patients whose needs can be met by the services it provides and who meet admission criteria.

7. Initial and ongoing patient assessment data will identify patient health care needs.

8. In compliance with standard medical practice, all services will be delivered under physician's (or other authorized licensed independent practitioner's) orders and in compliance with state law and ethical policies.

9. Any areas of concern identified will be reviewed by the Program Director and Administrator as part of the organization's performance improvement process.

10. Information regarding financial incentives to leaders, managers, clinical personnel, or physicians will be available upon written request.

Title: Death with Dignity – WA **Policy Number: _____**

POLICY

Employees and independent contractors acting in the course and scope of their employment or otherwise on behalf of the _____ Hospice (the "Agency") shall not participate in the Death with Dignity program ("DWD").

PURPOSE

This policy provides direction to the Agency's employees and independent contractors, regarding Agency's decision not to participate in DWD related activities

SCOPE

Applies to all employees, independent contractors, and other persons or entities, including other health care providers while such individuals or entities are under the management or direct control of the Agency or while acting within the course and scope of any employment by, or contract with, the Agency.

PROVISIONS OF THE DWD

1. The DWD is a Washington law that enables individuals with a terminal illness to make a request for a drug prescription which will end his or her life. The DWD allows health care providers the option to refuse to participate in the DWD, which includes refusing to inform a patient regarding his or her rights in the DWD, and not referring an individual to a physician who participates in activities authorized by the DWD. Further, the DWD allows health care providers to prohibit its employees, independent contractors, or other persons or entities, including other health care providers, from participating in activities outlined in the DWD while under the management or direct control of the prohibiting health care provider or while acting within the course and scope of any employment by, or contract with, the prohibiting health care provider.

2. A health care provider who refuses to allow its employees, contractors, and other affiliated entities to participate in the DWD must first give notice of its policy prohibiting participation to such individuals and entities.

3. A prohibiting health care provider may not prohibit any employee, contractor, or other affiliated entity from participating in the DWD while such individuals or entities are acting outside the management or control of the prohibiting employer or are acting outside the course and scope of any employment duties by, or contract with, the prohibiting health care provider.

4. A prohibiting health care provider may take action, including, but not limited to, the following, as applicable, against any individual or entity that violates its policy prohibiting participation in the DWD:

i. Suspension, loss of employment, or other action authorized by the policies and practices of the prohibiting health care provider.

ii. Termination of any contract between the prohibiting health care provider and the individual or entity that violates the policy.

iii. Imposition of any other nonmonetary remedy provided for in any contract between the prohibiting health care provider and the individual or entity in violation of this policy.

PARTICIPATION IN THE DWD

1. Agency employees and contractors are prohibited from participating in activities outlined in the DWD while under the management or direct control of the Agency or while acting within the course and scope of any employment by, or contract with, the Agency.

2. Agency employees and contractors are prohibited from informing a hospice or home health patient or such patient's family, guardian, or agent, regarding the patient's participation in the DWD, and shall not refer an individual to a physician for the purpose of participating in activities authorized by the DWD.

3. Agency employees and contractors that participate in activities outlined in the DWD while under the management or direct control of the Agency or while acting within the course and scope of any employment by, or contract with, the Agency, or who otherwise act in violation of this policy, shall be subject to disciplinary action or termination of contract, as outlined below.

4. Agency will not prohibit any employee, independent contractor (including physicians), or other affiliated entity from participating in the DWD while such individuals or entities are acting outside the management or control of or the course and scope of any employment duties by, or contract with, the Agency. Should an employee, contractor, agent or other affiliated entity participate in DWD related activities outside of their employment/ affiliation with the Agency, such individuals or entities shall clearly identify his or her self to the patient, patient's family, and/or patient's agent and make clear the he or she is acting in a capacity that is not affiliated with the Agency.

DISCIPLINARY ACTION OR TERMINATION FOR PARTICIPATION IN THE DWD

Agency employees and contractors that participate in activities outlined in the DWD while under the management or direct control of the Agency or while acting within the course and scope of any employment by, or contract with, the Agency, or who act in violation of this policy, shall be subject to disciplinary action, up to and including

termination, as well as disciplinary action set forth in Agency's Personnel Management Policy 408-H, as amended, or termination of contract.

ORIENTATION
Policy No. 1-022.1

PURPOSE

To provide guidelines for the orientation process.

POLICY

All personnel will be required to attend an orientation program upon employment and at the time of reassignment. The goal of orientation will be to inform and instruct new personnel regarding Puget Sound Hospice's mission, policies and procedures, benefits (if applicable), the performance appraisal process, competency testing, as well as individual responsibilities and relationships to other personnel.

All personnel will demonstrate knowledge and proficiency in skills appropriate to their assigned responsibilities during the orientation period.

All clinical personnel prior to being assigned to care must present documentation of current CPR certification. CPR certification must be renewed per American Heart Association guidelines.

(See "Competency Based Orientation" Policy No. 3-002.)

PROCEDURE

1. The orientation content for all personnel will include the following as applicable and appropriate to the care and service provided:

   A. General company orientation including the organization's mission/philosophy, policy and procedures, environmental safety program, etc.

   B. Review of organizational chart and lines of authority and responsibility

   C. Hours of work

   D. Job related responsibilities (job description), including orientation to equipment, if applicable

   E. Care and services provided by the organization; diseases and medication conditions common to hospice

   F. Baseline skills assessments as applicable to job classification

   G. Infection prevention and control within the organization and the home care setting

   H. Performance standards

I. Confidentiality of organization and patient information/HIPAA regulations

J. Documentation requirements (record keeping and requirements)

K. OSHA compliance

L. Medical Device Reporting/Incident Reporting

M. Equal Employment Opportunity Act

N. Ethical issue identification and resolution including conflict of interest, professional boundaries, etc.

O. Sexual Harassment Act

P. Compensation and benefits information (salary/wages, benefits, etc.)

Q. Unemployment and workers' compensation

R. Malpractice coverage, as applicable

S. Collective bargaining information, as applicable

T. Drug testing

U. Family/State Medical Leave Act

V. Cultural Diversity and communication barriers

W. Client/Patient Rights including Advance Directives

X. Standards of Conduct and Ethical Issues

Y. QAPI and activities

Z. Concept of death, dying, hospice philosophy, bereavement, caregiver as unit of service, etc.

AA. Pain and symptom management

BB. Emotional support of staff and client/patient (stress management)

CC. Compliance Plan and employee compliance responsibilities

DD. Emergency Management Plan for the organization and the employee's family emergency response plan

EE. Handling of patient complaints/grievances

FF. If applicable, converging of charges for care/services

2. The orientation process, for all personnel will consist of both didactic and field supervision. Observation visits will be made by an appropriate supervisor to assess the skills demonstrated by new or reassigned personnel as well as reinforce the information presented during classroom time.

3. The orientation process for contract personnel will consist of the following:

   A. For contract personnel, the contracted organization will have one (1) member of the organization that has been oriented to Puget Sound Hospice policies, procedures, and information presented during orientation. That individual will be responsible for orienting other contract personnel from that organization to Puget Sound Hospice.

   B. For personnel the organization individually contracts with, a preceptor will be assigned during the orientation process.

4. During the orientation process, the supervisor will be responsible for evaluating the knowledge and skills of the personnel being oriented. Any areas of concern will be brought to the immediate attention of the new personnel. Appropriate guidance/monitoring will be provided or additional training recommended, if needed.

5. Assigned personnel will orient newly assigned personnel or volunteers to their responsibilities and to the patient needs when changes in patient assignment occur. The following will be included as appropriate:

   A. Patient needs including physical, psychosocial, and environmental aspects of care and service

   B. Personnel responsibilities

   C. Specific care and services to be provided

6. Orientation of new and reassigned personnel may include verbal or written instructions. Orientation may be provided in the patient's home.

7. Orientation of current employees assigned to new job classifications will include.

   A. Lines of authority and responsibility

   B. Hours of work

   C. Job responsibilities

   D. Skills assessment as applicable to the specific job classification

   E. Documentation responsibilities

8. A Personnel Orientation Checklist (See "Personnel Orientation Checklist" Addendum 1-022.A.) will be completed for all new personnel. New personnel will sign and date when their orientation has been completed.

9. The supervisor will sign and date the checklist when new personnel have completed all the required activities.

10. The probationary period will be 90 days, during which time the orientation process may be extended if the supervisor, or employee feels it is warranted.

ADDENDUM 1-022.A

PERSONNEL ORIENTATION CHECKLIST

PERSONNEL ORIENTATION CHECKLIST

Name: _____ Date:_____

CHECKLIST	DATE COMPLETED	ORIENTATION BY WHOM	PERSONNEL INITIALS
1. Tour of office/Introduction of organization personnel			
2. Introduction to work stations			
3. Completion of all employment forms			
4. Personnel file A. Application B. Sign job description (copy to personnel) C. Professional license, certification, registration, CPR documentation, as appropriate D. Driver's license, as appropriate E. Proof of auto insurance, as appropriate F. Physical exam, drug test, as appropriate G. TB Screening, as appropriate H. Hep B vaccination, as appropriate I. Standard precautions orientation J. Criminal background check/National Sex Offender Registry check K. OIG Exclusion List check verification			
5. Name and Photo Identification			
6. The orientation content for all personnel will include the following as applicable and appropriate to the care and service provided: A. General orientation to organization, including philosophy, mission, and purpose, policies and procedures, environmental safety program B. Review of organizational chart and lines of authority and responsibility C. Hours of work D. Job related responsibilities E. Care and services provided by the organization F. Baseline skills assessments as applicable to job classification G. Infection prevention and control within the organization and home care setting H. Performance standards I. Confidentiality of organization and patient information/HIPAA J. Documentation requirements (Record keeping and reporting) K. OSHA compliance L. Medical Device Reporting M. Equal Employment Opportunity Act N. Ethical issue identification, resolution and boundaries/Standards of Conduct O. Sexual Harassment Act P. Compensation and benefits Q. Unemployment and workers compensation R. Malpractice coverage, as applicable S. Collective bargaining information, as applicable T. Drug testing U. Family/State Medical Leave Act			

CHECKLIST	DATE COMPLETED	ORIENTATION BY WHOM	PERSONNEL INITIALS
V. Cultural Diversity/Communication barriers W. Patient/Client Rights and Handling of patient complaints X. Concepts of death, dying and bereavement Y. Pain and symptom management Z. Emotional support of staff and patient (Stress management) AA. Advance Directives BB. Conflict of Interest CC. QAPI Plan DD. Incident/Variance Reporting EE. Compliance Program/Employee Responsibilities FF. Emergency Management Plan GG. Intro to hospice/hospice philosophy, unit of service, emotional support, psychosocial and spiritual issues HH. Diseases/Conditions common to hospice II. Job specific: medical equipment, special populations			
7. Orientation to job description and job responsibilities (list or cross-reference)			
8. Skills/Competency Assessment (list or cross-reference)			

PERSONNEL DEVELOPMENT
Policy No. 1-023.1

PURPOSE

To ensure ongoing training and development for all personnel to maintain competence in assigned duties.

POLICY

Puget Sound Hospice will provide for personnel development including, but not limited to, continuing education, inservices, training sessions, one-on-one mentoring, and continuing education. Documentation of attendance will be requested and filed in the personnel file.

PROCEDURE

1. The need for training and education is determined by:

   A. Requests of personnel

   B. Specific patient care/service needs

   C. New assignments

   D. New technology

   E. New care/service

2. Needs assessment forms will be distributed to personnel as appropriate to determine their interest for inservice planning. (See "Personnel Development/Inservice Needs Assessment" Addendum 1-023.A.)

3. At the discretion of Puget Sound Hospice, internal and external continuing education will be sponsored.

4. Continuing education provided internally by the organization may take the form of:

   A. Formal presentations

   B. Documented "on the job specialty training"

   C. Distance learning

5. Personnel will be encouraged to participate in self-development and learning through the following means, but not limited to:

A. Membership in professional organization

B. Self-directed learning modules

C. Attendance at continuing education seminars

D. Satellite learning

E. Formal courses of study

F. Mentoring

6. An attendance record of all inservice/organization personnel development programs offered will be maintained by the organization. The organization will also validate continuing education units (CEUs) per applicable state licensure law for direct care, independent contractor, and subcontract personnel.

7. Personnel will be requested to provide feedback using an inservice evaluation form regarding the content, value, and applicability of all inservice education offered by the organization. Personnel feedback will be used to evaluate the education provided by the organization and to assist in the development of future education programs.

8. Puget Sound Hospice requires that each staff member complete a minimum of the following programs each year. Any employee that fails to attend the annual mandatory training is subject to disciplinary action up to and including termination. These mandatory inservices include:

   A. Standard Precautions and Infection Control

   B. Safety Program including OSHA (Safety Data Sheet Elements) and Medical Device Reporting Compliance

   C. Body Mechanics

   D. Emergency Management Plan/Disaster Training

   E. Corporate Compliance and Standards of Conduct

   F. HIPAA

   G. Complaints and Grievances

   H. Cultural diversity and communication barriers

   I. Patient rights and responsibilities

   J. Ethics training

9. In addition, clinical personnel must attend a minimum of the following:

A. CPR (when appropriate).

B. All clinical staff and hospice aides will attend 12 hours of inservice education annually.

10. Non-clinical personnel are required to attend a minimum of eight (8) hours of ongoing education annually, which includes all mandatory inservices listed above.

11. When new information pertaining to discipline specific practice is received by the organization, it will be provided to personnel during the next regularly scheduled personnel meeting.

ADDENDUM 1-023.A

PERSONNEL DEVELOPMENT/INSERVICE NEEDS ASSESSMENT

PERSONNEL DEVELOPMENT/INSERVICE NEEDS ASSESSMENT
PERSONNEL SURVEY

Date: _____

Your classification: _____

Year license/certification received (if applicable): _____

Approximately how many hours per week do you work? _____

Approximately how many continuing educational activities have you attended in the past 12 months?

_____

Were they accredited programs? _____

What type of inservices or personnel development programs would you like to see offered? Please list:

_____

_____

_____

_____

_____

Additional comments: _____

_____

Please return form to the Executive Director/Administrator.

RESOURCE INFORMATION
Policy No. 1-024.1

PURPOSE

To establish guidelines for the maintenance of relevant literature and information.

POLICY

The organization will maintain clinical, scientific, and management literature and identify community resources for use in designing, managing, and improving patient-specific and organizational processes.

PROCEDURE

1. The Education Coordinator will be responsible for maintaining authoritative and up-to-date resource information for the organization.

2. Resource information will include, but will not be limited to:

   A. Industry related journals (i.e., Home Health Line, Caring, etc.)

   B. Home care manuals (i.e., Aspen's Manual of Policies and Procedures)

   C. Clinical resources specific to discipline (i.e., Lippincott's Manual of Nursing Practice)

   D. Performance improvement resources (i.e., QAPI, etc.)

   E. Films/videos (i.e., OSHA Bloodborne Pathogens, etc.)

   F. Listing of community resources available to patients and organization personnel

   G. Pamphlets from national agencies, pharmaceutical companies, etc.

   H. Current medical dictionary

   I. Current statutes and rules related to clinical practice acts

   J. Current billing resources: ICD-10-CM manuals, HCPCS and CPT coding manuals, other revenue code guides

3. All organization personnel will have access to the resource information. Each item will be checked out and returned within a reasonable period of time.

4. Requests for additional resource information will be made to the appropriate supervisor who will respond in a timely manner to the request.

5. Information that is needed but not accessible internally, such as practice guidelines, will be secured, if applicable and accessible, through a community resource such as a hospital library, medical center library, etc.

COMPETENCY PROGRAM
Policy No. 1-025.1

PURPOSE

To ensure that the competence of clinical organization personnel is assessed, maintained, and improved on a continuing basis.

POLICY

Puget Sound Hospice will define and implement an objective, measurable assessment system to evaluate the competency of patient contact personnel.

Personnel will demonstrate knowledge and proficiency of skills appropriate to their assigned responsibilities, including an ability to perform specified duties determined by the organization. Skills will be maintained and improved through continuing education programs, based on the analysis of trends and outcomes identified through the competency program, on-site supervision, and established reviews.

Skill proficiency can be determined by: verbal or written examination; skill demonstration in a lab setting or patient's home; or by completion of a specialized training course specific to a clinical procedure (i.e., PICC Certification).

PROCEDURE

1. The organization will establish and annually re-evaluate its job specific "Competency Based Orientation Checklist" which reflects duties commonly required in the performance of patient contact positions. (See "Competency Based Orientation" Policy No. 3-002.)

2. The organization will establish and annually evaluate a group of specific skills related to patient care/service responsibilities and complexity of care/service provided by personnel. Competencies must be successfully demonstrated before organization personnel complete orientation.

3. The organization will clearly identify and define the skills, which are essential to observe for the determination of competence, for each job category. In the identification of core competence, the essential skills will be demonstrated upon hire and annually thereafter.

4. Specific competencies will be developed for high-risk, problem prone, and specialty service care areas. Personnel providing service in the defined target areas will receive specialty training and provide demonstrated competence prior to the provision of specialty service.

5. A preceptor will be assigned to each new staff member as part of the orientation process. The preceptor/supervisor will observe and deem proficient the indicated skills and core competencies. If necessary, additional training, or inservice education will be provided to the staff member. Organization personnel will not provide the care or service independently until satisfactory completion of required skills competency.

6. After the completion of orientation, competency will be monitored annually thereafter as part of the annual performance evaluation process. Competency will also be monitored when:

   A. Personnel are performing a new procedure, or using a piece of equipment for the first time.

   B. The Orientation Skills Checklist indicates a trend for retraining. The trend can be identified by a demonstrated knowledge deficit when the skill is an invasive procedure, or when the organization expects the skill to be performed routinely in the scope of patient care/service.

   C. Care/service is provided in a specialized area for the first time.

   D. Reporting systems indicate that organization personnel require additional training or supervision.

   E. Requested by personnel.

7. Qualified evaluators will conduct the proficiency demonstration component of the clinical competency program.

8. Clinical competency of qualified evaluators (preceptors, supervisors, peers, clinical specialists) will also be defined and regularly evaluated.

9. Competency of supervisors and/or management personnel is assessed by the individual's immediate supervisor and may include peer evaluation as a component of the process.

COMPETENCY ASSESSMENT
Policy No. 1-026.1

PURPOSE

To outline the process of assessing professional and paraprofessional competence.

POLICY

The competence of all organization clinical personnel (employed, contract, or volunteer) will be assessed during orientation, during the probationary period, periodically throughout the course of the year and during the annual performance evaluation. Educational activities will be based, in part, on the outcomes of the competency evaluation.

Competency of supervisors and/or management staff will be assessed by the individual's immediate supervisor and may include peer review as a component of the process.

PROCEDURE

Orientation and Probationary Period

1. As part of the orientation process, a preceptor/Clinical Supervisor will be assigned to each new person.

2. Using a Competency Skills Performance Checklist, and the Orientation Checklist, the preceptor/Clinical Supervisor will observe the new personnel performing the required skills and activities.

3. Upon completion of the checklists, the new personnel will end orientation and probationary period.

Ongoing Assessments

1. Competency assessments will be completed at least one (1) time per year. Additional competencies may be required for performance issues, new technology, or other appropriate indications.

2. Using a Competency Skills Performance Checklist developed specifically for each clinical job category, the Clinical Supervisor will evaluate the competence in performing and rendering care according to organization policies and standards of practice.

3. Clinical personnel will make a joint visit with a Clinical Supervisor annually for direct observation assessment.

4. Based on the identified clinical needs during reviews, the inservice education plan will incorporate training on issues where trends and patterns are identified for all personnel.

5. Isolated episodes relating to individual performance will be addressed on an individual basis. Actions may include one-on-one counseling and/or mentoring, reviewing resource information, inservice training or continuing education.

Annual Performance Evaluation

1. During the annual performance evaluation, personnel's competence in performing specified activities will be evaluated.

2. Personnel will be asked to demonstrate their core competencies in specific areas relating to their job description and functions (i.e., hospice aides demonstrate skills for ADLs, bathing, toileting, etc.; nurses performing Infusion Therapy demonstrate skills for venipuncture, accessing ports; medical word processors demonstrate skill for word processing.)

3. Improving skills for competency will be part of the annual performance evaluation and performance plans for the next year, as well as establishing individual goals for personal/professional growth and development.

TRAINING/INSERVICE EDUCATION
Policy No. 1-028.1

PURPOSE

To delineate organization policies for inservice education programs designed to increase competence in a specific area and improve overall organization performance of major functions and processes.

POLICY

1. Puget Sound Hospice will provide training and education to give personnel opportunities to learn new skills and improve/expand existing knowledge. Training topics may include information regarding the organization's professional standards of care/practice, performance improvement monitoring results, updates in patient care techniques/resources, and safety/infection control requirements.

2. Mandatory inservices will be attended by all disciplines.

3. Attendance at education programs will be required relative to job classification.

4. Professional personnel will receive at least the number of continuing education units to maintain their licenses. Professional staff (direct care staff) will receive at least twelve (12) hours of inservice training per calendar year.

5. Paraprofessional personnel will receive education as follows:

    A. Aides (CNAs/HAs) must receive at least twelve (12) hours of inservice training per calendar year. This may be provided while the aide is furnishing care to patients. Note: Any education offering must be supervised by a RN.

    B. Personal care workers must receive at least twelve (12) hours of inservice training per calendar year. This may be provided while the worker is furnishing care to patients.

    C. Chore workers must receive at least twelve (12) hours of inservice training per calendar year. This may be provided while the worker is furnishing care to patients.

6. NON DIRECT Care Staff must receive at least eight (8) hours of inservice training per calendar year

PROCEDURE:

1. The written plan for annual inservices will include, but not be limited to:

    A. Safety; patient and personnel including emergency management plan

    B. Infection control

C. Psychosocial considerations, including methods for coping with work related issues of grief, loss and change

D. Skills updates

E. Issues related to patient populations served including cultural diversity and communication barriers

F. Ethical issues

G. Medical Device Act, Safety testing of equipment used in the work environment

H. Emergency/disaster training

I. Patient Bill of Rights including handling of complaints/grievances

J. Compliance Plan and HIPAA

K. OSHA

2. Personnel will receive notification of organization-sponsored programs at least one (1) week in advance.

3. A record will be maintained for each session, including:

   A. Program objectives

   B. Content outline

   C. Speaker (and his/her qualifications)

   D. List of attendees

4. An inservice log will be kept to track the number of inservice hours the aides (CNAs/HAs) and all staff have obtained on a cumulative basis.

5. During ongoing supervision and competency reviews, the supervisors will evaluate if the training and education has improved the competence of the organization personnel.

EXHIBIT 8

CONSULTING, PROFESSIONAL, AND OPERATIONAL SUPPORT SERVICES AGREEMENT (Clinical Services)

Effective Date:	**October 1, 2019**
CONSULTANT:	**Cornerstone Service Center, Inc., a Nevada corporation**
Address:	1675 E. Riverside Drive, Ste. 200, Eagle, ID 83616
Phone:	(208) 401-1400
Fax:	(208) 401-1401
FACILITY:	**Symbol Healthcare, Inc. d/b/a Puget Sound Home Health of King County**
Address:	4002 Tacoma Mall Blvd Ste 204A, Tacoma, WA 98409
Phone:	253-735-4282
Fax:	253-833-8933
FEIN:	82-1048747

THIS CONSULTING, PROFESSIONAL, AND OPERATIONAL SUPPORT SERVICES AGREEMENT ("Agreement") is made and entered into by and between the above-named Consultant and Agency as of the Effective Date, with respect to the following facts and intentions:

R E C I T A L S

A. Agency is an independently operated, licensed and certified Home Health, Hospice and/or Home Care Agency operating from the address set forth above (the "Agency Primary Location");

B. Consultant is a provider of centralized consulting, professional, and operational support designed to aid the efficient, competitive, and sound operation of entities like Agency;

C. Agency desires to engage the services of Consultant to assist Agency personnel with aspects of Agency's operations and activities, in order to facilitate Agency personnel's focus on Agency's primary mission of rendering superior hospice services to the Agency's patients and clients.

NOW THEREFORE, IN CONSIDERATION OF THE PREMISES and for other good and valuable consideration, the receipt and sufficiency of which the parties hereby mutually acknowledge, the parties agree to the following:

TERMS AND CONDITIONS

1. Incorporation of Exhibits and Recitals. The Recitals set forth above, as well as the exhibits attached hereto, are incorporated herein by this reference as if fully set forth herein.

2. Consultant's Duties. The Consultant agrees to provide such of the following services ("Services") as Agency, at Agency's option and request from time to time, desires to obtain from Consultant during the term of this Agreement, and to perform its duties hereunder in a good, professional and workmanlike manner. Such duties shall include, without limitation (herein the "Services"):

2.1. General Consultant's Duties, Generally.

2.1.1. Consultant will provide Services in substantial conformance to applicable federal and state laws and the established policies of Consultant and Agency in effect from time to time, and Consultant will conduct periodic self-audit/compliance reviews in order to ensure that Consultant substantially complies with federal, state and local statutes and regulations applicable to the provision of the Services. Agency hereby grants to Consultant a limited power of attorney to act in Agency's name and stead for the convenience of Agency and/or Consultant, provided that this power shall not be used except in conjunction with the enumerated Services under this Agreement.

2.1.2. Consultant shall make clear to all parties with whom it deals in the course of rendering the Services that it is an independent contractor and not an employer, employee, partner, co-venturer, or management Agency of Agency. At all times while in the Agency and while with Agency's patients, Consultant's employees and representatives shall wear uniforms and/or badges clearly indicating their affiliation with Consultant.

2.2. Specific Duties of Consultant. During the term of this Agreement, Consultant shall provide to Agency the specific Services listed in Exhibit A at the request of the Agency. In the event of any conflict between the terms of Exhibit A and the terms contained in the main body of this Agreement, the terms of Exhibit A shall control. Consultant's duties shall specifically not include (i) the rendition of any direct care to patients or residents, (ii) maintenance or handling of patient trust property, or (iii) any other service not specifically enumerated herein as a part of the Services and requested by Agency, all of which shall be the sole duty and domain of Agency, its administrators, caregivers and other staff.

3. Agency's Duties. Agency shall:

3.1. Operate its business in and from the Agency in substantial compliance with applicable laws and regulations, and maintain all federal and state licenses and certifications required to operate the Agency and provide Services to patients (collectively the "Licenses"). Agency shall perform all duties required of a licensee and provider under applicable local, state and federal laws, codes, regulations and provider agreements affecting the operation of the Agency. Within five (5) days of receipt, Agency shall deliver to Consultant notification of any actual revocation or suspension of its Licenses.

3.2. Not unreasonably restrict or limit the Consultant's right to exercise its independent professional judgment, including its right to recommend Services to be rendered

and to render such Services using such methods, technologies and procedures as Consultant deems appropriate.

3.3. Timely furnish Consultant with such information and materials as might ordinarily be expected for Consultant to perform its duties hereunder. Agency shall be solely responsible to assure the accuracy and completeness of all information provided by Agency and its personnel to Consultant, and Consultant shall be entitled to rely thereon without inquiry or diligence of any kind.

3.4. As and to the extent that Consultant's employees and agents require access to the Agency to perform the Services, Agency shall provide adequate working space, equipment and access to Agency's staff for the provision of Services. Equipment and materials placed at the Agency by Consultant shall be used exclusively for the purposes of this Agreement. Upon termination or at Consultant's request, Agency shall return equipment and materials, in the same condition as when delivered to Agency, reasonable wear and tear excepted.

3.5. In addition to the foregoing, during the term of this Agreement, Agency shall cooperate with Consultant and Consultant's other client agencies and businesses as more fully set forth in Exhibit A.

4. Compensation.

4.1. For and in consideration of the Services to be provided under this Agreement, the Agency shall pay to the Consultant as the "Consultant Compensation" a monthly consulting fee equal to five percent (5.0%) of Agency's gross revenue from all sources. A reasonable estimate of anticipated monthly Consultant Compensation shall be paid on or before the first (1st) day of each month during the Term hereof, and shall be "trued up" at the beginning of the next following month with such following month's estimated payment. Payment for any partial month of the Term shall be prorated based on the number of days during the month that Consultant served under this Agreement. In the event Agency closes during any month during the Term, the Consultant Compensation for any such month or partial month shall be calculated, at Consultant's option, based on historical revenues and patient mix. At Consultant's option Consultant shall be entitled to deduct the Consultant Compensation from sums collected for Agency by Consultant, and shall provide Agency with invoices (or if paid by deduction accountings) for the monthly fee by the last day of the month following the month of service.

4.2. In addition to and not as part of the Consultant Compensation, Agency shall reimburse Consultant for all costs and expenses advanced, incurred, or paid by Consultant in the rendition of Services.

5. Insurance.

5.1. Both Consultant and Agency agree to maintain general and professional liability insurance during the term of this agreement in an amount not less than One Million Dollars ($1,000,000) per claim and Three Million Dollars ($3,000,000) in the aggregate.

5.2. Both parties agree to maintain such other and further insurance as may be required by law or the terms of any agreement to which they are parties, including without

limitation worker's compensation insurance (where required by law), crime insurance, directors and officers coverage, automobile and similar liability, and property and casualty insurance, and will list Agency as named insured on all obtained policies.

5.3. All insurance policies shall be issued by insurance companies with a policyholder rating of at least "B+" in the most recent version of Best's Key Rating Guide.

6. Term and Termination. The Term of this Agreement shall commence on the Effective Date and continue thereafter for a period of one (1) year. This Agreement shall automatically extend for additional periods of one (1) year each unless written notice of termination is given not less than sixty (60) days prior to the end of the then-current term. Notwithstanding anything contained herein to the contrary, either party may terminate this Agreement and the Term hereof at any time during the Term upon sixty (60) days written notice; further, in the event of (i) abandonment by a party of its duties hereunder, (ii) nonpayment of any Consultant Compensation within five (5) days after delivery of invoice or other written demand therefor; (iii) any breach or violation of this Agreement (other than non- payment of Consultant Compensation) which is not cured within thirty (30) days following delivery of written notice of such breach or violation, (iv) any material violation of law or regulations, or loss or failure of license or licensure, or violation of the eligibility requirements for reimbursement under any government program by a party, or (v) the occurrence or existence of any condition, practice, procedure, action, inaction or omission of, by or involving a party which, in the reasonable opinion of the other party constitutes either a threat to the health, safety, and welfare of any patient or client or a violation of any law, regulation, requirement, Licenses, eligibility or material agreement governing Agency's or Consultant's operation, then the other party shall have the right to summarily and immediately terminate this Agreement upon written notice to the first party.

7. Regulatory Changes. Agency and Consultant mutually agree that in the event local, state or federal government agencies promulgate regulations which materially affect the terms of this Agreement, including but not limited to changes affecting the cost of providing Services hereunder, this Agreement shall be immediately subject to renegotiation upon the initiative of either party.

8. Warranties.

8.1. Agency's Warranties. Agency hereby makes the following warranties and representations to Consultant in connection with Consultant's entry into this Agreement, which warranties shall survive the termination of this Agreement:

8.1.1. Agency is properly licensed by the State in which the Agency's operation(s) is located by the proper licensing and certification authorities for such State, and all permits and licenses required for the operation of Agency's business(es) have been received and are now currently effective.

8.1.2. As of the Effective Date, except as specifically disclosed on Schedule 1 attached hereto and incorporated herein, there is no litigation, administrative proceedings, event, or hold or similar lien on State or Federal payments to Agency, either underway or threatened, nor are there arbitration proceedings or governmental investigations relating to the Agency, or the business conducted thereon underway or threatened against Agency or brought by the Agency

9.3. Consultant acknowledges that it has received a copy of Agency's Code of Conduct, and agrees to abide by the provisions thereof governing Vendors and Vendor services.

10. Consultant's Schedule and Availability.

10.1. Consultant shall be reasonably available on an on-call basis to the Agency to fulfill Consultant's duties hereunder.

10.2. Nothing in this Agreement shall be construed as limiting or restricting in any manner Consultant's right to render the same or similar services to other individuals or entities, including but not limited to, other hospice and in-home care during or subsequent to the Term of this Agreement; similarly, nothing in this Agreement shall require Agency to exclusively use all of Consultant's services in the Agency during the Term of this Agreement.

10.3. Consultant's employees and representatives are entitled to be reasonably absent for annual vacations, sick leave, continuing education, and personal reasons; provided that in the event of any absence Consultant shall consult with the Agency concerning the impending absence and cooperate with the Agency in providing alternate resources to Agency to temporarily fulfill Consultant's duties during the period of absence.

11. Contractual Relationship.

11.1. Independent Contractor. It is expressly acknowledged by both parties that Consultant is an independent contractor. Nothing herein is intended to be construed to create an employer-employee, partnership, joint venturer or other relationship between Consultant and the Agency. Agency has and shall retain all statutory liability and responsibility for the continued operation of the Agency as the licensee under Agency's Licenses. No provision of this Agreement shall create any right in the Agency to exercise control or direction over the manner or method by which Consultant performs its duties or renders Services hereunder, nor shall Consultant exercise control or direction over the manner or method by which Agency operates or serves its patients and clients; provided always, that services shall be provided in a manner consistent with all applicable laws, rules and regulations of all governmental authorities, and Agency's Code of Conduct. Agency will not withhold from compensation payable to Consultant hereunder, or be in any way responsible for, any sums for income tax, employment insurance, Social Security, or any other agency and Consultant agrees that the payment of all such amounts as may be required by law are and shall be the sole responsibility of Consultant.

11.2. Fair Market Value. The amounts to be paid to Consultant hereunder have been determined by the parties through good faith and arms-length bargaining to be the fair market value of the services to be rendered hereunder. No amount paid or to be paid hereunder is intended to be, nor will it be construed as, an offer, inducement or payment, whether directly or indirectly, overtly or covertly, for the referral of patients by Consultant to Agency, or by Agency to Consultant, or for the recommending or arranging of the purchase, lease or order of any item or service. For purposes of this section, Consultant and Agency will include each such entity and any affiliate thereof. No referrals are required under this Agreement.

11.3. Work Product. The work product created in the course of Consultant's services under this agreement shall be the exclusive property of Consultant, and all manuals, forms, and documents (including without limitation, all writings, drawings, blueprints, pictures, recordings, computer or machine readable data, and all copies or reproductions thereof) which result from, describe or relate to the services performed or to be performed pursuant to this agreement or the results thereof, including without limitation all notes, data, reports or other information received or generated in the performance of this Agreement (excepting data incorporated in medical records required to be kept and maintained by Agency), shall be the exclusive property of Consultant and shall be delivered to Consultant upon request.

11.4. Non-Solicitation of Consultant's Employees. During the term of this Agreement, Agency shall not solicit the services of, or hire as an employee or independent contractor at the Agency, any Consultant employee, agent or representative who provided, managed or otherwise was involved in the provision of Services to Agency within the previous twelve (12) months (a "Restricted Employee"). Nothing herein shall preclude Agency from advertising available positions or opportunities by posting in the Agency or through newspaper ads or other generally accepted recruiting mediums. The parties acknowledge that the restrictions set forth in this Article are reasonable in scope and important to Consultant's business interests, and that the enforcement of this Article does not restrict Agency from engaging in Services for its own account. In the event that Agency hires a Restricted Employee, Agency shall pay a recruiting fee to Consultant in the amount of Seven Thousand Five Hundred and No/100 Dollars ($7,500.00) per Restricted Employee hired.

12. Indemnification.

12.1. Agency agrees to defend, indemnify, and hold Consultant, its parent, subsidiaries, affiliated and related companies, directors, officers, employees, and agents, wholly harmless from and against any and all costs (including reasonable attorney's fees) liabilities, claims, losses, lawsuits, settlements, demands, causes, judgments and expenses arising from the performance of this Agreement to the extent that such costs and liabilities result from the negligence or willful misconduct of Agency.

12.2. Consultant agrees to defend, indemnify, and hold Agency, its parent, subsidiaries, affiliated and related companies, directors, officers, employees, and agents, wholly harmless for, from and against any and all costs (including reasonable attorney's fees), liabilities, claims, losses, lawsuits, settlements, demands, causes, judgments and expenses arising from or connected with Consultant's acts or omissions or the performance of this Agreement, to the extent that such costs and liabilities are alleged to result from the negligence or willful misconduct of Consultant.

12.3. A party receiving notice of a claim or potential claim shall send written notice to the other within ten (10) business days, and shall fully cooperate in the defense thereof by counsel mutually acceptable to the parties. The parties' rights to indemnification set forth in this Article are non-exclusive and are not intended to affect in any way any other rights of the parties to indemnification under applicable federal, state or local laws and regulations.

13. Access to Books and Records. Pursuant to 42 U.S.C. §1395x(V)(1)(l), during the four (4) year period after completion of services hereunder, the Agency will, upon written request, make available to the Secretary of Health and Human Services or to the Comptroller General, or their duly authorized representatives, this Agreement, books, documents, and

records that are necessary to certify the nature and extent of costs incurred by the Agency under the provisions of this Agreement. This provision shall be in force for any twelve (12) month period during which the total value of services provided or goods delivered hereunder is Ten Thousand Dollars ($10,000) or more. This section shall have no effect unless Consultant is deemed a "subcontractor" under any regulation adopted under the provision of the United States Code cited above.

14. Privacy.

14.1. HIPAA Applicability and Compliance. Agency may be a "Covered Entity" under, and required to comply with, the applicable provisions of the Health Insurance Portability and Accountability Act of 1996 as amended ("HIPAA") and the regulations and guidelines pertaining thereto (collectively with HIPAA the "HIPAA Rules"), and to obtain sufficient assurances that its contracting parties will appropriately safeguard patients' "Protected Health Information" ("PHI") as defined in the HIPAA Rules. In the course of performing Consultant's services, duties and obligations herein, Consultant may receive, create or obtain access to PHI. Consultant agrees to maintain the security and confidentiality of PHI, as required of Agency by applicable laws and regulations, including without limitation the HIPAA Rules, and to execute and deliver such additional documentation and assurances as Agency may reasonably request to comply with HIPAA and any amendments thereto and related laws and regulations, including, but not limited to, the Business Associate Agreement attached hereto as Exhibit B.

14.2. Correlation of Record Handling Requirements. In the event of any conflict between the requirements of this Article 14 and/or between the various laws, statutes, ordinances and regulations relating to or otherwise affecting the subject matter thereof, the requirement or applicable law that that presents the most stringent standard for compliance, as reasonably determined by Agency, shall be followed, such that compliance is achieved or maximized in all cases.

14.3. Confidential Information. Consultant shall preserve the confidentiality of all private, confidential and/or proprietary information disclosed to or discovered by Consultant in connection with this Agreement, including, without limitation, nonpublic financial information, manuals, protocols, policies, procedures, marketing, and strategic information, Agency lists, computer software, training materials, resident/patient health information, resident/patient records, and resident/patient care and outcomes data ("Confidential Information") as and to the extent required by law. Consultant shall not use for its own benefit or disclose or otherwise disseminate to third parties, directly or indirectly, any Confidential Information without prior written consent from Agency, provided however that if Consultant grants Agency access to, and Agency uses, Consultant's databases or information sharing mechanisms, Agency's information may be provided to similar agencies and Agency hereby grants Agency's consent to such information sharing as a condition to Agency's receipt of access to such mechanisms and the data they contain form time to time. Upon termination of this Agreement, all Confidential Information and copies thereof shall be returned to Agency. Consultant and Agency shall comply with applicable federal, state and local laws and regulations with respect to all Confidential Information, including, but not limited to, any disclosures thereof pursuant to this section.

15. Notices. All notices which are required or which may be given pursuant to the terms of this Agreement shall be in writing and shall be sufficient in all respects if given in writing and delivered personally or by registered or certified mail, return receipt requested, or

by a comparable commercial delivery system, and notice shall be deemed to be given on the date hand-delivered or on the date which is three (3) business days after the date deposited in United States mail, or with a comparable commercial delivery system, with postage or other delivery charges thereon prepaid, at the addresses first set forth above or such other addresses as Agency and Consultant may designate by written notice to the other from time to time.

16. Arbitration.

16.1. Any controversy, dispute or claim arising in connection with the interpretation, performance or breach of this Lease, including any claim based on contract, tort or statute, shall be determined by final and binding, confidential arbitration with Judicial Mediation and Arbitration Service ("JAMS/Endispute") in Ada County, Idaho, provided that if JAMS/Endispute (or any successor organization thereto) no longer exists, then such arbitration shall be administered by the American Arbitration Association ("AAA") in accordance with its then-existing Commercial Arbitration Rules, and the sole arbitrator shall be selected in accordance with such AAA rules. Any arbitration hereunder shall be governed by the United States Arbitration Act, 9 U.S.C. 1-16 (or any successor legislation thereto), and judgment upon the award rendered by the arbitrator may be entered by any state or federal court having jurisdiction thereof. Neither Agency, Consultant, nor the arbitrator shall disclose the existence, content or results of any arbitration hereunder without the prior written consent of all parties; provided, however, that either party may disclose the existence, content or results of any such arbitration to its partners, officers, directors, employees, agents, attorneys and accountants and to any other Person to whom disclosure is required by applicable Legal Requirements, including pursuant to an order of a court of competent jurisdiction. Unless otherwise agreed by the parties, any arbitration hereunder shall be held at a neutral location selected by the arbitrator in Ada County, Idaho. The cost of the arbitrator and the expenses relating to the arbitration (exclusive of legal fees) shall be borne equally by Agency and Consultant unless otherwise specified in the award of the arbitrator, in which case such fees and costs paid or payable to the arbitrator shall be included in "reasonable costs and attorneys' fees" for purposes of Section 17.2, and the arbitrator shall specifically have the power to award to the prevailing party pursuant to such Section 17.2 such party's costs and expenses, including fees and costs paid to the arbitrator.

16.2. NOTICE: BY INITIALING IN THE SPACE BELOW YOU ARE AGREEING TO HAVE ANY DISPUTES ARISING IN THIS "ARBITRATION OF DISPUTES" PROVISION DECIDED BY NEUTRAL ARBITRATION AS PROVIDED HEREIN AND BY IDAHO LAW AND YOU ARE GIVING UP ANY RIGHTS YOU MIGHT POSSESS TO HAVE SUCH DISPUTE LITIGATED IN A COURT OR JURY TRIAL. BY INITIALING IN THE SPACE BELOW, YOU ARE GIVING UP YOUR JUDICIAL RIGHTS TO DISCOVERY AND APPEAL, UNLESS THOSE RIGHTS ARE SPECIFICALLY INCLUDED IN THIS "ARBITRATION OF DISPUTES" PROVISION. IF YOU REFUSE TO SUBMIT TO ARBITRATION AFTER AGREEING TO THIS PROVISION, YOU MAY BE COMPELLED TO ARBITRATE UNDER THE AUTHORITY OF THE IDAHO CODE OF CIVIL PROCEDURE. YOUR AGREEMENT OF THE PARTIES TO THIS ARBITRATION PROVISION IS VOLUNTARY.

BY INITIALLING BELOW YOU AFFIRM THAT YOU HAVE READ AND UNDERSTAND THE FOREGOING AND AGREE TO SUBMIT DISPUTES ARISING OUT OF THE MATTERS INCLUDED IN THIS "ARBITRATION OF DISPUTES" PROVISION TO NEUTRAL ARBITRATION.

CONSULTANT AGENCY

17. Miscellaneous.

17.1. This Agreement has been negotiated by and between Consultant and Agency in arms-length negotiations, and both parties are responsible for its drafting. Both parties have reviewed this Agreement with appropriate counsel, or have waived their right to do so, and the parties hereby mutually and irrevocably agree that this Agreement shall be construed neither for nor against either party, but in accordance with the plain language and intent hereof. The invalidity or unenforceability of any provision of this Agreement shall not affect the other provision hereto, and this Agreement shall be construed in all respects as if such invalid or unenforceable provisions were omitted. Headings are used herein for convenience only, and shall play no part in the construction of any provision of this Agreement

17.2. In the event of any dispute between the parties arising under or in relation to this Agreement, the prevailing party in such dispute or litigation shall have the right to receive from the non-prevailing party all of the prevailing party's reasonable costs and attorneys' fees incurred in connection with any such dispute and/or litigation. As used herein, the term "prevailing party" shall refer to that party to this Agreement for whom the result ultimately obtained most closely approximates such party's position in such dispute or litigation.

17.3. This Agreement shall be governed by the laws of the State of Idaho. Notwithstanding anything contained herein to the contrary, venue for any action involving this Agreement shall lie solely in Ada County, Idaho.

17.4. Time is of the essence of this Agreement and every term and condition hereof.

17.5. The waiver by any party hereto of breach of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach by any party.

17.6. This Agreement shall binding upon the parties hereto, their heirs, successors and assigns. Notwithstanding the foregoing, the parties mutually acknowledge that a material and substantial consideration in the parties' mutual execution of this Agreement is the identity and reputation of the other party, and each party's subjective perception of the other's value to and compatibility with such party and its officers, employees, facilities and

patients. As such, notwithstanding anything contained herein to the contrary, this Agreement and the rights of the parties hereunder are personal to the parties and may not be assigned or subcontracted to, nor shall the duties and responsibilities of either hereunder be delegated to or rendered by, any other person or entity without the express prior written consent of the other party, which consent may be granted or denied, conditionally or unconditionally, by a party in its sole, absolute and unfettered discretion.

17.7. Notwithstanding the expiration or earlier termination of this Agreement, the obligations and/or liabilities of the parties hereunder, relating to events, occurring during the Term, to which the parties' indemnification obligations under Section 12 apply, shall continue in full force and effect after the Agreement terminates, subject to applicable statutes of limitation. Additionally, the covenants of the parties under Sections 11.4, 13, 14 and 16 shall survive the termination of this Agreement.

17.8. This Agreement is solely between the parties hereto, and shall not create any right or benefit in any third party, including without limitation any creditor, agent, partner, employee or affiliate of Current Operator, or any entity or agency having jurisdiction of any of the Licenses, the Agency or the operation of the business therein.

17.9. This Agreement represents the entire agreement and understanding of the parties with respect to the subject matter hereof, and supersedes and negates any previous contracts between Agency and Consultant. Agency and Consultant mutually agree that this Agreement may not be modified unless such modification is in writing and signed by both parties.

IN WITNESS WHEREOF, the parties have affixed their signatures hereto as of the dates set forth below.

CONSULTANT:

CORNERSTONE SERVICE CENTER, INC.
a Nevada corporation

BY:_____
Brent Guerisoli
Authorized Agent
Date: September 28, 2019

AGENCY:

EMERALD HEALTHCARE, INC.,
a Nevada corporation

BY:_____
Lee Johnson
Authorized Agent
Date: September 28, 2019

EXHIBIT A
CONSULTING, PROFESSIONAL, AND
OPERATIONAL SUPPORT SERVICES AGREEMENT
(Clinical Services)

THIS EXHIBIT A supplements the foregoing CONSULTING, PROFESSIONAL, AND OPERATIONAL SUPPORT SERVICES AGREEMENT (the "Agreement") made and entered into by and between the therein-named Consultant and Agency and forms a part thereof. The specific duties and obligations described herein may or may not be performed by either party, depending upon the needs, preferences and requests of the other from time to time. The lists of duties and activities are not exhaustive, but where certain duties or activities are expressly limited, excluded or proscribed hereby, such activities shall not be requested or performed. Consultant's services shall be rendered on a non-exclusive basis, and Consultant shall have no duty to limit its services solely to Agency. Any service to be rendered by Consultant hereunder may be, at Consultant's sole option, rendered on a joint or "pooled" basis with or to Agency and other clients of Consultant. Consultant may provide any of its services hereunder through the use or assistance of subcontractors, but such subcontractors shall be subject to all of the terms and conditions of this Agreement. Although Consultant shall have discretion to make certain decisions regarding its Services for Agency in the day-to-day rendition of such services, Agency shall remain solely responsible for all decisions and actions made by, at, for or involving Agency and the operation of Agency's business.

SPECIFIC SERVICES TO BE RENDERED BY CONSULTANT:

1. Technical & Compliance Resource.

A. Assists in the identification and, where requested by Agency the evaluation, of prospective candidates and contractors to serve in clinical and/or leadership roles in the Agency.

B. Assists in designing policies and procedures to periodically review the status of employees to ascertain continued compliance with local and state health regulations for the various specific categories of employees, and proper documentation of compliance.

C. Provides sample form clinical policy and procedure manuals, handbooks and forms; provided that all manuals, materials and forms provided in connection therewith shall be and remain the property of Consultant and may not be copied, reproduced, distributed or used other than with the express written permission of Consultant.

D. Provides a delegate to serve as a resource to and advisory member of the Agency's Quality Assessment and Performance Improvement Committee, who attends and participates in both quarterly and special QAPI meetings; provided that such delegate shall be subject to the same obligations of confidentiality as any other member of the Committee, but shall not be allowed to vote or direct the work of the Committee or the Agency.

E. Assists Agency management in preparing for, reviewing and responding to the various official surveys and inspections of Agency's premises and nursing practices.

F. Participates, solely as a resource and not as a director, in the development of patient care policies and systems for the Agency.

G. Assists in the identification and, where requested by Agency the evaluation, of prospective candidates and contractors to serve in nursing service, nursing, therapy service and other leadership and line staff roles in the Agency. In addition, and at Agency's request and at Agency's sole cost and expense, facilitates the sharing of nursing resource personnel, including specialists, among Agency and other clients of Consultant who wish to obtain such additional personnel and share the cost of hiring, training, and compensating such personnel.

H. Assists in designing policies and procedures to periodically review the health status of employees to ascertain freedom from infection, compliance with local and state health regulations for the various specific categories of employees, and proper documentation of compliance.

I. Participates, in an advisory capacity, with the utilization review committee to develop norms, standards and criteria for the design and conduct of the committee's medical care evaluation studies. However, Consultant shall not direct in any way the functions of the utilization review committee such as individual patient reviews.

J. Participates in the design and periodic evaluation of the Agency's staff development and nursing in-service programs, provided that all manuals, materials and forms provided in connection therewith shall be and remain the property of Consultant and may not be copied, reproduced, distributed or used other than with the express written permission of Consultant.

K. Provides periodic in-services and other formal and informal trainings as requested by Agency, which may be offered simultaneously and in conjunction with the trainings for other of Consultant's clients. Such trainings shall include no nursing, therapy or direct care services by Consultant's representatives, but may or may not include, without limitation, assistance with patient assessment, charting and similar activities when performed in connection with in-services, survey readiness reviews, mock surveys and other similar nursing consulting and training, in order to assist nursing leadership and staff in the lawful and efficient conduct of caregiving and therapy operations; provided that all trainings and materials provided in connection therewith shall be and remain the property of Consultant and may not be copied, reproduced, distributed or used other than with the express written permission of Consultant.

L. Assists in the development, implementation and periodic valuation of certified nursing assistant training programs and other experience-based nursing training activities, whether conducted by Agency or by a third-party educator at Agency's site under a nursing affiliation agreement.

ADDITIONAL DUTIES TO BE PERFORMED BY AGENCY:

Without limiting any other duty or obligation of Agency at law or under the Agreement, Agency shall do all of the following:

2. Agency shall be solely responsible for (i) naming and managing its own Governing Body as required by applicable laws and regulations, (ii) hiring, supervising and evaluating its administrator and other employees, and (iii) overseeing the day-to-day conduct of its business and related activities.

3. Agency shall be solely responsible for providing a safe and sanitary environment for Agency personnel.

4. Agency shall be solely responsible for (i) operating its business in and from the Agency location(s) in substantial compliance with applicable laws and regulations, (ii) maintaining all federal and state licenses and certifications required to operate the Agency and provide Services to patients and clients, (iii) performing all duties required of a licensee and provider under applicable local, state and federal laws, codes, regulations and provider agreements affecting the operation of the Agency, and (iv) notifying Consultant of any threatened, pending or actual revocation or suspension of its Licenses.

5. Timely furnish Consultant with such information and materials as might ordinarily be expected for Consultant to perform its duties hereunder. Agency shall be solely responsible to assure the accuracy and completeness of all information provided by Agency and its personnel to Consultant, and Consultant shall be entitled to rely thereon without inquiry or diligence of any kind.

6. Agency shall not unreasonably restrict or limit Consultant's access to necessary information, and acknowledges Consultant's right to exercise its independent professional judgment, including recommending Services and rendering such Services using such methods, technologies and procedures as Consultant deems appropriate.

7. Consultant's corporate address: 1675 E. Riverside Drive, Suite 150, Eagle, ID 83616, shall serve Agency's mailing address and address for service of process.

8. If requested by Consultant, Agency shall send delegates to Consultant's customer service teams, operator forums, evaluation and other service teams, trainings, and other committees and events as reasonably requested and available. In addition, to the extent available Agency delegates shall from time to time participate, both as trainees and trainers, in training and leadership conferences and events for the benefit of Consultant and others.

9. With Agency's acquiescence, and at Consultant's expense to the extent the trainee does not provide value to Agency, Agency agrees to periodically serve as a training site for Consultant's employees, providing (where available) preceptorship and organized training for CITs and other trainees of Consultant. In the event that a compensated trainee does not provide full value to Agency during his/her training program, Consultant shall pay directly, or reimburse Agency for, the portion of the trainee's compensation and training expenses that exceed the reasonable value provided.

Exhibit B

BUSINESS ASSOCIATE AGREEMENT

AGREEMENT EFFECTIVE DATE:	October 1, 2019
COVERED ENTITY:	**EMERALD HEALTHCARE, INC.** ADDRESS: 4002 TACOMA MALL BLVD STE 204A, TACOMA, WA 98409
BUSINESS ASSOCIATE:	**CORNERSTONE SERVICE CENTER, INC.** ADDRESS: 1675 E. RIVERSIDE DRIVE, SUITE 200, EAGLE, ID 83616

This Business Associate Agreement ("Agreement") is made and entered into as of the Effective Date listed in this Exhibit B, and between the above-listed Covered Entity and Business Associate, with reference to the following facts:

RECITALS

WHEREAS, Business Associate has been engaged to provide staffing services to Covered Entity pursuant to a separate agreement (the "Services Agreement"), and, in connection with those services, Covered Entity may need to disclose to Business Associate, or Business Associate may need to create on Covered Entity's behalf, certain Protected Health Information (as defined below) that is subject to protection under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("HITECH Act"), and regulations promulgated thereunder by the U.S. Department of Health and Human Services to implement certain privacy and security provisions of HIPAA (the "HIPAA Regulations"), codified at 45 C.F.R. Parts 160 and 164; and

WHEREAS, pursuant to the HIPAA Regulations, all business associates of Covered Entity, as a condition of doing business with Covered Entity, must agree in writing to certain mandatory provisions regarding the privacy and security of PHI (as defined below).

NOW THEREFORE, IN CONSIDERATION OF THE FOREGOING, and the mutual promises and covenants contained herein, Business Associate and Covered Entity agree as follows:

AGREEMENT

Definitions.

Unless otherwise specified in this Agreement, all terms not otherwise defined shall have the meanings established in Title 45, Parts 160 and 164, of the United States Code of Federal Regulations, as amended from time to time. Further, capitalized terms used, but not otherwise defined, in this Agreement shall have the meanings set forth in HIPAA, the HIPAA Regulations and the HITECH Act.

1.1 *Breach* shall have the meaning given to such term in 42 U.S.C. § 17921, and shall include the unauthorized acquisition, access, use, or disclosure of PHI which compromises the security or privacy of such information.

1.2 *Business Associate* shall have the meaning given to such phrase under the HIPAA Regulations and the HITECH Act, including, but not limited to, 45 C.F.R. § 160.103 and 42 U.S.C. § 17938, respectively. For purposes of this Agreement, "Business Associate" shall also refer specifically to the entity or individual set forth in the Preamble above.

1.3 *Covered Entity* shall have the meaning given to such phrase under the HIPAA Regulations including, but not limited to, 45 C.F.R. § 160.103. For purposes of this Agreement, "Covered Entity" shall also refer specifically to the entity set forth in the Preamble above.

1.4 *Data Aggregation* shall have the meaning given to such phrase under the Privacy Rule, including, but not limited to, 45 C.F.R. § 164.501.

1.5 *Designated Record Set* means a group of records maintained by or for Covered Entity that may include (i) medical records and billing records about Individuals maintained by or for a covered health care provider, (ii) the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan, or (iii) records used, in whole or in part, by or for Covered Entity to make decisions about Individuals.

1.6 *Electronic Health Record* shall have the meaning given to such phrase in the HITECH Act, including, but not limited to, 42 U.S.C. § 17921(5).

1.7 *Electronic Protected Health Information* ("ePHI") means individually identifiable health information that is transmitted by, or maintained in, electronic media.

1.8 *Health Care Operations* shall have the meaning given to such phrase under the Privacy Rule, including, but not limited to, 45 C.F.R. § 164.501.

1.9 *Individual* has the same meaning as the term *individual* in 45 C.F.R. § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).

1.10 *Privacy Rule* shall mean the Standards for Privacy of Individually Identifiable Health Information codified at 45 C.F.R. Part 160 and Part 164, Subparts A and E, as amended by the HITECH Act and as may otherwise be amended from time to time.

1.11 *Protected Health Information* ("PHI") means any information, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an Individual; the provision of health care to an Individual; or the past, present or future payment for the provision of health care to an Individual; and (ii) that identifies the Individual or with respect to which there is a reasonable basis to believe the information can be used to identify that Individual; and (iii) shall include the definition as set forth in the Privacy Rule including, but not limited to, 45 C.F.R. § 160.103. For purposes of this Agreement, PHI shall include ePHI.

1.12 *Required By Law* shall have the same meaning as the phrase *required by law* in 45 C.F.R. § 164.103.

1.13 *Secretary* means the Secretary of the U.S. Department of Health and Human Services or his/her designee.

1.14 *Security Incident* means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

1.15 *Security Rule* shall mean the HIPAA Regulations that are codified at 45 C.F.R. Part 160 and Part 164, Subparts A and C, as amended by the HITECH Act and as may otherwise be amended from time to time.

1.16 *Unsecured PHI* shall mean PHI that is not secured through the use of a technology or methodology specified by the Secretary in guidance or as otherwise defined in 42 U.S.C. § 17932(h).

Scope of Agreement.

This Agreement applies to the PHI of Covered Entity to which Business Associate may be exposed as a result of the services that Business Associate will provide to Covered Entity pursuant to the Services Agreement. Business Associate shall abide by HIPAA, the HIPAA Regulations and the HITECH Act with respect to PHI of Covered Entity, as outlined below.

Obligations and Activities of Business Associate.

3.1 *Permitted Uses*. Except as otherwise limited in this Agreement, Business Associate may use PHI (i) for the proper management and administration of Business Associate, (ii) to carry out the legal responsibilities of Business Associate, or (iii) for Data Aggregation purposes for the Health Care Operations of Covered Entity. Business Associate may use PHI to provide services to Covered Entity under the Services Agreement provided that Business Associate shall not use PHI in any manner that would constitute a violation of the Privacy Rule or the HITECH Act if so used by Covered Entity.

3.2 *Permitted Disclosures*. Business Associate may disclose PHI (i) for the proper management and administration of Business Associate; (ii) to carry out the legal responsibilities of Business Associate; (iii) as Required By Law; or (iv) for Data Aggregation purposes for the Health Care Operations of Covered Entity. Business Associate may disclose PHI to provide services to Covered Entity under the Services Agreement, provided that Business Associate shall not disclose PHI in any manner that would constitute a violation of the Privacy Rule or the HITECH Act if so disclosed by Covered Entity.

3.2.1 In addition, if Business Associate discloses PHI to a third party, for Business Associate's management and administration purposes as specified in Section 3.2, Business Associate must obtain, prior to making any such disclosure, (i) reasonable written assurances from such third party that the PHI will be held as confidential as provided pursuant to this Agreement and only disclosed as Required By Law or for the purposes for which it was disclosed to such third party; and (ii) a written agreement from such third party to immediately notify Business Associate of any breaches of confidentiality of the PHI, to the extent such third party has obtained knowledge of such breach.

3.3 *Prohibited Uses and Disclosures*. Business Associate shall not use or disclose PHI for fundraising or marketing purposes. In accordance with 42 U.S.C. § 17935(a), Business Associate shall not disclose PHI to a health plan for payment or Health Care Operations purposes if the patient has requested this special restriction, and has paid out of pocket in full for the health care item or service to which the PHI solely relates. Business Associate shall not directly or indirectly receive remuneration in exchange for PHI, except with the prior written consent of Covered Entity and Individual and as permitted by 42 U.S.C. § 17935(d)(1) and (2); however, this prohibition shall not affect payment by Covered Entity to Business Associate for services provided pursuant to the Services Agreement.

3.4 *Other Business Associates.* As part of its providing functions, activities, and/or services to Covered Entity, Business Associate may disclose information, including PHI, to other business associates of Covered Entity, and Business Associate may use and disclose information, including PHI, received from other business associates of Covered Entity as if this information was received from, or originated with, Covered Entity.

3.5 *Safeguards for Protection of ePHI*. Business Associate agrees to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of Covered Entity. In accordance with 42 U.S.C. § 17931 of the HITECH Act, Business Associate shall be directly responsible for full compliance with the policies and procedures and documentation requirements of the HIPAA Security Rule, including, but not limited to, 45 C.F.R. §§ 164.308, 164.310, 164.312, and 164.316. Business Associate shall implement and at all times use all appropriate safeguards to prevent any use or disclosure of PHI not authorized under this Agreement.

3.6 *Reporting of Unauthorized Uses or Disclosures and Security Incidents*. Business Associate agrees to report to Covered Entity in writing any access, use or disclosure of the PHI not provided for or permitted by this Agreement and, any Security Incidents of which Business Associate (or Business Associate's employee, officer or agent) becomes aware. Business Associate shall so notify Covered Entity pursuant to this Section within twenty-four (24) hours after Business Associate becomes aware of such unauthorized use, disclosure or Security Incident. The notice to be provided pursuant to this Section shall be substantially in the same form as **Exhibit 1**, which is attached hereto.

3.7 *Reporting of Breach of Unsecured PHI*. Business Associate agrees to report to Covered Entity any Breach of Unsecured PHI of which Business Associate (or Business Associate's employee, officer or agent) becomes aware without unreasonable delay and in no case later than the next business day after Business Associate learns of such Breach, except where a law enforcement official determines that a notification would impede a criminal investigation or cause damage to national security. Business Associate's notification to Covered Entity hereunder shall be substantially in the same form as **Exhibit 1**.

3.8 *Agents and Subcontractors*. Business Associate agrees to ensure that any agent, including a subcontractor, to whom Business Associate provides PHI, agrees in writing to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such PHI, and implement the safeguards required by Section 3.5 above with respect to ePHI.

3.9 *Mitigation of Unauthorized Uses or Disclosures*. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate or one of its agents or subcontractors in violation of the requirements of this Agreement.

3.10 *Authorized Access to PHI*.

3.10.1 *Individual Requests for Access*. Business Associate shall cooperate with Covered Entity to fulfill all requests by Individuals for access to the Individual's PHI that are approved by Covered Entity. Business Associate shall cooperate with Covered Entity in all respects necessary for Covered Entity to comply with 45 C.F.R. §164.524 and applicable State law. If Business Associate receives a request from an Individual for access to PHI, Business Associate shall immediately forward such request to Covered Entity.

3.10.2 *Scope of Disclosure*. Covered Entity shall be solely responsible for determining the scope of PHI and/or Designated Record Set with respect to each request by an Individual for access to PHI. In the event that Covered Entity decides to charge a reasonable cost-based fee for the reproduction and delivery of PHI to an Individual, Covered Entity shall deliver a

portion of this fee to Business Associate in the event any such reproduction or delivery is made by Business Associate, and in proportion to the amount of work done by Business Associate in producing and delivering the PHI.

3.10.3 Designated Record Set. To the extent that Business Associate maintains PHI in a Designated Record Set and at the request of Covered Entity, Business Associate agrees to provide access to PHI in a Designated Record Set to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 C.F.R. § 164.524 and applicable State law. If Business Associate maintains PHI in a Designated Record Set, and maintains an Electronic Health Record, then Business Associate shall provide such Designated Record Set in electronic format to enable Covered Entity to fulfill its obligations under the HITECH Act, including, but not limited to, 42 U.S.C. § 17935(e).

3.10.4 Patient Right to Amend to PHI. A patient has the right to have Covered Entity amend his/her PHI, or a record in a Designated Record Set for as long as the PHI is maintained in the Designated Record Set, in accordance with 42 C.F.R. §164.526. To the extent that Business Associate maintains PHI in a Designated Record Set, Business Associate agrees to make any amendment(s) to PHI in a Designated Record Set at the request of Covered Entity in accordance with 45 C.F.R. § 164.526. Within fifteen (15) business days following Business Associate's amendment of PHI as directed by Covered Entity, Business Associate shall provide written notice to Covered Entity confirming that Business Associate has made the amendments or addenda to PHI as directed by Covered Entity and containing any other information as may be necessary for Covered Entity to provide adequate notice to the Individual in accordance with 45 C.F.R. §164.526.

3.11 Accounting for Disclosures.

3.11.1 Disclosures. In the event that Business Associate makes any disclosures of PHI that are subject to the accounting requirements of the Privacy Rule 45 C.F.R. §164.528 and/or the HITECH Act including, but not limited to, 42 U.S.C. § 17935(c))[1], Business Associate shall report such disclosures to Covered Entity within three (3) days of such disclosure. The notice by Business Associate to Covered Entity of the disclosure shall include the name of the Individual, the recipient, the reason for disclosure, and the date of the disclosure. Business Associate shall maintain a record of each such disclosure that shall include: (i) the date of the disclosure; (ii) the name and, if available, the address of the recipient of the PHI; (iii) a brief description of the PHI disclosed; and (iv) a brief description of the purpose of the disclosure. Business Associate shall maintain this record for a period of six (6) years and make it available to Covered Entity upon request in an electronic format so that Covered Entity may meet its disclosure accounting obligations under 45 C.F.R. §164.528. If Covered Entity provides a list of its business associates to an Individual in response to a request by an Individual for an accounting of disclosures, and the Individual thereafter specifically requests an accounting of disclosures from Business Associate, then Business Associate shall provide an accounting of disclosures to such Individual.

3.11.2 Electronic Health Record. Business Associate acknowledges that, to the extent Business Associate maintains an Electronic Health Record for Covered Entity, Business Associate is only required to provide an Individual with an accounting of disclosures related to treatment, payment or Health Care Operations for a period of three (3) years prior to such Individual's request. Therefore, upon request by an Individual to Covered Entity for an accounting of disclosures related to treatment, payment or Health Care Operations, Business Associate shall provide to Covered Entity, within three (3) days of Business

[1] The provisions of 42 U.S.C. § 17935(c) become effective on the following dates: (i) for users of electronic health records as of January 1, 2009, this section shall apply to disclosures made by the Covered Entity on and after January 1, 2014; (ii) for covered entities that acquire an electronic health record after January 1, 2009, this section shall apply to disclosures made by the Covered Entity after the later of January 1, 2011 or the date it acquires an electronic health record.

Associate's receipt of a written request from Covered Entity, an accounting of such disclosures for the three (3) year period prior to such request. Notwithstanding this Section, a record of disclosures pertaining to information disclosed by Business Associate for treatment, payment or Health Care Operations shall be maintained in accordance with Section 3.11.1, above.

3.12 *Secretary's Right to Audit*. Business Associate agrees to make its internal practices, books, and records relating to the use and disclosure of PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity, available to the Secretary for purposes of the Secretary determining Covered Entity's and/or Business Associate's compliance with HIPAA, the HIPAA Regulations and the HITECH Act. No attorney-client, or other legal privilege will be deemed to have been waived by Business Associate by virtue of this provision of the Agreement. Business Associate shall provide to Covered Entity a copy of any PHI and related documents that Business Associate provides to the Secretary concurrently with providing such documents to the Secretary.

3.13 *Data Ownership*. All PHI shall be deemed owned by Covered Entity unless otherwise agreed in writing.

3.14 *Compliance*. To the extent Business Associate is to carry out a Covered Entity's obligation under the HIPAA Privacy Regulations, Business Associate shall comply with the requirements of the Privacy Regulations that apply to Covered Entity in the performance of such obligation.

4 **Obligations of Covered Entity**.

4.1 *Notice of Privacy Practices*. Upon written request by Business Associate, Covered Entity shall provide Business Associate with Covered Entity's then current Notice of Privacy Practices.

4.2 *Revocation of Permitted Use or Disclosure of PHI*. Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by the patient to use or disclose PHI of Covered Entity, to the extent that such changes may affect Business Associate's use or disclosure of PHI of Covered Entity.

4.3 *Restrictions on Use or Disclosure of PHI*. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 C.F.R. § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

4.4 *Requested Uses or Disclosures of PHI*. Except for Data Aggregation or management and administrative activities of Business Associate, Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the HIPAA Regulations if done by Covered Entity.

5 **Term and Termination**.

5.1 *Term*. The term of this Agreement shall be coterminous with the Services Agreement. However, Business Associate shall have a continuing obligation to safeguard the confidentiality of PHI received from Covered Entity after the termination of the Services Agreement.

5.2 *Termination Without Cause*. Either party may terminate this Agreement without cause or penalty by the delivery of a written notice from the terminating party to the other party. Such termination is effective thirty (30) calendar days from the date that the other party receives such notice.

5.3 *Termination for Cause*. A breach of any provision of this Agreement by Business Associate shall constitute a material breach of this Agreement and shall provide grounds for immediate termination

of this Agreement by Covered Entity, any provision in this Agreement to the contrary notwithstanding.

5.4 *Judicial or Administrative Proceedings*. Either party may terminate the Agreement, effective immediately, if (i) the other party is named as a defendant in a criminal proceeding for a violation of HIPAA, the HIPAA Regulations, the HITECH Act, or other security or privacy laws or (ii) a finding or stipulation that the other party has violated any standard or requirement of HIPAA, the HIPAA Regulations, the HITECH Act or other security or privacy laws is made in any administrative or civil proceeding in which the party has been joined.

5.5 *Effect of Termination*.

5.5.1 Except as provided in Section 5.5.2, herein, upon termination of this Agreement for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity, including PHI in possession of any Business Associate's subcontractors and retain no copies or backup records of such PHI in any form or medium. Business Associate shall certify in writing to Covered Entity that such PHI has been destroyed.

5.5.2 In the event that Business Associate determines that returning or destroying the PHI is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction unfeasible. Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures to those purposes that make the return or destruction of the PHI unfeasible, for so long as Business Associate maintains such PHI.

6 **Breach Pattern or Practice**.

If either party (the "Non-Breaching Party") knows of a pattern of activity or practice of the other party (the "Breaching Party") that constitutes a material breach or violation of the Breaching Party's obligations under this Agreement, the Non-Breaching Party shall either (i) terminate this Agreement in accordance with Section 5 above, or (ii) take reasonable steps to cure the breach or end the violation. If the steps are unsuccessful, the Non-Breaching Party must terminate the Agreement if feasible. The Non-Breaching Party shall provide written notice to the Breaching Party of any pattern of activity or practice of the Breaching Party that the Non-Breaching Party believes constitutes a material breach or violation of the Breaching Party's obligations under this Agreement within three (3) days of discovery and shall meet with the Breaching Party's Privacy Coordinator to discuss and attempt to resolve the problem as one of the reasonable steps to cure the breach or end the violation.

7 **Disclaimer**.

Covered Entity makes no warranty or representation that compliance by Business Associate with this Agreement, HIPAA, the HIPAA Regulations, or the HITECH Act will be adequate or satisfactory for Business Associate's own purposes. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.

8 **Certification**.

To the extent that Covered Entity determines that such examination is necessary to comply with Covered Entity's legal obligation pursuant to HIPAA, the HIPAA Regulations, and the HITECH Act, Covered Entity or its authorized agents or contractors may, at Covered Entity's expense, examine Business Associate's facilities, systems, procedures (including but not limited to review of training procedures for Business Associate's staff) and records as may be necessary for such agents or contractors to certify to Covered Entity the extent to which Business Associate's security safeguards comply with HIPAA, the HIPAA Regulations, the HITECH Act, and this Agreement.

9 **Indemnification**.

Notwithstanding any contrary provision in the Services Agreement, Business Associate agrees to indemnify, defend and hold harmless Covered Entity, its shareholders, directors, officers, employees, affiliates, and agents ("Indemnified Party") against all actual and direct losses suffered by the Indemnified Party from any breach of this Agreement, negligence or wrongful acts or omissions, including, without limitation, failure to perform its obligations under this Agreement or Breach of Unsecured PHI, by Business Associate or its employees, directors, officers, subcontractors, agents or other members of its workforce. Accordingly, on demand, Business Associate shall reimburse the Indemnified Party for any and all actual and direct losses, liabilities, lost profits, fines, penalties, costs or expenses (including reasonable attorneys' fees) which may for any reason be incurred by Indemnified Party or imposed upon the Indemnified Party by reason of any suit, claim, action, proceeding or demand by any third party, as a result of the Business Associate's breach hereunder.

10 **Compliance With State Law**.

Business Associate acknowledges that Business Associate and Covered Entity may have confidentiality and privacy obligations under applicable State law. If any provisions of this Agreement or HIPAA/HIPAA Regulations/HITECH Act conflict with state law regarding the degree of protection provided for PHI and patient medical records, then Business Associate shall comply with the more restrictive requirements.

11 **Miscellaneous**.

11.1 *Amendment*. Business Associate and Covered Entity agree to take such action as is necessary to amend this Agreement from time to time to enable Covered Entity to comply with the requirements of HIPAA, the HIPAA Regulations and the HITECH Act. This Agreement may not be modified, nor shall any provision hereof be waived or amended, except in a writing duly signed and agreed to by Business Associate and Covered Entity.

11.2 *Interpretation*. The provisions of this Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HIPAA Regulations, the HITECH Act, the Privacy Rule and the Security Rule. The parties agree that any ambiguity in this Agreement shall be resolved in favor of a meaning that complies and is consistent with HIPAA, the HIPAA Regulations, the HITECH Act, the Privacy Rule and the Security Rule.

11.3 *No Third Party Beneficiaries*. Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than Business Associate and Covered Entity, and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.

11.4 *Notices*. All notices or other communications required or permitted hereunder shall be in writing and shall be deemed given or delivered (i) when delivered personally, against written receipt; (ii) if sent by registered or certified mail, return receipt requested, postage prepaid, when received; (iii) when received by facsimile transmission; or (iv) when delivered by a nationally recognized overnight courier service, prepaid, and shall be sent to the addresses set forth on the signature page of this Agreement or at such other address as each party may designate by written notice to the other by following this notice procedure.

11.5 *Regulatory References*. A reference in this Agreement to a section in the HIPAA Regulations or the HITECH Act means the section as in effect or as amended, and for which compliance is required.

11.6 *Assistance in Litigation or Administrative Proceedings*. Business Associate shall make itself, and any subcontractors, employees or agents, available to Covered Entity, at no cost to Covered Entity, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being

commenced against Covered Entity, its directors, officers or employees based upon a claimed violation of HIPAA, the HIPAA Regulations, the HITECH Act, the Privacy Rule, the Security Rule, or other laws relating to security and privacy, except where Business Associate or its subcontractor, employee or agent is a named adverse party.

11.7 *Subpoenas*. In the event that Business Associate receives a subpoena or similar notice or request from any judicial, administrative or other party arising out of or in connection with this Agreement, including, but not limited to, any unauthorized use or disclosure of PHI, Business Associate shall promptly forward a copy of such subpoena, notice or request to Covered Entity and afford Covered Entity the opportunity to exercise any rights it may have under law.

11.8 *Survival*. The respective rights and obligations of Business Associate under Section 3 et seq. of this Agreement shall survive the termination of this Agreement. In addition, Section 5.5 (Effect of Termination), Section 7 (Disclaimer), Section 9 (Indemnification), Section 10 (Compliance with State Law), Section 11.4 (Notices), Section 11.6 (Assistance in Litigation and Administrative Proceedings), Section 11.7 (Subpoenas), and Section 11.9 (Governing Law) shall survive the termination of this Agreement.

11.9 *Governing Law*. This Agreement shall be governed by and construed in accordance with the laws of the state in which the covered entity is principally located to the extent that the provisions of HIPAA, the HIPAA Regulations or the HITECH Act do not preempt the laws of that state.

11.10 *Independent Contractors*. Covered Entity and Business Associate shall be independent contractors and nothing in this Agreement is intended nor shall be construed to create an agency, partnership, employer-employee, or joint venture relationship between them.

[Signature Page to follow]

IN WITNESS WHEREOF, the parties have affixed their signatures hereto as of the dates set forth below.

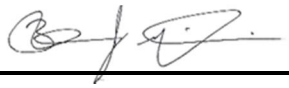
COVERED ENTITY: Emerald Healthcare, Inc.	**BUSINESS ASSOCIATE: PENNANT SERVICES, INC.**
Sign: 	**Sign:** 
Name: Lee Johnson	Name: Brent Guerisoli
Title: Authorized Agent	Title: Authorized Agent
Date: September 28, 2019	Date: September 28, 2019

Exhibit 1

Notification to Emerald Healthcare, Inc. of
Unauthorized Use or Disclosure of PHI/Breach of Unsecured PHI

Attn: Privacy Officer
Emerald Healthcare, Inc.
4002 Tacoma Mall Blvd Ste 204A, Tacoma, WA 98409
Phone: 253-735-4282
Fax: 253-833-8933
Email: _____

This notification is made pursuant to Sections 3.6 and 3.7 of the Business Associate Agreement between Covered Entity and Business Associate.

Business Associate hereby notifies Covered Entity that there has been a breach of protected health information ("PHI") that Business Associate has used or has had access to under the terms of the Business Associate Agreement.

Description of the breach: _____
_____

Date of the breach: _____

Date of the discovery of the breach: _____

Number of individuals affected by the breach: _____

The types of PHI that were involved in the breach (e.g., full name, Social Security number, date of birth, home address, account number): _____
_____

Description of what Business Associate is doing to investigate the breach, mitigate losses, and protect against further breaches: _____
_____
_____
_____

Business Associate contact information: _____
_____
_____

CONSULTING, PROFESSIONAL, AND OPERATIONAL SUPPORT SERVICES AGREEMENT
(Administrative Services)

Effective Date:	**October 1, 2019**
CONSULTANT:	**Pennant Services, Inc., a Nevada corporation**
Address:	1675 E. Riverside Drive, Ste. 150, Eagle, ID 83616
Phone:	(208) 401-1400
Fax:	(208) 401-1401
FACILITY:	**Emerald Healthcare, Inc. d/b/a Puget Sound Home Health of King County**
Address:	4002 Tacoma Mall Blvd Ste 204A, Tacoma, WA 98409
Phone:	253-735-4282
Fax:	253-833-8933
FEIN:	82-1048747

THIS CONSULTING, PROFESSIONAL, AND OPERATIONAL SUPPORT SERVICES AGREEMENT ("Agreement") is made and entered into by and between the above-named Consultant and Agency as of the Effective Date, with respect to the following facts and intentions:

R E C I T A L S

A. Agency is an independently operated, licensed and certified Home Health, Hospice and/or Home Care Agency operating from the address set forth above (the "Agency Primary Location");

B. Consultant is a provider of centralized consulting, professional, and operational support designed to aid the efficient, competitive, and sound operation of entities like Agency;

C. Agency desires to engage the services of Consultant to assist Agency personnel with aspects of Agency's operations and activities, in order to facilitate Agency personnel's focus on Agency's primary mission of rendering superior hospice services to the Agency's patients and clients.

NOW THEREFORE, IN CONSIDERATION OF THE PREMISES and for other good and valuable consideration, the receipt and sufficiency of which the parties hereby mutually acknowledge, the parties agree to the following:

TERMS AND CONDITIONS

1. Incorporation of Exhibits and Recitals. The Recitals set forth above, as well as the exhibits attached hereto, are incorporated herein by this reference as if fully set forth herein.

2. Consultant's Duties. The Consultant agrees to provide such of the following services ("Services") as Agency, at Agency's option and request from time to time, desires to obtain from Consultant during the term of this Agreement, and to perform its duties hereunder in a good, professional and workmanlike manner. Such duties shall include, without limitation (herein the "Services"):

2.1. General Consultant's Duties, Generally.

2.1.1. Consultant will provide Services in substantial conformance to applicable federal and state laws and the established policies of Consultant and Agency in effect from time to time, and Consultant will conduct periodic self-audit/compliance reviews in order to ensure that Consultant substantially complies with federal, state and local statutes and regulations applicable to the provision of the Services. Agency hereby grants to Consultant a limited power of attorney to act in Agency's name and stead for the convenience of Agency and/or Consultant, provided that this power shall not be used except in conjunction with the enumerated Services under this Agreement.

2.1.2. Consultant shall make clear to all parties with whom it deals in the course of rendering the Services that it is an independent contractor and not an employer, employee, partner, co-venturer, or management Agency of Agency. At all times while in the Agency and while with Agency's patients, Consultant's employees and representatives shall wear uniforms and/or badges clearly indicating their affiliation with Consultant.

2.2. Specific Duties of Consultant. During the term of this Agreement, Consultant shall provide to Agency the specific Services listed in Exhibit A at the request of the Agency. In the event of any conflict between the terms of Exhibit A and the terms contained in the main body of this Agreement, the terms of Exhibit A shall control. Consultant's duties shall specifically not include (i) the rendition of any direct care to patients or residents, (ii) maintenance or handling of patient trust property, or (iii) any other service not specifically enumerated herein as a part of the Services and requested by Agency, all of which shall be the sole duty and domain of Agency, its administrators, caregivers and other staff.

3. Agency's Duties. Agency shall:

3.1. Operate its business in and from the Agency in substantial compliance with applicable laws and regulations, and maintain all federal and state licenses and certifications required to operate the Agency and provide Services to patients (collectively the "Licenses"). Agency shall perform all duties required of a licensee and provider under applicable local, state and federal laws, codes, regulations and provider agreements affecting the operation of the Agency. Within five (5) days of receipt, Agency shall deliver to Consultant notification of any actual revocation or suspension of its Licenses.

3.2. Not unreasonably restrict or limit the Consultant's right to exercise its independent professional judgment, including its right to recommend Services to be rendered

and to render such Services using such methods, technologies and procedures as Consultant deems appropriate.

3.3. Timely furnish Consultant with such information and materials as might ordinarily be expected for Consultant to perform its duties hereunder. Agency shall be solely responsible to assure the accuracy and completeness of all information provided by Agency and its personnel to Consultant, and Consultant shall be entitled to rely thereon without inquiry or diligence of any kind.

3.4. As and to the extent that Consultant's employees and agents require access to the Agency to perform the Services, Agency shall provide adequate working space, equipment and access to Agency's staff for the provision of Services. Equipment and materials placed at the Agency by Consultant shall be used exclusively for the purposes of this Agreement. Upon termination or at Consultant's request, Agency shall return equipment and materials, in the same condition as when delivered to Agency, reasonable wear and tear excepted.

3.5. In addition to the foregoing, during the term of this Agreement, Agency shall cooperate with Consultant and Consultant's other client agencies and businesses as more fully set forth in Exhibit A.

4. Compensation.

4.1. For and in consideration of the Services to be provided under this Agreement, the Agency shall pay to the Consultant as the "Consultant Compensation" a monthly consulting fee equal to five percent (5.0%) of Agency's gross revenue from all sources. A reasonable estimate of anticipated monthly Consultant Compensation shall be paid on or before the first (1st) day of each month during the Term hereof, and shall be "trued up" at the beginning of the next following month with such following month's estimated payment. Payment for any partial month of the Term shall be prorated based on the number of days during the month that Consultant served under this Agreement. In the event Agency closes during any month during the Term, the Consultant Compensation for any such month or partial month shall be calculated, at Consultant's option, based on historical revenues and patient mix. At Consultant's option Consultant shall be entitled to deduct the Consultant Compensation from sums collected for Agency by Consultant, and shall provide Agency with invoices (or if paid by deduction accountings) for the monthly fee by the last day of the month following the month of service.

4.2. In addition to and not as part of the Consultant Compensation, Agency shall reimburse Consultant for all costs and expenses advanced, incurred, or paid by Consultant in the rendition of Services.

5. Insurance.

5.1. Both Consultant and Agency agree to maintain general and professional liability insurance during the term of this agreement in an amount not less than One Million Dollars ($1,000,000) per claim and Three Million Dollars ($3,000,000) in the aggregate.

5.2. Both parties agree to maintain such other and further insurance as may be required by law or the terms of any agreement to which they are parties, including without

limitation worker's compensation insurance (where required by law), crime insurance, directors and officers coverage, automobile and similar liability, and property and casualty insurance, and will list Agency as named insured on all obtained policies.

5.3. All insurance policies shall be issued by insurance companies with a policyholder rating of at least "B+" in the most recent version of Best's Key Rating Guide.

6. Term and Termination. The Term of this Agreement shall commence on the Effective Date and continue thereafter for a period of one (1) year. This Agreement shall automatically extend for additional periods of one (1) year each unless written notice of termination is given not less than sixty (60) days prior to the end of the then-current term. Notwithstanding anything contained herein to the contrary, either party may terminate this Agreement and the Term hereof at any time during the Term upon sixty (60) days written notice; further, in the event of (i) abandonment by a party of its duties hereunder, (ii) nonpayment of any Consultant Compensation within five (5) days after delivery of invoice or other written demand therefor; (iii) any breach or violation of this Agreement (other than non- payment of Consultant Compensation) which is not cured within thirty (30) days following delivery of written notice of such breach or violation, (iv) any material violation of law or regulations, or loss or failure of license or licensure, or violation of the eligibility requirements for reimbursement under any government program by a party, or (v) the occurrence or existence of any condition, practice, procedure, action, inaction or omission of, by or involving a party which, in the reasonable opinion of the other party constitutes either a threat to the health, safety, and welfare of any patient or client or a violation of any law, regulation, requirement, Licenses, eligibility or material agreement governing Agency's or Consultant's operation, then the other party shall have the right to summarily and immediately terminate this Agreement upon written notice to the first party.

7. Regulatory Changes. Agency and Consultant mutually agree that in the event local, state or federal government agencies promulgate regulations which materially affect the terms of this Agreement, including but not limited to changes affecting the cost of providing Services hereunder, this Agreement shall be immediately subject to renegotiation upon the initiative of either party.

8. Warranties.

8.1. Agency's Warranties. Agency hereby makes the following warranties and representations to Consultant in connection with Consultant's entry into this Agreement, which warranties shall survive the termination of this Agreement:

8.1.1. Agency is properly licensed by the State in which the Agency's operation(s) is located by the proper licensing and certification authorities for such State, and all permits and licenses required for the operation of Agency's business(es) have been received and are now currently effective.

8.1.2. As of the Effective Date, except as specifically disclosed on Schedule 1 attached hereto and incorporated herein, there is no litigation, administrative proceedings, event, or hold or similar lien on State or Federal payments to Agency, either underway or threatened, nor are there arbitration proceedings or governmental investigations relating to the Agency, or the business conducted thereon underway or threatened against Agency or brought by the Agency

8.1.3. To the best of Agency's knowledge, the business operations of the Agency at the Commencement Date comply with all local, State and Federal zoning, labor and other applicable laws, ordinances, rules and regulations applicable to the Agency.

8.1.4. Agency has been duly formed in the state of its domicile and remains in good standing in such state, and (if operating in a state other than its domicile) has been duly registered and authorized to do business in the state where its business operation(s) is located and is in good standing in that state as well.

8.1.5. Agency is authorized to consummate the transactions covered by this Agreement.

8.2. Consultant's Warranties. Consultant hereby makes the following warranties and representations to Agency in connection with Agency's entry into this Agreement, which warranties shall survive the termination of this Agreement:

8.2.1. Consultant is a Nevada corporation in good standing, and is registered to do business in, and is in good standing with, the State of Idaho.

8.2.2. Consultant is authorized to consummate the transactions covered by this Consulting Agreement.

9. Licensure, Eligibility and Compliance.

9.1. Consultant acknowledges that its activities under this Agreement may be governed by, *inter alia*, the United States Department of Health and Human Services' Office of the Inspector General's ("OIG") Compliance Program Guidance for Home Health Agencies and/or the OIG's Compliance Program Guidance for Hospices. Consultant represents and warrants that neither Consultant nor any individual or entity with a direct or indirect ownership or control interest of five percent (5%) or more in Consultant, nor any director, officer, agent or employee of such party, is debarred, suspended or excluded under any state or federal healthcare program it is currently eligible to participate in Medicare, Medicaid, and all other federally funded health care programs and is not subject to any sanction or exclusion by any of those programs. Consultant agrees to immediately disclose any actual or threatened federal, state or local investigations or imposed sanctions of any kind, in progress or initiated subsequent to the date of entering into this Agreement. Consultant further represents and warrants that it is not currently sanctioned under any applicable state or federal fraud and abuse statutes, including exclusion from any state or federal health care program. If, during the term of this Agreement, Consultant, its parent, or any officer, director or owner receives such a sanction, or notice of proposed sanction, Consultant shall provide notice of and a full explanation of such sanction or proposed sanction and the period of its duration within ten (10) days of receipt. Agency reserves the right to terminate the Agreement immediately upon receipt of notice that Consultant has been sanctioned under fraud and abuse statutes and/or any other federal, state or local regulation.

9.2. If the Agency Primary Location is located in the state of Texas, Consultant agrees to complete, execute and deliver to Agency upon request a Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion for Covered Contracts on Form 2046 as promulgated by the Texas Department of Protective & Regulatory Services.

9.3. Consultant acknowledges that it has received a copy of Agency's Code of Conduct, and agrees to abide by the provisions thereof governing Vendors and Vendor services.

10. Consultant's Schedule and Availability.

10.1. Consultant shall be reasonably available on an on-call basis to the Agency to fulfill Consultant's duties hereunder.

10.2. Nothing in this Agreement shall be construed as limiting or restricting in any manner Consultant's right to render the same or similar services to other individuals or entities, including but not limited to, other hospice and in-home care during or subsequent to the Term of this Agreement; similarly, nothing in this Agreement shall require Agency to exclusively use all of Consultant's services in the Agency during the Term of this Agreement.

10.3. Consultant's employees and representatives are entitled to be reasonably absent for annual vacations, sick leave, continuing education, and personal reasons; provided that in the event of any absence Consultant shall consult with the Agency concerning the impending absence and cooperate with the Agency in providing alternate resources to Agency to temporarily fulfill Consultant's duties during the period of absence.

11. Contractual Relationship.

11.1. Independent Contractor. It is expressly acknowledged by both parties that Consultant is an independent contractor. Nothing herein is intended to be construed to create an employer-employee, partnership, joint venturer or other relationship between Consultant and the Agency. Agency has and shall retain all statutory liability and responsibility for the continued operation of the Agency as the licensee under Agency's Licenses. No provision of this Agreement shall create any right in the Agency to exercise control or direction over the manner or method by which Consultant performs its duties or renders Services hereunder, nor shall Consultant exercise control or direction over the manner or method by which Agency operates or serves its patients and clients; provided always, that services shall be provided in a manner consistent with all applicable laws, rules and regulations of all governmental authorities, and Agency's Code of Conduct. Agency will not withhold from compensation payable to Consultant hereunder, or be in any way responsible for, any sums for income tax, employment insurance, Social Security, or any other agency and Consultant agrees that the payment of all such amounts as may be required by law are and shall be the sole responsibility of Consultant.

11.2. Fair Market Value. The amounts to be paid to Consultant hereunder have been determined by the parties through good faith and arms-length bargaining to be the fair market value of the services to be rendered hereunder. No amount paid or to be paid hereunder is intended to be, nor will it be construed as, an offer, inducement or payment, whether directly or indirectly, overtly or covertly, for the referral of patients by Consultant to Agency, or by Agency to Consultant, or for the recommending or arranging of the purchase, lease or order of any item or service. For purposes of this section, Consultant and Agency will include each such entity and any affiliate thereof. No referrals are required under this Agreement.

11.3. Work Product. The work product created in the course of Consultant's services under this agreement shall be the exclusive property of Consultant, and all manuals, forms, and documents (including without limitation, all writings, drawings, blueprints, pictures, recordings, computer or machine readable data, and all copies or reproductions thereof) which result from, describe or relate to the services performed or to be performed pursuant to this agreement or the results thereof, including without limitation all notes, data, reports or other information received or generated in the performance of this Agreement (excepting data incorporated in medical records required to be kept and maintained by Agency), shall be the exclusive property of Consultant and shall be delivered to Consultant upon request.

11.4. Non-Solicitation of Consultant's Employees. During the term of this Agreement, Agency shall not solicit the services of, or hire as an employee or independent contractor at the Agency, any Consultant employee, agent or representative who provided, managed or otherwise was involved in the provision of Services to Agency within the previous twelve (12) months (a "Restricted Employee"). Nothing herein shall preclude Agency from advertising available positions or opportunities by posting in the Agency or through newspaper ads or other generally accepted recruiting mediums. The parties acknowledge that the restrictions set forth in this Article are reasonable in scope and important to Consultant's business interests, and that the enforcement of this Article does not restrict Agency from engaging in Services for its own account. In the event that Agency hires a Restricted Employee, Agency shall pay a recruiting fee to Consultant in the amount of Seven Thousand Five Hundred and No/100 Dollars ($7,500.00) per Restricted Employee hired.

12. Indemnification.

12.1. Agency agrees to defend, indemnify, and hold Consultant, its parent, subsidiaries, affiliated and related companies, directors, officers, employees, and agents, wholly harmless from and against any and all costs (including reasonable attorney's fees) liabilities, claims, losses, lawsuits, settlements, demands, causes, judgments and expenses arising from the performance of this Agreement to the extent that such costs and liabilities result from the negligence or willful misconduct of Agency.

12.2. Consultant agrees to defend, indemnify, and hold Agency, its parent, subsidiaries, affiliated and related companies, directors, officers, employees, and agents, wholly harmless for, from and against any and all costs (including reasonable attorney's fees), liabilities, claims, losses, lawsuits, settlements, demands, causes, judgments and expenses arising from or connected with Consultant's acts or omissions or the performance of this Agreement, to the extent that such costs and liabilities are alleged to result from the negligence or willful misconduct of Consultant.

12.3. A party receiving notice of a claim or potential claim shall send written notice to the other within ten (10) business days, and shall fully cooperate in the defense thereof by counsel mutually acceptable to the parties. The parties' rights to indemnification set forth in this Article are non-exclusive and are not intended to affect in any way any other rights of the parties to indemnification under applicable federal, state or local laws and regulations.

13. Access to Books and Records. Pursuant to 42 U.S.C. §1395x(V)(1)(l), during the four (4) year period after completion of services hereunder, the Agency will, upon written request, make available to the Secretary of Health and Human Services or to the Comptroller General, or their duly authorized representatives, this Agreement, books, documents, and

records that are necessary to certify the nature and extent of costs incurred by the Agency under the provisions of this Agreement. This provision shall be in force for any twelve (12) month period during which the total value of services provided or goods delivered hereunder is Ten Thousand Dollars ($10,000) or more. This section shall have no effect unless Consultant is deemed a "subcontractor" under any regulation adopted under the provision of the United States Code cited above.

14. Privacy.

14.1. HIPAA Applicability and Compliance. Agency may be a "Covered Entity" under, and required to comply with, the applicable provisions of the Health Insurance Portability and Accountability Act of 1996 as amended ("HIPAA") and the regulations and guidelines pertaining thereto (collectively with HIPAA the "HIPAA Rules"), and to obtain sufficient assurances that its contracting parties will appropriately safeguard patients' "Protected Health Information" ("PHI") as defined in the HIPAA Rules. In the course of performing Consultant's services, duties and obligations herein, Consultant may receive, create or obtain access to PHI. Consultant agrees to maintain the security and confidentiality of PHI, as required of Agency by applicable laws and regulations, including without limitation the HIPAA Rules, and to execute and deliver such additional documentation and assurances as Agency may reasonably request to comply with HIPAA and any amendments thereto and related laws and regulations, including, but not limited to, the Business Associate Agreement attached hereto as Exhibit B.

14.2. Correlation of Record Handling Requirements. In the event of any conflict between the requirements of this Article 14 and/or between the various laws, statutes, ordinances and regulations relating to or otherwise affecting the subject matter thereof, the requirement or applicable law that that presents the most stringent standard for compliance, as reasonably determined by Agency, shall be followed, such that compliance is achieved or maximized in all cases.

14.3. Confidential Information. Consultant shall preserve the confidentiality of all private, confidential and/or proprietary information disclosed to or discovered by Consultant in connection with this Agreement, including, without limitation, nonpublic financial information, manuals, protocols, policies, procedures, marketing, and strategic information, Agency lists, computer software, training materials, resident/patient health information, resident/patient records, and resident/patient care and outcomes data ("Confidential Information") as and to the extent required by law. Consultant shall not use for its own benefit or disclose or otherwise disseminate to third parties, directly or indirectly, any Confidential Information without prior written consent from Agency, provided however that if Consultant grants Agency access to, and Agency uses, Consultant's databases or information sharing mechanisms, Agency's information may be provided to similar agencies and Agency hereby grants Agency's consent to such information sharing as a condition to Agency's receipt of access to such mechanisms and the data they contain form time to time. Upon termination of this Agreement, all Confidential Information and copies thereof shall be returned to Agency. Consultant and Agency shall comply with applicable federal, state and local laws and regulations with respect to all Confidential Information, including, but not limited to, any disclosures thereof pursuant to this section.

15. Notices. All notices which are required or which may be given pursuant to the terms of this Agreement shall be in writing and shall be sufficient in all respects if given in writing and delivered personally or by registered or certified mail, return receipt requested, or

by a comparable commercial delivery system, and notice shall be deemed to be given on the date hand-delivered or on the date which is three (3) business days after the date deposited in United States mail, or with a comparable commercial delivery system, with postage or other delivery charges thereon prepaid, at the addresses first set forth above or such other addresses as Agency and Consultant may designate by written notice to the other from time to time.

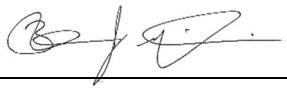
16. Arbitration.

16.1. Any controversy, dispute or claim arising in connection with the interpretation, performance or breach of this Lease, including any claim based on contract, tort or statute, shall be determined by final and binding, confidential arbitration with Judicial Mediation and Arbitration Service ("JAMS/Endispute") in Ada County, Idaho, provided that if JAMS/Endispute (or any successor organization thereto) no longer exists, then such arbitration shall be administered by the American Arbitration Association ("AAA") in accordance with its then-existing Commercial Arbitration Rules, and the sole arbitrator shall be selected in accordance with such AAA rules. Any arbitration hereunder shall be governed by the United States Arbitration Act, 9 U.S.C. 1-16 (or any successor legislation thereto), and judgment upon the award rendered by the arbitrator may be entered by any state or federal court having jurisdiction thereof. Neither Agency, Consultant, nor the arbitrator shall disclose the existence, content or results of any arbitration hereunder without the prior written consent of all parties; provided, however, that either party may disclose the existence, content or results of any such arbitration to its partners, officers, directors, employees, agents, attorneys and accountants and to any other Person to whom disclosure is required by applicable Legal Requirements, including pursuant to an order of a court of competent jurisdiction. Unless otherwise agreed by the parties, any arbitration hereunder shall be held at a neutral location selected by the arbitrator in Ada County, Idaho. The cost of the arbitrator and the expenses relating to the arbitration (exclusive of legal fees) shall be borne equally by Agency and Consultant unless otherwise specified in the award of the arbitrator, in which case such fees and costs paid or payable to the arbitrator shall be included in "reasonable costs and attorneys' fees" for purposes of Section 17.2, and the arbitrator shall specifically have the power to award to the prevailing party pursuant to such Section 17.2 such party's costs and expenses, including fees and costs paid to the arbitrator.

16.2. NOTICE: BY INITIALING IN THE SPACE BELOW YOU ARE AGREEING TO HAVE ANY DISPUTES ARISING IN THIS "ARBITRATION OF DISPUTES" PROVISION DECIDED BY NEUTRAL ARBITRATION AS PROVIDED HEREIN AND BY IDAHO LAW AND YOU ARE GIVING UP ANY RIGHTS YOU MIGHT POSSESS TO HAVE SUCH DISPUTE LITIGATED IN A COURT OR JURY TRIAL. BY INITIALING IN THE SPACE BELOW, YOU ARE GIVING UP YOUR JUDICIAL RIGHTS TO DISCOVERY AND APPEAL, UNLESS THOSE RIGHTS ARE SPECIFICALLY INCLUDED IN THIS "ARBITRATION OF DISPUTES" PROVISION. IF YOU REFUSE TO SUBMIT TO ARBITRATION AFTER AGREEING TO THIS PROVISION, YOU MAY BE COMPELLED TO ARBITRATE UNDER THE AUTHORITY OF THE IDAHO CODE OF CIVIL PROCEDURE. YOUR AGREEMENT OF THE PARTIES TO THIS ARBITRATION PROVISION IS VOLUNTARY.

BY INITIALLING BELOW YOU AFFIRM THAT YOU HAVE READ AND UNDERSTAND THE FOREGOING AND AGREE TO SUBMIT DISPUTES ARISING OUT OF THE MATTERS INCLUDED IN THIS "ARBITRATION OF DISPUTES" PROVISION TO NEUTRAL ARBITRATION.

CONSULTANT



AGENCY

17. Miscellaneous.

17.1. This Agreement has been negotiated by and between Consultant and Agency in arms-length negotiations, and both parties are responsible for its drafting. Both parties have reviewed this Agreement with appropriate counsel, or have waived their right to do so, and the parties hereby mutually and irrevocably agree that this Agreement shall be construed neither for nor against either party, but in accordance with the plain language and intent hereof. The invalidity or unenforceability of any provision of this Agreement shall not affect the other provision hereto, and this Agreement shall be construed in all respects as if such invalid or unenforceable provisions were omitted. Headings are used herein for convenience only, and shall play no part in the construction of any provision of this Agreement

17.2. In the event of any dispute between the parties arising under or in relation to this Agreement, the prevailing party in such dispute or litigation shall have the right to receive from the non-prevailing party all of the prevailing party's reasonable costs and attorneys' fees incurred in connection with any such dispute and/or litigation. As used herein, the term "prevailing party" shall refer to that party to this Agreement for whom the result ultimately obtained most closely approximates such party's position in such dispute or litigation.

17.3. This Agreement shall be governed by the laws of the State of Idaho. Notwithstanding anything contained herein to the contrary, venue for any action involving this Agreement shall lie solely in Ada County, Idaho.

17.4. Time is of the essence of this Agreement and every term and condition hereof.

17.5. The waiver by any party hereto of breach of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach by any party.

17.6. This Agreement shall binding upon the parties hereto, their heirs, successors and assigns. Notwithstanding the foregoing, the parties mutually acknowledge that a material and substantial consideration in the parties' mutual execution of this Agreement is the identity and reputation of the other party, and each party's subjective perception of the other's value to and compatibility with such party and its officers, employees, facilities and

patients. As such, notwithstanding anything contained herein to the contrary, this Agreement and the rights of the parties hereunder are personal to the parties and may not be assigned or subcontracted to, nor shall the duties and responsibilities of either hereunder be delegated to or rendered by, any other person or entity without the express prior written consent of the other party, which consent may be granted or denied, conditionally or unconditionally, by a party in its sole, absolute and unfettered discretion.

17.7. Notwithstanding the expiration or earlier termination of this Agreement, the obligations and/or liabilities of the parties hereunder, relating to events, occurring during the Term, to which the parties' indemnification obligations under Section 12 apply, shall continue in full force and effect after the Agreement terminates, subject to applicable statutes of limitation. Additionally, the covenants of the parties under Sections 11.4, 13, 14 and 16 shall survive the termination of this Agreement.

17.8. This Agreement is solely between the parties hereto, and shall not create any right or benefit in any third party, including without limitation any creditor, agent, partner, employee or affiliate of Current Operator, or any entity or agency having jurisdiction of any of the Licenses, the Agency or the operation of the business therein.

17.9. This Agreement represents the entire agreement and understanding of the parties with respect to the subject matter hereof, and supersedes and negates any previous contracts between Agency and Consultant. Agency and Consultant mutually agree that this Agreement may not be modified unless such modification is in writing and signed by both parties.

IN WITNESS WHEREOF, the parties have affixed their signatures hereto as of the dates set forth below.

CONSULTANT:

PENNANT SERVICES, INC.
a Nevada corporation

BY: _____
John Gochnour
Authorized Agent
Date: September 28, 2019

AGENCY:

EMERALD HEALTHCARE, INC.,
a Nevada corporation

BY: _____
Brent Guerisoli
Authorized Agent
Date: September 28, 2019

EXHIBIT A
CONSULTING, PROFESSIONAL, AND
OPERATIONAL SUPPORT SERVICES AGREEMENT
(Administrative Services)

THIS EXHIBIT A supplements the foregoing CONSULTING, PROFESSIONAL, AND OPERATIONAL SUPPORT SERVICES AGREEMENT (the "Agreement") made and entered into by and between the therein-named Consultant and Agency and forms a part thereof. The specific duties and obligations described herein may or may not be performed by either party, depending upon the needs, preferences and requests of the other from time to time. The lists of duties and activities are not exhaustive, but where certain duties or activities are expressly limited, excluded or proscribed hereby, such activities shall not be requested or performed. Consultant's services shall be rendered on a non-exclusive basis, and Consultant shall have no duty to limit its services solely to Agency. Any service to be rendered by Consultant hereunder may be, at Consultant's sole option, rendered on a joint or "pooled" basis with or to Agency and other clients of Consultant. Consultant may provide any of its services hereunder through the use or assistance of subcontractors, but such subcontractors shall be subject to all of the terms and conditions of this Agreement. Although Consultant shall have discretion to make certain decisions regarding its Services for Agency in the day-to-day rendition of such services, Agency shall remain solely responsible for all decisions and actions made by, at, for or involving Agency and the operation of Agency's business.

SPECIFIC SERVICES TO BE RENDERED BY CONSULTANT:

1. Accounting.

A. Provides regular financial statements, analysis and reports to Agency management and Agency's lenders and customers.

B. Provides billing and collections oversight and assistance, including without limitation general compliance counseling, provided however that Agency shall be solely responsible for assessment, billing and collection compliance.

C. Tracks lockbox and other revenues, as well as all expenses submitted to Consultant, including without limitation capital projects expenses, and consults on the advisability of major capital expenditures.

D. Provides accounts payable processing based on Agency-supplied payables data.

E. Provides payroll services based upon Agency-generated payroll data; including without limitation providing separate payrolls for key employee groups as deemed prudent by Consultant or requested by Agency.

F. Assists in the preparation and filing of cost reports and other required financial filings and reports.

G. Oversees borrowing and other financial relationships and acts as liaison for lenders and outside accounting and financial consultants, and assists in procuring, maintaining and complying with the terms of financing and credit relationships, which may, with

Agency's acquiescence AND at Consultant's sole option, be created on a standalone basis for Agency or jointly in concert with some or all of Consultant's other clients.

2. Human Resources.

A. Procures and assists Agency in administering employee benefits plans as requested by Agency for its employees, such as health, dental, defined benefit, defined contribution, life insurance, disability, employee assistance programs and other benefits which may, with Agency's acquiescence AND at Consultant's sole option, be created on a standalone basis for Agency or jointly or in concert with some or all of Consultant's other clients.

B. Provides sample form non-nursing policy and procedure manuals, employee handbooks and hiring, performance evaluation and disciplinary forms and the like, to facilitate the efficient establishment and conduct of employer-employee relations; provided that all manuals, materials and template forms provided in connection therewith shall be and remain the property of Consultant and may not be copied, reproduced, distributed or used other than with the express written permission of Consultant.

C. Provides general assistance with human resources, labor and employment questions and issues, including questions related to hiring, disciplining and separation of employees; provided that Consultant shall have no responsibility for hiring, discipline or separation of Agency employees, which responsibility shall be an remain the sole province of Agency.

D. Provides periodic in-services and other trainings as requested by Agency, including an annual training meeting or convention for Agency's Administrator and Director of Nursing (which may be offered simultaneously and in conjunction with the annual trainings for other of Consultant's clients), to assist managers and staff in the lawful and efficient conduct of their business affairs; provided that all trainings and materials provided in connection therewith shall be and remain the property of Consultant and may not be copied, reproduced, distributed or used other than with the express written permission of Consultant.

E. Provides, as requested by Agency, independent third-party investigation of employment-related allegations of managerial and/or staff misconduct and recommendations (but not directives) with respect thereto.

3. Legal Services.

A. Provides general legal counsel consisting of limited legal services and assistance, including litigation management, corporate filings and governance assistance, legal compliance tools, licensing assistance and similar services; provided however that Consultant shall render no legal advice or court representation in any jurisdiction where an employee of Consultant is not licensed to do so unless otherwise permitted by law.

B. Provides contract review, processing and general assistance with vendor, customer and other contracts; and Agency hereby authorizes Consultant to negotiate and enter into contracts on Agency's behalf as Agency's agent solely for such limited purpose, but Consultant shall not be bound to perform such contracts for Agency. Consultant is also authorized to include Agency in "pooled" or joint contracts with other of Consultant's clients,

provided that in no event shall Agency ever be jointly, severally or in any other way authorized, bound or liable for the acts or omissions of Consultant or any other client of Consultant for or under any such contract or arrangement, and the scope of Consultant's authority shall not include obligating Agency in any way for the obligations of Consultant or any other person or entity.

C. Provides periodic legal, compliance, regulatory and similar in-services and other formal and informal trainings as requested by Agency, which may be offered simultaneously and in conjunction with the trainings for other of Consultant's clients. Such trainings shall include no nursing or direct care services by Consultant's representatives, but may or may not include, without limitation, assistance with proper patient charting and similar activities when performed in connection with in-services, medical records, survey readiness reviews, mock surveys and other similar consulting and training, in order to assist nursing leadership and staff in the lawful, prudent and efficient conduct of caregiving operations; provided that all trainings and materials provided in connection therewith shall be and remain the property of Consultant and may not be copied, reproduced, distributed or used other than with the express written permission of Consultant.

D. Provides assistance in labor and employment matters, including collective bargaining and other labor relations activities, and processing of state and federal employment (e.g., EEOC, DFEH, OCR, NLRB and similar agencies and programs) claims.

4. Risk Management.

A. Interfaces with insurance brokers and carriers to procure and maintain necessary and desirable insurance coverages. Consultant may, at Consultant's option and unless Agency objects, provide coverages under "pooled risk arrangements or "blanket" policies that cover other clients of Consultant, and Agency shall pay its allocated share of the premiums for such coverages based on the rating and risk profile of Agency as determined by Consultant, the broker and/or the insurance underwriters setting the premium. In addition, Consultant may provide such services, at Consultant's option, through captives or pooled insurance arrangements with other clients of Consultant or other insureds.

B. Provides, itself or through brokers or outside consultants, limited loss prevention evaluations and services.

C. Provides worker's compensation coverages, training, resources and systems, which may or may not include, at Consultant's option, assisting Agency, either for Agency's own account with third-party carriers, or under self-insurance certificates issued to Consultant or Agency, to self-insure for worker's compensation and other risks.

5. Information Technology.

A. Provides basic technology services, including assistance with computer, peripheral and network installations and troubleshooting where Agency uses hardware and software supported by Consultant.

B. Provides centralized Internet, Intranet, and other technology programs

and services to promote the efficient, accurate and timely collection and collation of operating and other business data.

C. Provides assistance in designing and maintaining web addresses, email services and informational websites for the Agency.

D. Provides centralized purchasing and procurement services and counseling for Agency's planning, acquisition and use of technology products and services.

6. Miscellaneous Services.

A. Provides periodic CEO-in-Training ("CIT") and Leadership programs, as well as other formal and informal trainings as requested by Agency, which may be offered simultaneously and in conjunction with the trainings for other of Consultant's clients. Such trainings shall include no nursing or direct care services by Consultant's representatives, but may or may not include, without limitation, assistance with filing of nursing home administrator and similar certification and licensing applications, and other similar assistance, consulting and training, in order to assist Agency leadership and staff in obtaining and maintaining necessary and appropriate certifications and licenses; provided that all trainings and materials provided in connection therewith shall be and remain the property of Consultant and may not be copied, reproduced, distributed or used other than with the express written permission of Consultant

B. Provides centralized purchasing opportunities from vendors, and service providers; provided that (i) Agency shall not be required to participate on any such purchasing cooperative or arrangement, (ii) Agency shall never be liable for the expenses, acts or omissions of Consultant or other clients of Consultant under such arrangements, but shall be responsible solely for its own purchases thereunder, (iii) catalogs, materials and forms provided in connection therewith shall be and remain the property of Consultant and may not be copied, reproduced, distributed or used other than with the express written permission of Consultant, and (iv) Consultant shall be authorized to act as Agency's agent for the limited purpose of negotiating and entering into such arrangements, but not for actually committing to the ordering of any product or service or the incurrence of any obligation thereunder, which shall be the sole province of Agency.

ADDITIONAL DUTIES TO BE PERFORMED BY AGENCY:

Without limiting any other duty or obligation of Agency at law or under the Agreement, Agency shall do all of the following:

7. Agency shall be solely responsible for (i) naming and managing its own Governing Body as required by applicable laws and regulations, (ii) hiring, supervising and evaluating its administrator and other employees, and (iii) overseeing the day-to-day conduct of its business and related activities.

8. Agency shall be solely responsible for providing a safe and sanitary environment for Agency personnel.

9. Agency shall be solely responsible for (i) operating its business in and from the

Agency location(s) in substantial compliance with applicable laws and regulations, (ii) maintaining all federal and state licenses and certifications required to operate the Agency and provide Services to patients and clients, (iii) performing all duties required of a licensee and provider under applicable local, state and federal laws, codes, regulations and provider agreements affecting the operation of the Agency, and (iv) notifying Consultant of any threatened, pending or actual revocation or suspension of its Licenses.

10. Timely furnish Consultant with such information and materials as might ordinarily be expected for Consultant to perform its duties hereunder. Agency shall be solely responsible to assure the accuracy and completeness of all information provided by Agency and its personnel to Consultant, and Consultant shall be entitled to rely thereon without inquiry or diligence of any kind.

11. Agency shall not unreasonably restrict or limit Consultant's access to necessary information, and acknowledges Consultant's right to exercise its independent professional judgment, including recommending Services and rendering such Services using such methods, technologies and procedures as Consultant deems appropriate.

12. Consultant's corporate address: 1675 E. Riverside Drive, Suite 150, Eagle, ID 83616, shall serve Agency's mailing address and address for service of process.

13. If requested by Consultant, Agency shall send delegates to Consultant's customer service teams, operator forums, evaluation and other service teams, trainings, and other committees and events as reasonably requested and available. In addition, to the extent available Agency delegates shall from time to time participate, both as trainees and trainers, in training and leadership conferences and events for the benefit of Consultant and others.

14. With Agency's acquiescence, and at Consultant's expense to the extent the trainee does not provide value to Agency, Agency agrees to periodically serve as a training site for Consultant's employees, providing (where available) preceptorship and organized training for CITs and other trainees of Consultant. In the event that a compensated trainee does not provide full value to Agency during his/her training program, Consultant shall pay directly, or reimburse Agency for, the portion of the trainee's compensation and training expenses that exceed the reasonable value provided.

Exhibit B

BUSINESS ASSOCIATE AGREEMENT

AGREEMENT EFFECTIVE DATE:	October 1, 2019
COVERED ENTITY:	**EMERALD HEALTHCARE, INC.** ADDRESS: 4002 TACOMA MALL BLVD STE 204A, TACOMA, WA 98409
BUSINESS ASSOCIATE:	**PENNANT SERVICES, INC.** ADDRESS: 1675 E. RIVERSIDE DRIVE, SUITE 150, EAGLE, ID 83616

This Business Associate Agreement ("Agreement") is made and entered into as of the Effective Date listed in this Exhibit B, and between the above-listed Covered Entity and Business Associate, with reference to the following facts:

RECITALS

WHEREAS, Business Associate has been engaged to provide staffing services to Covered Entity pursuant to a separate agreement (the "Services Agreement"), and, in connection with those services, Covered Entity may need to disclose to Business Associate, or Business Associate may need to create on Covered Entity's behalf, certain Protected Health Information (as defined below) that is subject to protection under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("HITECH Act"), and regulations promulgated thereunder by the U.S. Department of Health and Human Services to implement certain privacy and security provisions of HIPAA (the "HIPAA Regulations"), codified at 45 C.F.R. Parts 160 and 164; and

WHEREAS, pursuant to the HIPAA Regulations, all business associates of Covered Entity, as a condition of doing business with Covered Entity, must agree in writing to certain mandatory provisions regarding the privacy and security of PHI (as defined below).

NOW THEREFORE, IN CONSIDERATION OF THE FOREGOING, and the mutual promises and covenants contained herein, Business Associate and Covered Entity agree as follows:

AGREEMENT

Definitions.

Unless otherwise specified in this Agreement, all terms not otherwise defined shall have the meanings established in Title 45, Parts 160 and 164, of the United States Code of Federal Regulations, as amended from time to time. Further, capitalized terms used, but not otherwise defined, in this Agreement shall have the meanings set forth in HIPAA, the HIPAA Regulations and the HITECH Act.

1.1 *Breach* shall have the meaning given to such term in 42 U.S.C. § 17921, and shall include the unauthorized acquisition, access, use, or disclosure of PHI which compromises the security or privacy of such information.

1.2 *Business Associate* shall have the meaning given to such phrase under the HIPAA Regulations and the HITECH Act, including, but not limited to, 45 C.F.R. § 160.103 and 42 U.S.C. § 17938, respectively. For purposes of this Agreement, "Business Associate" shall also refer specifically to the entity or individual set forth in the Preamble above.

1.3 *Covered Entity* shall have the meaning given to such phrase under the HIPAA Regulations including, but not limited to, 45 C.F.R. § 160.103. For purposes of this Agreement, "Covered Entity" shall also refer specifically to the entity set forth in the Preamble above.

1.4 *Data Aggregation* shall have the meaning given to such phrase under the Privacy Rule, including, but not limited to, 45 C.F.R. § 164.501.

1.5 *Designated Record Set* means a group of records maintained by or for Covered Entity that may include (i) medical records and billing records about Individuals maintained by or for a covered health care provider, (ii) the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan, or (iii) records used, in whole or in part, by or for Covered Entity to make decisions about Individuals.

1.6 *Electronic Health Record* shall have the meaning given to such phrase in the HITECH Act, including, but not limited to, 42 U.S.C. § 17921(5).

1.7 *Electronic Protected Health Information* ("ePHI") means individually identifiable health information that is transmitted by, or maintained in, electronic media.

1.8 *Health Care Operations* shall have the meaning given to such phrase under the Privacy Rule, including, but not limited to, 45 C.F.R. § 164.501.

1.9 *Individual* has the same meaning as the term *individual* in 45 C.F.R. § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).

1.10 *Privacy Rule* shall mean the Standards for Privacy of Individually Identifiable Health Information codified at 45 C.F.R. Part 160 and Part 164, Subparts A and E, as amended by the HITECH Act and as may otherwise be amended from time to time.

1.11 *Protected Health Information* ("PHI") means any information, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an Individual; the provision of health care to an Individual; or the past, present or future payment for the provision of health care to an Individual; and (ii) that identifies the Individual or with respect to which there is a reasonable basis to believe the information can be used to identify that Individual; and (iii) shall include the definition as set forth in the Privacy Rule including, but not limited to, 45 C.F.R. § 160.103. For purposes of this Agreement, PHI shall include ePHI.

1.12 *Required By Law* shall have the same meaning as the phrase *required by law* in 45 C.F.R. § 164.103.

1.13 *Secretary* means the Secretary of the U.S. Department of Health and Human Services or his/her designee.

1.14 *Security Incident* means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

1.15 *Security Rule* shall mean the HIPAA Regulations that are codified at 45 C.F.R. Part 160 and Part 164, Subparts A and C, as amended by the HITECH Act and as may otherwise be amended from time to time.

1.16 *Unsecured PHI* shall mean PHI that is not secured through the use of a technology or methodology specified by the Secretary in guidance or as otherwise defined in 42 U.S.C. § 17932(h).

Scope of Agreement.

This Agreement applies to the PHI of Covered Entity to which Business Associate may be exposed as a result of the services that Business Associate will provide to Covered Entity pursuant to the Services Agreement. Business Associate shall abide by HIPAA, the HIPAA Regulations and the HITECH Act with respect to PHI of Covered Entity, as outlined below.

Obligations and Activities of Business Associate.

3.1 *Permitted Uses*. Except as otherwise limited in this Agreement, Business Associate may use PHI (i) for the proper management and administration of Business Associate, (ii) to carry out the legal responsibilities of Business Associate, or (iii) for Data Aggregation purposes for the Health Care Operations of Covered Entity. Business Associate may use PHI to provide services to Covered Entity under the Services Agreement provided that Business Associate shall not use PHI in any manner that would constitute a violation of the Privacy Rule or the HITECH Act if so used by Covered Entity.

3.2 *Permitted Disclosures*. Business Associate may disclose PHI (i) for the proper management and administration of Business Associate; (ii) to carry out the legal responsibilities of Business Associate; (iii) as Required By Law; or (iv) for Data Aggregation purposes for the Health Care Operations of Covered Entity. Business Associate may disclose PHI to provide services to Covered Entity under the Services Agreement, provided that Business Associate shall not disclose PHI in any manner that would constitute a violation of the Privacy Rule or the HITECH Act if so disclosed by Covered Entity.

3.2.1 In addition, if Business Associate discloses PHI to a third party, for Business Associate's management and administration purposes as specified in Section 3.2, Business Associate must obtain, prior to making any such disclosure, (i) reasonable written assurances from such third party that the PHI will be held as confidential as provided pursuant to this Agreement and only disclosed as Required By Law or for the purposes for which it was disclosed to such third party; and (ii) a written agreement from such third party to immediately notify Business Associate of any breaches of confidentiality of the PHI, to the extent such third party has obtained knowledge of such breach.

3.3 *Prohibited Uses and Disclosures*. Business Associate shall not use or disclose PHI for fundraising or marketing purposes. In accordance with 42 U.S.C. § 17935(a), Business Associate shall not disclose PHI to a health plan for payment or Health Care Operations purposes if the patient has requested this special restriction, and has paid out of pocket in full for the health care item or service to which the PHI solely relates. Business Associate shall not directly or indirectly receive remuneration in exchange for PHI, except with the prior written consent of Covered Entity and Individual and as permitted by 42 U.S.C. § 17935(d)(1) and (2); however, this prohibition shall not affect payment by Covered Entity to Business Associate for services provided pursuant to the Services Agreement.

3.4 *Other Business Associates.* As part of its providing functions, activities, and/or services to Covered Entity, Business Associate may disclose information, including PHI, to other business associates of Covered Entity, and Business Associate may use and disclose information, including PHI, received from other business associates of Covered Entity as if this information was received from, or originated with, Covered Entity.

3.5 *Safeguards for Protection of ePHI*. Business Associate agrees to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of Covered Entity. In accordance with 42 U.S.C. § 17931 of the HITECH Act, Business Associate shall be directly responsible for full compliance with the policies and procedures and documentation requirements of the HIPAA Security Rule, including, but not limited to, 45 C.F.R. §§ 164.308, 164.310, 164.312, and 164.316. Business Associate shall implement and at all times use all appropriate safeguards to prevent any use or disclosure of PHI not authorized under this Agreement.

3.6 *Reporting of Unauthorized Uses or Disclosures and Security Incidents*. Business Associate agrees to report to Covered Entity in writing any access, use or disclosure of the PHI not provided for or permitted by this Agreement and, any Security Incidents of which Business Associate (or Business Associate's employee, officer or agent) becomes aware. Business Associate shall so notify Covered Entity pursuant to this Section within twenty-four (24) hours after Business Associate becomes aware of such unauthorized use, disclosure or Security Incident. The notice to be provided pursuant to this Section shall be substantially in the same form as **Exhibit 1**, which is attached hereto.

3.7 *Reporting of Breach of Unsecured PHI*. Business Associate agrees to report to Covered Entity any Breach of Unsecured PHI of which Business Associate (or Business Associate's employee, officer or agent) becomes aware without unreasonable delay and in no case later than the next business day after Business Associate learns of such Breach, except where a law enforcement official determines that a notification would impede a criminal investigation or cause damage to national security. Business Associate's notification to Covered Entity hereunder shall be substantially in the same form as **Exhibit 1**.

3.8 *Agents and Subcontractors*. Business Associate agrees to ensure that any agent, including a subcontractor, to whom Business Associate provides PHI, agrees in writing to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such PHI, and implement the safeguards required by Section 3.5 above with respect to ePHI.

3.9 *Mitigation of Unauthorized Uses or Disclosures*. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate or one of its agents or subcontractors in violation of the requirements of this Agreement.

3.10 *Authorized Access to PHI*.

3.10.1 *Individual Requests for Access*. Business Associate shall cooperate with Covered Entity to fulfill all requests by Individuals for access to the Individual's PHI that are approved by Covered Entity. Business Associate shall cooperate with Covered Entity in all respects necessary for Covered Entity to comply with 45 C.F.R. §164.524 and applicable State law. If Business Associate receives a request from an Individual for access to PHI, Business Associate shall immediately forward such request to Covered Entity.

3.10.2 *Scope of Disclosure*. Covered Entity shall be solely responsible for determining the scope of PHI and/or Designated Record Set with respect to each request by an Individual for access to PHI. In the event that Covered Entity decides to charge a reasonable cost-based fee for the reproduction and delivery of PHI to an Individual, Covered Entity shall deliver a

portion of this fee to Business Associate in the event any such reproduction or delivery is made by Business Associate, and in proportion to the amount of work done by Business Associate in producing and delivering the PHI.

3.10.3 Designated Record Set. To the extent that Business Associate maintains PHI in a Designated Record Set and at the request of Covered Entity, Business Associate agrees to provide access to PHI in a Designated Record Set to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 C.F.R. § 164.524 and applicable State law. If Business Associate maintains PHI in a Designated Record Set, and maintains an Electronic Health Record, then Business Associate shall provide such Designated Record Set in electronic format to enable Covered Entity to fulfill its obligations under the HITECH Act, including, but not limited to, 42 U.S.C. § 17935(e).

3.10.4 Patient Right to Amend to PHI. A patient has the right to have Covered Entity amend his/her PHI, or a record in a Designated Record Set for as long as the PHI is maintained in the Designated Record Set, in accordance with 42 C.F.R. §164.526. To the extent that Business Associate maintains PHI in a Designated Record Set, Business Associate agrees to make any amendment(s) to PHI in a Designated Record Set at the request of Covered Entity in accordance with 45 C.F.R. § 164.526. Within fifteen (15) business days following Business Associate's amendment of PHI as directed by Covered Entity, Business Associate shall provide written notice to Covered Entity confirming that Business Associate has made the amendments or addenda to PHI as directed by Covered Entity and containing any other information as may be necessary for Covered Entity to provide adequate notice to the Individual in accordance with 45 C.F.R. §164.526.

3.11 Accounting for Disclosures.

3.11.1 Disclosures. In the event that Business Associate makes any disclosures of PHI that are subject to the accounting requirements of the Privacy Rule 45 C.F.R. §164.528 and/or the HITECH Act including, but not limited to, 42 U.S.C. § 17935(c))[1], Business Associate shall report such disclosures to Covered Entity within three (3) days of such disclosure. The notice by Business Associate to Covered Entity of the disclosure shall include the name of the Individual, the recipient, the reason for disclosure, and the date of the disclosure. Business Associate shall maintain a record of each such disclosure that shall include: (i) the date of the disclosure; (ii) the name and, if available, the address of the recipient of the PHI; (iii) a brief description of the PHI disclosed; and (iv) a brief description of the purpose of the disclosure. Business Associate shall maintain this record for a period of six (6) years and make it available to Covered Entity upon request in an electronic format so that Covered Entity may meet its disclosure accounting obligations under 45 C.F.R. §164.528. If Covered Entity provides a list of its business associates to an Individual in response to a request by an Individual for an accounting of disclosures, and the Individual thereafter specifically requests an accounting of disclosures from Business Associate, then Business Associate shall provide an accounting of disclosures to such Individual.

3.11.2 Electronic Health Record. Business Associate acknowledges that, to the extent Business Associate maintains an Electronic Health Record for Covered Entity, Business Associate is only required to provide an Individual with an accounting of disclosures related to treatment, payment or Health Care Operations for a period of three (3) years prior to such Individual's request. Therefore, upon request by an Individual to Covered Entity for an accounting of disclosures related to treatment, payment or Health Care Operations, Business Associate shall provide to Covered Entity, within three (3) days of Business

[1] The provisions of 42 U.S.C. § 17935(c) become effective on the following dates: (i) for users of electronic health records as of January 1, 2009, this section shall apply to disclosures made by the Covered Entity on and after January 1, 2014; (ii) for covered entities that acquire an electronic health record after January 1, 2009, this section shall apply to disclosures made by the Covered Entity after the later of January 1, 2011 or the date it acquires an electronic health record.

Associate's receipt of a written request from Covered Entity, an accounting of such disclosures for the three (3) year period prior to such request. Notwithstanding this Section, a record of disclosures pertaining to information disclosed by Business Associate for treatment, payment or Health Care Operations shall be maintained in accordance with Section 3.11.1, above.

3.12 *Secretary's Right to Audit*. Business Associate agrees to make its internal practices, books, and records relating to the use and disclosure of PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity, available to the Secretary for purposes of the Secretary determining Covered Entity's and/or Business Associate's compliance with HIPAA, the HIPAA Regulations and the HITECH Act. No attorney-client, or other legal privilege will be deemed to have been waived by Business Associate by virtue of this provision of the Agreement. Business Associate shall provide to Covered Entity a copy of any PHI and related documents that Business Associate provides to the Secretary concurrently with providing such documents to the Secretary.

3.13 *Data Ownership*. All PHI shall be deemed owned by Covered Entity unless otherwise agreed in writing.

3.14 *Compliance*. To the extent Business Associate is to carry out a Covered Entity's obligation under the HIPAA Privacy Regulations, Business Associate shall comply with the requirements of the Privacy Regulations that apply to Covered Entity in the performance of such obligation.

4 **Obligations of Covered Entity**.

4.1 *Notice of Privacy Practices*. Upon written request by Business Associate, Covered Entity shall provide Business Associate with Covered Entity's then current Notice of Privacy Practices.

4.2 *Revocation of Permitted Use or Disclosure of PHI*. Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by the patient to use or disclose PHI of Covered Entity, to the extent that such changes may affect Business Associate's use or disclosure of PHI of Covered Entity.

4.3 *Restrictions on Use or Disclosure of PHI*. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 C.F.R. § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

4.4 *Requested Uses or Disclosures of PHI*. Except for Data Aggregation or management and administrative activities of Business Associate, Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the HIPAA Regulations if done by Covered Entity.

5 **Term and Termination**.

5.1 *Term*. The term of this Agreement shall be coterminous with the Services Agreement. However, Business Associate shall have a continuing obligation to safeguard the confidentiality of PHI received from Covered Entity after the termination of the Services Agreement.

5.2 *Termination Without Cause*. Either party may terminate this Agreement without cause or penalty by the delivery of a written notice from the terminating party to the other party. Such termination is effective thirty (30) calendar days from the date that the other party receives such notice.

5.3 *Termination for Cause*. A breach of any provision of this Agreement by Business Associate shall constitute a material breach of this Agreement and shall provide grounds for immediate termination

of this Agreement by Covered Entity, any provision in this Agreement to the contrary notwithstanding.

5.4 *Judicial or Administrative Proceedings*. Either party may terminate the Agreement, effective immediately, if (i) the other party is named as a defendant in a criminal proceeding for a violation of HIPAA, the HIPAA Regulations, the HITECH Act, or other security or privacy laws or (ii) a finding or stipulation that the other party has violated any standard or requirement of HIPAA, the HIPAA Regulations, the HITECH Act or other security or privacy laws is made in any administrative or civil proceeding in which the party has been joined.

5.5 *Effect of Termination*.

5.5.1 Except as provided in Section 5.5.2, herein, upon termination of this Agreement for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity, including PHI in possession of any Business Associate's subcontractors and retain no copies or backup records of such PHI in any form or medium. Business Associate shall certify in writing to Covered Entity that such PHI has been destroyed.

5.5.2 In the event that Business Associate determines that returning or destroying the PHI is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction unfeasible. Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures to those purposes that make the return or destruction of the PHI unfeasible, for so long as Business Associate maintains such PHI.

6 **Breach Pattern or Practice**.

If either party (the "Non-Breaching Party") knows of a pattern of activity or practice of the other party (the "Breaching Party") that constitutes a material breach or violation of the Breaching Party's obligations under this Agreement, the Non-Breaching Party shall either (i) terminate this Agreement in accordance with Section 5 above, or (ii) take reasonable steps to cure the breach or end the violation. If the steps are unsuccessful, the Non-Breaching Party must terminate the Agreement if feasible. The Non-Breaching Party shall provide written notice to the Breaching Party of any pattern of activity or practice of the Breaching Party that the Non-Breaching Party believes constitutes a material breach or violation of the Breaching Party's obligations under this Agreement within three (3) days of discovery and shall meet with the Breaching Party's Privacy Coordinator to discuss and attempt to resolve the problem as one of the reasonable steps to cure the breach or end the violation.

7 **Disclaimer**.

Covered Entity makes no warranty or representation that compliance by Business Associate with this Agreement, HIPAA, the HIPAA Regulations, or the HITECH Act will be adequate or satisfactory for Business Associate's own purposes. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.

8 **Certification**.

To the extent that Covered Entity determines that such examination is necessary to comply with Covered Entity's legal obligation pursuant to HIPAA, the HIPAA Regulations, and the HITECH Act, Covered Entity or its authorized agents or contractors may, at Covered Entity's expense, examine Business Associate's facilities, systems, procedures (including but not limited to review of training procedures for Business Associate's staff) and records as may be necessary for such agents or contractors to certify to Covered Entity the extent to which Business Associate's security safeguards comply with HIPAA, the HIPAA Regulations, the HITECH Act, and this Agreement.

9 **Indemnification**.

Notwithstanding any contrary provision in the Services Agreement, Business Associate agrees to indemnify, defend and hold harmless Covered Entity, its shareholders, directors, officers, employees, affiliates, and agents ("Indemnified Party") against all actual and direct losses suffered by the Indemnified Party from any breach of this Agreement, negligence or wrongful acts or omissions, including, without limitation, failure to perform its obligations under this Agreement or Breach of Unsecured PHI, by Business Associate or its employees, directors, officers, subcontractors, agents or other members of its workforce. Accordingly, on demand, Business Associate shall reimburse the Indemnified Party for any and all actual and direct losses, liabilities, lost profits, fines, penalties, costs or expenses (including reasonable attorneys' fees) which may for any reason be incurred by Indemnified Party or imposed upon the Indemnified Party by reason of any suit, claim, action, proceeding or demand by any third party, as a result of the Business Associate's breach hereunder.

10 **Compliance With State Law**.

Business Associate acknowledges that Business Associate and Covered Entity may have confidentiality and privacy obligations under applicable State law. If any provisions of this Agreement or HIPAA/HIPAA Regulations/HITECH Act conflict with state law regarding the degree of protection provided for PHI and patient medical records, then Business Associate shall comply with the more restrictive requirements.

11 **Miscellaneous**.

11.1 *Amendment*. Business Associate and Covered Entity agree to take such action as is necessary to amend this Agreement from time to time to enable Covered Entity to comply with the requirements of HIPAA, the HIPAA Regulations and the HITECH Act. This Agreement may not be modified, nor shall any provision hereof be waived or amended, except in a writing duly signed and agreed to by Business Associate and Covered Entity.

11.2 *Interpretation*. The provisions of this Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HIPAA Regulations, the HITECH Act, the Privacy Rule and the Security Rule. The parties agree that any ambiguity in this Agreement shall be resolved in favor of a meaning that complies and is consistent with HIPAA, the HIPAA Regulations, the HITECH Act, the Privacy Rule and the Security Rule.

11.3 *No Third Party Beneficiaries*. Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than Business Associate and Covered Entity, and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.

11.4 *Notices*. All notices or other communications required or permitted hereunder shall be in writing and shall be deemed given or delivered (i) when delivered personally, against written receipt; (ii) if sent by registered or certified mail, return receipt requested, postage prepaid, when received; (iii) when received by facsimile transmission; or (iv) when delivered by a nationally recognized overnight courier service, prepaid, and shall be sent to the addresses set forth on the signature page of this Agreement or at such other address as each party may designate by written notice to the other by following this notice procedure.

11.5 *Regulatory References*. A reference in this Agreement to a section in the HIPAA Regulations or the HITECH Act means the section as in effect or as amended, and for which compliance is required.

11.6 *Assistance in Litigation or Administrative Proceedings*. Business Associate shall make itself, and any subcontractors, employees or agents, available to Covered Entity, at no cost to Covered Entity, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being

commenced against Covered Entity, its directors, officers or employees based upon a claimed violation of HIPAA, the HIPAA Regulations, the HITECH Act, the Privacy Rule, the Security Rule, or other laws relating to security and privacy, except where Business Associate or its subcontractor, employee or agent is a named adverse party.

11.7 *Subpoenas*. In the event that Business Associate receives a subpoena or similar notice or request from any judicial, administrative or other party arising out of or in connection with this Agreement, including, but not limited to, any unauthorized use or disclosure of PHI, Business Associate shall promptly forward a copy of such subpoena, notice or request to Covered Entity and afford Covered Entity the opportunity to exercise any rights it may have under law.

11.8 *Survival*. The respective rights and obligations of Business Associate under Section 3 et seq. of this Agreement shall survive the termination of this Agreement. In addition, Section 5.5 (Effect of Termination), Section 7 (Disclaimer), Section 9 (Indemnification), Section 10 (Compliance with State Law), Section 11.4 (Notices), Section 11.6 (Assistance in Litigation and Administrative Proceedings), Section 11.7 (Subpoenas), and Section 11.9 (Governing Law) shall survive the termination of this Agreement.

11.9 *Governing Law*. This Agreement shall be governed by and construed in accordance with the laws of the state in which the covered entity is principally located to the extent that the provisions of HIPAA, the HIPAA Regulations or the HITECH Act do not preempt the laws of that state.

11.10 *Independent Contractors*. Covered Entity and Business Associate shall be independent contractors and nothing in this Agreement is intended nor shall be construed to create an agency, partnership, employer-employee, or joint venture relationship between them.

[Signature Page to follow]

IN WITNESS WHEREOF, the parties have affixed their signatures hereto as of the dates set forth below.

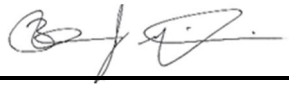
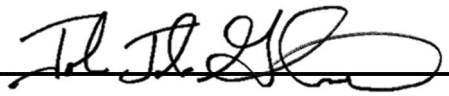
COVERED ENTITY: Emerald Healthcare, Inc.	**BUSINESS ASSOCIATE: PENNANT SERVICES, INC.**
Sign: 	**Sign:** 
Name: Brent Guerisoli	Name: John J. Gochnour
Title: Authorized Agent	Title: Authorized Agent
Date: September 28, 2019	Date: September 28, 2019

Exhibit 1

Notification to Emerald Healthcare, Inc. of
Unauthorized Use or Disclosure of PHI/Breach of Unsecured PHI

Attn: Privacy Officer
Emerald Healthcare, Inc.
4002 Tacoma Mall Blvd Ste 204A, Tacoma, WA 98409
Phone: 253-735-4282
Fax: 253-833-8933
Email: _____

This notification is made pursuant to Sections 3.6 and 3.7 of the Business Associate Agreement between Covered Entity and Business Associate.

Business Associate hereby notifies Covered Entity that there has been a breach of protected health information ("PHI") that Business Associate has used or has had access to under the terms of the Business Associate Agreement.

Description of the breach: _____
_____

Date of the breach: _____

Date of the discovery of the breach: _____

Number of individuals affected by the breach: _____

The types of PHI that were involved in the breach (e.g., full name, Social Security number, date of birth, home address, account number): _____
_____

Description of what Business Associate is doing to investigate the breach, mitigate losses, and protect against further breaches: _____
_____
_____
_____

Business Associate contact information: _____
_____
_____

EXHIBIT 9

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-Q

☒ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934.**

For the quarterly period ended September 30, 2021.

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934.**

For the transition period from _____ to _____.

Commission file number: 001-38900

THE PENNANT GROUP, INC.

(Exact Name of Registrant as Specified in Its Charter)

Delaware	**83-3349931**
(State or Other Jurisdiction of Incorporation or Organization)	(I.R.S. Employer Identification No.)

1675 East Riverside Drive, Suite 150, Eagle, ID 83616
(Address of Principal Executive Offices and Zip Code)
(208) 506-6100
(Registrant's Telephone Number, Including Area Code)
None
(Former name, former address and former fiscal year, if changed since last report)

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	**Trading Symbol(s)**	**Name of each exchange on which registered**
Common Stock, par value $0.001 per share	PNTG	Nasdaq Global Select Market

Securities registered pursuant to Section 12(g) of the Act: None

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. ☒ Yes ☐ No

Indicate by check mark whether the registrant has submitted electronically, every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). ☒ Yes ☐ No

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act:

Large accelerated filer	☐	Accelerated filer	☒	Non-accelerated filer	☐	Smaller reporting company	☐	Emerging growth company	☒

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☒

Indicate by a check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). ☐ Yes ☒ No

As of November 8, 2021, 28,477,119 shares of the registrant's common stock were outstanding.

THE PENNANT GROUP, INC.
QUARTERLY REPORT ON FORM 10-Q
FOR THE THREE AND NINE MONTHS ENDED SEPTEMBER 30, 2021
TABLE OF CONTENTS

PART I. FINANCIAL INFORMATION

Item I. *Financial Statements*

THE PENNANT GROUP, INC.
CONDENSED CONSOLIDATED BALANCE SHEETS
(unaudited, in thousands, except par value)

	September 30, 2021	December 31, 2020
Assets		
Current assets:		
Cash	$ 3,707	$ 43
Accounts receivable—less allowance for doubtful accounts of $933 and $643, respectively	53,402	47,221
Prepaid expenses and other current assets	17,850	12,335
Total current assets	74,959	59,599
Property and equipment, net	18,509	17,884
Right-of-use assets	299,685	308,650
Escrow deposits	—	525
Deferred tax assets, net	2,011	2,097
Restricted and other assets	6,041	4,289
Goodwill	73,785	66,444
Other indefinite-lived intangibles	54,210	47,488
Total assets	$ 529,200	$ 506,976
Liabilities and equity		
Current liabilities:		
Accounts payable	$ 9,763	$ 9,761
Accrued wages and related liabilities	22,229	26,873
Operating lease liabilities—current	15,399	14,106
Other accrued liabilities	29,140	38,275
Total current liabilities	76,531	89,015
Long-term operating lease liabilities—less current portion	287,239	296,615
Other long-term liabilities	8,841	11,897
Long-term debt, net	42,742	8,277
Total liabilities	415,353	405,804
Commitments and contingencies		
Equity:		
Common stock, $0.001 par value; 100,000 shares authorized; 28,800 and 28,464 shares issued and outstanding, respectively, at September 30, 2021, and 28,696 and 28,243 shares issued and outstanding, respectively, at December 31, 2020	28	28
Additional paid-in capital	92,843	84,671
Retained earnings	16,790	11,945
Treasury stock, at cost, 3 shares at September 30, 2021 and December 31, 2020	(65)	(65)
Total Pennant Group, Inc. stockholders' equity	109,596	96,579
Noncontrolling interest	4,251	4,593
Total equity	113,847	101,172
Total liabilities and equity	$ 529,200	$ 506,976

See accompanying notes to condensed consolidated financial statements.

THE PENNANT GROUP, INC.
CONDENSED CONSOLIDATED STATEMENTS OF INCOME
(unaudited, in thousands, except for per-share amounts)

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2021	2020	2021	2020
Revenue	$ 111,921	$ 98,397	$ 327,929	$ 282,986
Expense				
Cost of services	89,619	75,486	259,908	213,834
Rent—cost of services	10,334	9,721	30,455	29,194
General and administrative expense	9,066	7,500	27,137	21,699
Depreciation and amortization	1,200	1,212	3,545	3,434
Total expenses	110,219	93,919	321,045	268,161
Income from operations	1,702	4,478	6,884	14,825
Other income (expense):				
Other income (expense)	—	225	(24)	225
Interest expense, net	(512)	(192)	(1,344)	(896)
Other income (expense), net	(512)	33	(1,368)	(671)
Income before provision for income taxes	1,190	4,511	5,516	14,154
Provision for income taxes	69	104	1,013	2,430
Net income	1,121	4,407	4,503	11,724
Less: net loss attributable to noncontrolling interest	(124)	—	(342)	—
Net income and other comprehensive income attributable to The Pennant Group, Inc.	$ 1,245	$ 4,407	$ 4,845	$ 11,724
Earnings per share:				
Basic	$ 0.04	$ 0.16	$ 0.17	$ 0.42
Diluted	$ 0.04	$ 0.15	$ 0.16	$ 0.39
Weighted average common shares outstanding:				
Basic	28,444	28,055	28,364	27,967
Diluted	30,556	30,243	30,719	29,955

See accompanying notes to condensed consolidated financial statements.

THE PENNANT GROUP, INC.
CONDENSED CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
(unaudited, in thousands)

	Common Stock		Additional Paid-In Capital	Retained Earnings	Treasury Stock		Non-Controlling Interest	Total
	Shares	Amount			Shares	Amount		
Balance at December 31, 2020	28,696	$ 28	$ 84,671	$ 11,945	3	$ (65)	$ 4,593	$ 101,172
Net income attributable to The Pennant Group, Inc.	—	—	—	950	—	—	—	950
Net loss attributable to Non-Controlling Interests	—	—	—	—	—	—	(37)	(37)
Stock-based compensation	—	—	2,416	—	—	—	—	2,416
Issuance of common stock from the exercise of stock options	21	—	218	—	—	—	—	218
Net issuance of restricted stock	3	—	—	—	—	—	—	—
Balance at March 31, 2021	28,720	$ 28	$ 87,305	$ 12,895	3	$ (65)	$ 4,556	$ 104,719
Net income attributable to The Pennant Group, Inc.	—	—	—	2,650	—	—	—	2,650
Net loss attributable to Non-Controlling Interests	—	—	—	—	—	—	(181)	(181)
Stock-based compensation	—	—	2,499	—	—	—	—	2,499
Issuance of common stock from the exercise of stock options	35	—	295	—	—	—	—	295
Net issuance of restricted stock	4	—	—	—	—	—	—	—
Balance at June 30, 2021	28,759	$ 28	$ 90,099	$ 15,545	3	$ (65)	$ 4,375	$ 109,982
Net income attributable to The Pennant Group, Inc.	—	—	—	1,245	—	—	—	1,245
Net loss attributable to Non-Controlling Interests	—	—	—	—	—	—	(124)	(124)
Stock-based compensation	—	—	2,568	—	—	—	—	2,568
Issuance of common stock from the exercise of stock options	36	—	176	—	—	—	—	176
Net issuance of restricted stock	5	—	—	—	—	—	—	—
Balance at September 30, 2021	28,800	$ 28	$ 92,843	$ 16,790	3	$ (65)	$ 4,251	$ 113,847

THE PENNANT GROUP, INC.
CONDENSED CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
(unaudited, in thousands)

	Common Stock		Additional Paid-In Capital	Retained Earnings/ (Accumulated Deficit)	Treasury Stock		Non-Controlling Interest	Total
	Shares	Amount			Shares	Amount		
Balance at December 31, 2019	28,435	$ 28	$ 74,882	$ (3,799)	—	$ —	$ —	$ 71,111
Net income attributable to The Pennant Group, Inc.	—	—	—	2,980	—	—	—	2,980
Stock-based compensation	—	—	1,956	—	—	—	—	1,956
Issuance of common stock from the exercise of stock options	38	—	138	—	—	—	—	138
Net issuance of restricted stock	3	—	—	—	—	—	—	—
Balance at March 31, 2020	28,476	$ 28	$ 76,976	$ (819)	—	$ —	$ —	$ 76,185
Net income attributable to The Pennant Group, Inc.	—	—	—	4,337	—	—	—	4,337
Share-based compensation	—	—	1,959	—	—	—	—	1,959
Issuance of common stock from the exercise of stock options	20	—	77	—	—	—	—	77
Net issuance of restricted stock	20	—	—	—	—	—	—	—
Shares of common stock withheld to satisfy tax withholding obligations	(2)	—	—	—	2	(57)	—	(57)
Balance at June 30, 2020	28,514	$ 28	$ 79,012	$ 3,518	$ 2	$ (57)	$ —	$ 82,501
Net income attributable to The Pennant Group, Inc.	—	—	—	4,407	—	—	—	4,407
Share-based compensation	—	—	2,102	—	—	—	—	2,102
Issuance of common stock from the exercise of stock options	70	—	337	—	—	—	—	337
Net issuance of restricted stock	2	—	—	—	—	—	—	—
Shares of common stock withheld to satisfy tax withholding obligations	(1)	—	—	—	1	(8)	—	(8)
Balance at September 30, 2020	28,585	$ 28	$ 81,451	$ 7,925	$ 3	$ (65)	$ —	$ 89,339

See accompanying notes to condensed consolidated financial statements.

THE PENNANT GROUP, INC.
CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS
(unaudited, in thousands)

	Nine Months Ended September 30,	
	2021	**2020**
Cash flows from operating activities:		
Net income	$ 4,503	$ 11,724
Adjustments to reconcile net income to net cash (used in) provided by operating activities:		
Depreciation and amortization	3,545	3,434
Amortization of deferred financing fees	358	248
Provision for doubtful accounts	528	397
Share-based compensation	7,483	6,017
Deferred income taxes	87	—
Change in operating assets and liabilities, net of acquisitions:		
Accounts receivable	(6,708)	(4,201)
Prepaid expenses and other assets	(6,861)	(3,055)
Operating lease obligations	883	2,177
Accounts payable	(49)	(946)
Accrued wages and related liabilities	(4,644)	2,199
Other accrued liabilities	2,709	7,096
Contract liabilities (CARES Act advance payments)	(14,638)	27,997
Other long-term liabilities	(261)	—
Net cash (used in) provided by operating activities	(13,065)	53,087
Cash flows from investing activities:		
Purchase of property and equipment	(4,144)	(7,692)
Cash payments for business acquisitions, net of escrow	(13,550)	(14,093)
Escrow deposits	—	(5,287)
Other	(372)	(506)
Net cash used in investing activities	(18,066)	(27,578)
Cash flows from financing activities:		
Proceeds from Revolving Credit Facility	97,000	28,500
Payments on Revolving Credit Facility	(61,500)	(46,500)
Repurchase of shares of common stock to satisfy tax withholding obligations	—	(65)
Payments for deferred financing costs	(1,394)	(78)
Issuance of common stock upon the exercise of options	689	552
Net cash provided by (used in) financing activities	34,795	(17,591)
Net increase in cash	3,664	7,918
Cash beginning of period	43	402
Cash end of period	$ 3,707	$ 8,320

See accompanying notes to condensed consolidated financial statements.

THE PENNANT GROUP, INC.
CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS - (Continued)
(unaudited, in thousands)

	Nine Months Ended September 30,	
	2021	**2020**
Supplemental disclosures of cash flow information:		
Cash paid during the period for:		
Interest	$ 980	$ 854
Income taxes	$ 2,594	$ 6,447
Lease liabilities	$ 29,327	$ 28,999
Right-of-use assets obtained in exchange for new operating lease obligations	$ 2,842	$ 4,161
Net non-cash adjustment to right-of-use assets and lease liabilities from lease modifications	$ 159	$ 860
Non-cash investing activity:		
Capital expenditures in accounts payable	$ 551	$ 510

See accompanying notes to condensed consolidated financial statements.

THE PENNANT GROUP INC.
NOTES TO THE CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(In thousands, except per share data and operational senior living units)

1. DESCRIPTION OF BUSINESS

The Pennant Group, Inc. (herein referred to as "Pennant," the "Company," "it," or "its"), is a holding company with no direct operating assets, employees or revenue. The Company, through its independent operating subsidiaries, provides healthcare services across the post-acute care continuum. As of September 30, 2021, the Company's subsidiaries operated 88 home health, hospice and home care agencies and 54 senior living communities located in Arizona, California, Colorado, Idaho, Iowa, Montana, Nevada, Oklahoma, Oregon, Texas, Utah, Washington, Wisconsin and Wyoming.

On October 1, 2019, The Ensign Group, Inc. (NASDAQ: ENSG) ("Ensign" or the "Parent") completed the separation of Pennant (the "Spin-Off"). To accomplish the Spin-Off, Ensign contributed all of its home health and hospice and substantially all of its senior living businesses into Pennant. Each Ensign stockholder received a distribution of one share of Pennant's common stock for every two shares of Ensign's common stock, plus cash in lieu of fractional shares. The noncontrolling interest was converted into shares of Pennant at the established conversion ratio. As a result of the Spin-Off on October 1, 2019, Pennant began trading as an independent company on the NASDAQ under the symbol "PNTG."

Certain of the Company's subsidiaries, collectively referred to as the Service Center, provide accounting, payroll, human resources, information technology, legal, risk management, and other services to the operations through contractual relationships.

Each of the Company's affiliated operations are operated by separate, independent subsidiaries that have their own management, employees and assets. References herein to the consolidated "Company" and "its" assets and activities is not meant to imply, nor should it be construed as meaning, that Pennant has direct operating assets, employees or revenue, or that any of the subsidiaries are operated by Pennant.

2. BASIS OF PRESENTATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation - The accompanying unaudited condensed consolidated financial statements of the Company (the "Interim Financial Statements") reflect the Company's financial position, results of operations and cash flows of the business. The Interim Financial Statements have been prepared in accordance with accounting principles generally accepted in the United States ("GAAP") and pursuant to the regulations of the Securities and Exchange Commission ("SEC"). Management believes that the Interim Financial Statements reflect, in all material respects, all adjustments which are of a normal and recurring nature necessary to present fairly the Company's financial position, results of operations, and cash flows for the periods presented in conformity with GAAP. The results reported in these Interim Financial Statements are not necessarily indicative of results that may be expected for the entire year.

The Condensed Consolidated Balance Sheet as of December 31, 2020 is derived from the Company's annual audited Consolidated Financial Statements for the fiscal year ended December 31, 2020 which should be read in conjunction with these Interim Financial Statements. Certain information in the accompanying footnote disclosures normally included in annual financial statements was condensed or omitted for the interim periods presented in accordance with GAAP.

All intercompany transactions and balances between the various legal entities comprising the Company have been eliminated in consolidation. The Company presents noncontrolling interests within the equity section of its Condensed Consolidated Balance Sheets and the amount of consolidated net income that is attributable to the Company and the noncontrolling interest in its Condensed Consolidated Statements of Income.

The Company consists of various limited liability companies and corporations established to operate home health, hospice, home care, and senior living operations. The Interim Financial Statements include the accounts of all entities controlled by the Company through its ownership of a majority voting interest.

Estimates and Assumptions - The preparation of the Interim Financial Statements in conformity with GAAP requires management to make certain estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the Interim Financial Statements and the reported amounts of revenue and expenses during the reporting periods. The most significant estimates in the Interim Financial Statements relate to revenue, intangible assets and goodwill, right-of-use assets and lease liabilities for leases greater than 12 months, self-insurance reserves, and income taxes. Actual results could differ from those estimates.

CARES Act: The Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act") was enacted on March 27, 2020 in the United States. The CARES Act allowed for deferred payment of the employer-paid portion of social security taxes

through the end of 2020, with 50% due on December 31, 2021 and the remainder due on December 31, 2022. As of September 30, 2021, the Company deferred approximately $7,836 of the employer-paid portion of social security taxes, of which $3,918 is included in other long-term liabilities and the current portion of $3,918 in accrued wages and related liabilities. The CARES Act also expanded the Centers for Medicare & Medicaid Services' ("CMS") ability to provide accelerated/advance payments intended to increase the cash flow of healthcare providers and suppliers impacted by COVID-19. During the prior year, the Company applied for and received $27,997 in funds under the Accelerated and Advance Payment ("AAP") Program, of which $14,638 had been recouped as of September 30, 2021. See Note 10, *Other Accrued Liabilities* for further discussion of the AAP.

The American Rescue Plan Act of 2021 (the "ARP Act") was enacted on March 11, 2021 in the United States. The ARP Act was designed to assist the country with the effects of the COVID-19 pandemic and included a number of tax components. The ARP Act's primary tax impact on the Company requires the Company to include the next five highest paid employees to the list of covered officers already subject to the IRC Section 162(m) wage limitation beginning in the 2027 tax year. The Company will continue to assess the effect of the ARP Act and ongoing other government legislation related to the COVID-19 pandemic that may be issued.

Recent Accounting Standards Adopted by the Company

FASB Accounting Standards Update, or ASU, ASU 2021-01 "Reference Rate Reform (Topic 848): Scope" or ASU 2020-4 - On January 7, 2021, the FASB issued ASU 2021-01 to amend the scope of the guidance in ASU 2020-04 "Reference Rate Reform (Topic 848): Facilitation of the Effects of Reference Rate Reform on Financial Reporting" or ASU 2020-4. Specifically, the amendments in ASU 2021-01 clarify that "certain optional expedients and exceptions in Topic 848 for contract modifications and hedge accounting apply to derivatives that are affected by the discounting transition." The amendment in ASU 2021-1 is available to all entities: (i) on a full retrospective basis as of any date from the beginning of an interim period that includes or is subsequent to March 12, 2020 through the date that the final update to the standard was issued or (ii) on a prospective basis for new contract modifications through December 31, 2022. The Company has adopted ASU 2021-01 on a prospective basis effective as of January 7, 2021. There was no material impact to the Company's Interim Financial Statements or related disclosures as a result of the adoption of ASU 2021-01.

3. RELATED PARTY TRANSACTIONS

The Company leases 31 of its senior living communities from subsidiaries of Ensign, and each of the leases have a term of between 14 and 20 years from the lease commencement date. The total amount of rent expense included in Rent - cost of services paid to subsidiaries of Ensign was $3,169 and $9,415 for the three and nine months ended September 30, 2021, respectively, and $3,131 and $9,363 for the three and nine months ended September 30, 2020, respectively.

The Company's subsidiaries received services from Ensign's subsidiaries. Services included in cost of services were $760 and $2,377 for the three and nine months ended September 30, 2021 and $1,111 and $3,299 for the three and nine months ended September 30, 2020, respectively.

On October 1, 2019, in connection with the Spin-Off, Pennant entered into several agreements with Ensign that set forth the principal actions taken or to be taken in connection with the Spin-Off and govern the relationship of the parties following the Spin-Off. The Company has incurred costs of $706 and $2,441 for the three and nine months ended September 30, 2021, respectively, and $1,502 and $4,583 for the three and nine months ended September 30, 2020, respectively, which costs related primarily to administrative support under the Transitions Services Agreement with Ensign (the "Transition Services Agreement"), which expired two years from the Spin-Off date.

4. COMPUTATION OF NET INCOME PER COMMON SHARE

Basic net income per share is computed by dividing net income attributable to stockholders of the Company by the weighted average number of outstanding common shares for the period. The computation of diluted net income per share is similar to the computation of basic net income per share except that the denominator is increased to include the number of additional common shares that would have been outstanding if the dilutive potential common shares had been issued.

The following table sets forth the computation of basic and diluted net income per share for the periods presented:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2021	2020	2021	2020
Numerator:				
Net income	$ 1,121	$ 4,407	$ 4,503	$ 11,724
Add: net loss attributable to noncontrolling interests	(124)	—	(342)	—
Net income attributable to The Pennant Group, Inc.	$ 1,245	$ 4,407	$ 4,845	$ 11,724
Denominator:				
Weighted average shares outstanding for basic net income per share	28,444	28,055	28,364	27,967
Plus: assumed incremental shares from exercise of options and assumed conversion or vesting of restricted stock[(a)]	2,112	2,188	2,355	1,988
Adjusted weighted average common shares outstanding for diluted income per share	30,556	30,243	30,719	29,955
Earnings Per Share:				
Basic net income per common share	$ 0.04	$ 0.16	$ 0.17	$ 0.42
Diluted net income per common share	$ 0.04	$ 0.15	$ 0.16	$ 0.39

(a) The calculation of dilutive shares outstanding excludes out-of-the-money stock options (i.e., such options' exercise prices were greater than the average market price of our common shares for the period) because their inclusion would have been antidilutive. Options outstanding which are anti-dilutive and therefore not factored into the weighted average common shares amount above were 815 and 437 for the three and nine months ended September 30, 2021 and 224 and 45 for the three and nine months ended September 30, 2020.

5. REVENUE AND ACCOUNTS RECEIVABLE

Revenue is recognized when services are provided to the patients at the amount that reflects the consideration to which the Company expects to be entitled from patients and third-party payors, including Medicaid, Medicare and managed care programs (Commercial, Medicare Advantage and Managed Medicaid plans), in exchange for providing patient care. The healthcare services in home health and hospice patient contracts include routine services in exchange for a contractual agreed-upon amount or rate. Routine services are treated as a single performance obligation satisfied over time as services are rendered. As such, patient care services represent a bundle of services that are not capable of being distinct within the context of the contract. Additionally, there may be ancillary services which are not included in the rates for routine services, but instead are treated as separate performance obligations satisfied at a point in time, if and when those services are rendered.

Revenue recognized from healthcare services are adjusted for estimates of variable consideration to arrive at the transaction price. The Company determines the transaction price based on contractually agreed-upon amounts or rate, adjusted for estimates of variable consideration. The Company uses the expected value method in determining the variable component that should be used to arrive at the transaction price, using contractual agreements and historical reimbursement experience within each payor type. The amount of variable consideration which is included in the transaction price may be constrained, and is included in the net revenue only to the extent that it is probable that a significant reversal in the amount of the cumulative revenue recognized will not occur in a future period. If actual amounts of consideration ultimately received differ from the Company's estimates, the Company adjusts these estimates, which would affect net service revenue in the period such variances become known.

Revenue from the Medicare and Medicaid programs accounted for 62.2% and 62.6% of the Company's revenue, for the three and nine months ended September 30, 2021, and 60.4% and 59.3% for the three and nine months ended September 30, 2020, respectively. The Company records revenue from these governmental and managed care programs as services are performed at their expected net realizable amounts under these programs. The Company's revenue from governmental and managed care programs is subject to audit and retroactive adjustment by governmental and third-party agencies. Consistent with healthcare industry accounting practices, any changes to these governmental revenue estimates are recorded in the period the change or adjustment becomes known based on final settlement.

Disaggregation of Revenue

The Company disaggregates revenue from contracts with its patients by reportable operating segments and payors. The Company has determined that disaggregating revenue into these categories achieves the disclosure objectives to depict how the nature, amount, timing and uncertainty of revenue and cash flows are affected by economic factors.

The Company's service specific revenue recognition policies are as follows:

Home Health Revenue

Medicare Revenue

For Medicare episodes that began after January 1, 2020, net service revenue is recognized in accordance with the Patient Driven Groupings Model ("PDGM"). This new reimbursement structure involves case mix calculation methodology refinements, changes to low-utilization payment adjustment ("LUPA") thresholds, the elimination of therapy thresholds, a change to the unit of payment from a 60-day episode to a 30-day payment period, and reduction of requests for anticipated payments ("RAPs") to 20% of the estimated payment for a patient's initial or subsequent period of care up-front (after the initial assessment is completed and upon initial billing). The RAPs were phased out effective January 1, 2021. Under PDGM, Medicare provides agencies with payments for each 30-day payment period provided to beneficiaries. If a beneficiary is still eligible for care after the end of the first 30-day payment period, a second 30-day payment period can begin. There are no limits to the number of periods of care a beneficiary who remains eligible for the home health benefit can receive. While payment for each 30-day payment period is adjusted to reflect the beneficiary's health condition and needs, a special outlier provision exists to ensure appropriate payment for those beneficiaries that have the most expensive care needs. The payment under the Medicare program is also adjusted for certain variables including, but not limited to: (a) a LUPA if the number of visits is below an established threshold that varies based on the diagnosis of a beneficiary; (b) a partial payment if the patient transferred to another provider or the Company received a patient from another provider before completing the period of care; (c) adjustment to the admission source of claim if it is determined that the patient had a qualifying stay in a post-acute care setting within 14 days prior to the start of a 30-day payment period; (d) the timing of the 30-day payment period provided to a patient in relation to the admission date, regardless of whether the same home health provider provided care for the entire series of episodes; (e) changes to the acuity of the patient during the previous 30-day payment period; (f) changes in the base payments established by the Medicare program; (g) adjustments to the base payments for case mix and geographic wages; and (h) recoveries of overpayments.

For all episodes that began prior to January 1, 2020, net service revenue was recorded under the Medicare prospective payment system based on a 60-day episode payment rate that is subject to adjustment based on certain variables including, but not limited to: (a) an outlier payment if the patient's care was unusually costly; (b) a LUPA if the number of visits was fewer than five; (c) a partial payment if the patient transferred to another provider or transferred from another provider before completing the episode; (d) a payment adjustment based upon the level of covered therapy services; (e) the number of episodes of care provided to a patient, regardless of whether the same home health provider provided care for the entire series of episodes; (f) changes in the base episode payments established by the Medicare program; (g) adjustments to the base episode payments for case mix and geographic wages; and (h) recoveries of overpayments.

The Company adjusts Medicare revenue on completed episodes to reflect differences between estimated and actual payment amounts, an inability to obtain appropriate billing documentation and other reasons unrelated to credit risk. Therefore, the Company believes that its reported net service revenue and patient accounts receivable will be the net amounts to be realized from Medicare for services rendered.

In addition to revenue recognized on completed episodes and periods, the Company also recognizes a portion of revenue associated with episodes and periods in progress. Episodes in progress are 30-day payment periods, if the episode started after January 1, 2020, or 60-day episodes of care, if the episode started prior to January 1, 2020, that begin during the reporting period but were not completed as of the end of the period. As such, the Company estimates revenue and recognizes it on a daily basis. The primary factors underlying this estimate are the number of episodes in progress at the end of the reporting period, expected Medicare revenue per period of care or episode of care and the Company's estimate of the average percentage complete based on the scheduled end of period and end of episode dates.

Non-Medicare Revenue

Episodic Based Revenue - The Company recognizes revenue in a similar manner as it recognizes Medicare revenue for episodic-based rates that are paid by other insurance carriers, including Medicare Advantage programs. These rates can vary based upon the negotiated terms.

Non-episodic Based Revenue - Revenue is recognized on an accrual basis based upon the date of service at amounts equal to its established or estimated per visit rates, as applicable.

Hospice Revenue

Revenue is recognized on an accrual basis based upon the date of service at amounts equal to the estimated payment rates. The estimated payment rates are calculated as daily rates for each of the levels of care the Company delivers. Revenue is adjusted for an inability to obtain appropriate billing documentation or authorizations acceptable to the payor and other reasons unrelated to credit risk. Additionally, as Medicare hospice revenue is subject to an inpatient cap and an overall payment cap, the Company monitors its provider numbers and estimates amounts due back to Medicare if a cap has been exceeded. The Company regularly evaluates and records these adjustments as a reduction to revenue and an increase to other accrued liabilities.

Senior Living Revenue

The Company has elected the lessor practical expedient within ASC Topic 842, *Leases* ("ASC 842") and therefore recognizes, measures, presents, and discloses the revenue for services rendered under the Company's senior living residency agreements based upon the predominant component, either the lease or non-lease component, of the contracts. The Company has determined that the services included under the Company's senior living residency agreements each have the same timing and pattern of transfer. The Company recognizes revenue under ASC Topic 606, *Revenue from Contracts with Customers* for its senior residency agreements, for which it has determined that the non-lease components of such residency agreements are the predominant component of each such contract.

The Company's senior living revenue consists of fees for basic housing and assisted living care. Accordingly, the Company records revenue when services are rendered on the date services are provided at amounts billable to individual residents. Residency agreements are generally for a term of 30 days, with resident fees billed monthly in advance. For residents under reimbursement arrangements with Medicaid, revenue is recorded based on contractually agreed-upon amounts or rates on a per resident, daily basis or as services are rendered.

Revenue By Payor

Revenue by payor for the three months ended September 30, 2021 and 2020, is summarized in the following tables:

	Three Months Ended September 30, 2021				
	Home Health and Hospice Services				
	Home Health Services	Hospice Services	Senior Living Services	Total Revenue	Revenue %
Medicare	$ 20,227	$ 35,059	$ —	$ 55,286	49.4 %
Medicaid	1,938	3,074	9,330	14,342	12.8
Subtotal	22,165	38,133	9,330	69,628	62.2
Managed care	11,969	879	—	12,848	11.5
Private and other[(a)]	5,800	57	23,588	29,445	26.3
Total revenue	$ 39,934	$ 39,069	$ 32,918	$ 111,921	100.0 %

(a) Private and other payors in our home health and hospice services segment includes revenue from all payors generated in our home care operations.

	Three Months Ended September 30, 2020				
	Home Health and Hospice Services				
	Home Health Services	Hospice Services	Senior Living Services	Total Revenue	Revenue %
Medicare	$ 15,156	$ 30,321	$ —	$ 45,477	46.2 %
Medicaid	1,938	2,813	9,181	13,932	14.2
Subtotal	17,094	33,134	9,181	59,409	60.4
Managed care	7,923	251	—	8,174	8.3
Private and other[(a)]	5,922	55	24,837	30,814	31.3
Total revenue	$ 30,939	$ 33,440	$ 34,018	$ 98,397	100.0 %

(a) Private and other payors in our home health and hospice services segment includes revenue from all payors generated in our home care operations.

Revenue by payor for the nine months ended September 30, 2021 and 2020, is summarized in the following tables:

	Nine Months Ended September 30, 2021				
	Home Health and Hospice Services				
	Home Health Services	Hospice Services	Senior Living Services	Total Revenue	Revenue %
Medicare	$ 61,055	$ 101,771	$ —	$ 162,826	49.7 %
Medicaid	6,659	8,507	27,266	42,432	12.9
Subtotal	67,714	110,278	27,266	205,258	62.6
Managed care	34,586	2,241	—	36,827	11.2
Private and other[(a)]	16,594	302	68,948	85,844	26.2
Total revenue	$ 118,894	$ 112,821	$ 96,214	$ 327,929	100.0 %

Private and other payors in our home health and hospice services segment includes revenue from all payors generated in our home care operations.

	Nine Months Ended September 30, 2020				
	Home Health and Hospice Services				
	Home Health Services	Hospice Services	Senior Living Services	Total Revenue	Revenue %
Medicare	$ 39,540	$ 85,551	$ —	$ 125,091	44.2 %
Medicaid	5,491	9,779	27,369	42,639	15.1
Subtotal	45,031	95,330	27,369	167,730	59.3
Managed care	21,885	1,064	—	22,949	8.1
Private and other[(a)]	15,706	109	76,492	92,307	32.6
Total revenue	$ 82,622	$ 96,503	$ 103,861	$ 282,986	100.0 %

Private and other payors in our home health and hospice services segment includes revenue from all payors generated in our home care operations.

Balance Sheet Impact

Included in the Company's Condensed Consolidated Balance Sheets are contract assets, comprised of billed accounts receivable and unbilled receivables, which are the result of the timing of revenue recognition, billings and cash collections, as well as, contract liabilities, which primarily represent payments the Company receives in advance of services provided. As of September 30, 2021, the Company had contract liabilities in the amount of $13,359 related to Advance Payments received in connection with the CARES Act reported in other current liabilities. As further discussed in Note 10, *Other Accrued Liabilities*, the repayment terms for Medicare advance payments were modified through the passage of the Continuing Appropriations Act, 2021 and Other Extensions Act on October 1, 2020.

Accounts receivable, net as of September 30, 2021 and December 31, 2020 is summarized in the following table:

	September 30, 2021	December 31, 2020
Medicare	$ 30,127	$ 28,569
Medicaid	9,655	7,669
Managed care	9,754	7,590
Private and other	4,799	4,036
Accounts receivable, gross	54,335	47,864
Less: allowance for doubtful accounts	(933)	(643)
Accounts receivable, net	$ 53,402	$ 47,221

Practical Expedients and Exemptions

As the Company's contracts have an original duration of one year or less, the Company uses the practical expedient applicable to its contracts and does not consider the time value of money. Further, because of the short duration of these contracts, the Company has not disclosed the transaction price for the remaining performance obligations as of the end of each reporting period or when the Company expects to recognize this revenue. In addition, the Company has applied the practical expedient provided by ASC 340, *Other Assets and Deferred Costs* ("ASC 340"), and all incremental customer contract acquisition costs are expensed as they are incurred because the amortization period would have been one year or less.

6. BUSINESS SEGMENTS

The Company classifies its operations into the following reportable operating segments: (1) home health and hospice services, which includes the Company's home health, hospice and home care businesses; and (2) senior living services, which includes the operation of assisted living, independent living and memory care communities. The reporting segments are business units that offer different services and are managed separately to provide greater visibility into those operations. Our Chief Executive Officer, who is our Chief Operating Decision Maker ("CODM"), reviews financial information at the operating segment level. We also report an "all other" category that includes general and administrative expense from our Service Center.

As of September 30, 2021, the Company provided services through 88 affiliated home health, hospice and home care agencies, and 54 affiliated senior living operations. The Company evaluates performance and allocates capital resources to each segment based on an operating model that is designed to maximize the quality of care provided and profitability. The Company's Service Center provides various services to all lines of business. The Company does not review assets by segment and therefore assets by segment are not disclosed below.

The CODM uses Segment Adjusted EBITDAR from Operations as the primary measure of profit and loss for the Company's reportable segments and to compare the performance of its operations with those of its competitors. Segment Adjusted EBITDAR from Operations is net income (loss) attributable to the Company's reportable segments excluding interest expense, provision for income taxes, depreciation and amortization expense, rent, and, in order to view the operations performance on a comparable basis from period to period, certain adjustments including: (1) costs at start-up operations, (2) share-based compensation, (3) acquisition related costs, (4) redundant and nonrecurring costs associated with the Transition Services Agreement, and (5) net loss attributable to noncontrolling interest. General and administrative expenses are not allocated to the reportable segments, and are included as "All Other", accordingly the segment earnings measure reported is before allocation of corporate general and administrative expenses. The Company's segment measures may be different from the calculation methods used by other companies and, therefore, comparability may be limited.

The following tables present certain financial information regarding our reportable segments, general and administrative expenses are not allocated to the reportable segments and are included in "All Other" for the three and nine months ended September 30, 2021 and 2020:

	Home Health and Hospice Services	Senior Living Services	All Other	Total
Three Months Ended September 30, 2021				
Revenue	$ 79,003	$ 32,918	$ —	$ 111,921
Segment Adjusted EBITDAR from Operations	$ 14,409	$ 9,106	$ (6,783)	$ 16,732
Three Months Ended September 30, 2020				
Revenue	$ 64,379	$ 34,018	$ —	$ 98,397
Segment Adjusted EBITDAR from Operations	$ 13,530	$ 11,684	$ (6,857)	$ 18,357

	Home Health and Hospice Services	Senior Living Services	All Other	Total
Nine Months Ended September 30, 2021				
Revenue	$ 231,715	$ 96,214	$ —	$ 327,929
Segment Adjusted EBITDAR from Operations	$ 43,131	$ 27,692	$ (19,249)	$ 51,574
Nine Months Ended September 30, 2020				
Revenue	$ 179,125	$ 103,861	$ —	$ 282,986
Segment Adjusted EBITDAR from Operations	$ 34,681	$ 37,673	$ (15,638)	$ 56,716

This following table provides a reconciliation of Segment Adjusted EBITDAR from Operations to income from operations:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2021	2020	2021	2020
Segment Adjusted EBITDAR from Operations	$ 16,732	$ 18,357	$ 51,574	$ 56,716
Less: Depreciation and amortization	1,200	1,212	3,545	3,434
Rent—cost of services	10,334	9,721	30,455	29,194
Other expense	—	225	(24)	225
Adjustments to Segment EBITDAR from Operations:				
Less: Costs at start-up operations[a]	532	717	991	1,422
Share-based compensation expense[b]	2,568	2,102	7,483	6,017
Acquisition related costs[c]	36	—	73	—
Transition services costs[d]	236	209	1,825	746
Net COVID-19 related costs[e]	—	(307)	—	853
Add: Net loss attributable to noncontrolling interest	(124)	—	(342)	—
Condensed Consolidated Income from Operations	$ 1,702	$ 4,478	$ 6,884	$ 14,825

Represents results related to start-up operations. This amount excludes rent and depreciation and amortization expense related to such operations.
Share-based compensation expense incurred which is included in cost of services and general and administrative expense.
Acquisition related costs related to business combinations during the periods.

A portion of the costs incurred under the Transition Services Agreement identified as redundant or nonrecurring that are included in general and administrative expense. Fees incurred under the Transition Services Agreement, net of the Company's payroll reimbursement, were $706 and $2,441 for the three and nine months ended September 30, 2021, and $1,502 and $4,583 for the three and nine months ended September 30, 2020, respectively. During the fourth quarter of fiscal 2020, we updated our Transition service costs adjustment to include duplicate software costs. The prior year transition service costs adjustment has been recast to reflect the change. The adjustment to the prior year transition service costs was $113 and $333 for the duplicative software costs for the three and nine months ended September 30, 2020 that were included in the 2020 full year amount in the Company's as filed Form 10-K.

Beginning in the first quarter of fiscal year 2021, we updated our definition of Segment Adjusted EBITDAR to no longer include an adjustment for COVID-19 expenses offset by the amount of sequestration relief. COVID-19 expenses continue to be part of daily operations for which less specific identification is visible. Furthermore, the sequestration relief has been extended through December 31, 2021. Sequestration relief was $867 and $2,685 for the three and nine months ended September 30, 2021, respectively.

The 2020 amounts represent incremental costs incurred as part of the Company's response to COVID-19 including direct medical supplies, labor, and other expenses, net of $1,121 and $1,675 in increased revenue related to the 2% payment increase in Medicare reimbursements for sequestration relief for the three and nine months ended September 30, 2020, respectively.

7. ACQUISITIONS

The Company's acquisition focus is to purchase or lease operations that are complementary to the Company's current businesses, accretive to the Company's business or otherwise advance the Company's strategy. The results of all the Company's independent operating subsidiaries are included in the Interim Financial Statements subsequent to the date of acquisition. Acquisitions are accounted for using the acquisition method of accounting.

2021 Acquisitions

During the nine months ended September 30, 2021, the Company expanded its operations with the addition of five home health, four hospice and two home care agencies. The aggregate purchase price for these acquisitions was $14,135. A subsidiary of the Company entered into a separate operations transfer agreement with the prior operator of each acquired operation as part of each transaction.

The fair value of assets for home health, hospice and home care acquisitions was mostly concentrated in goodwill and intangible assets and as such, these transactions were classified as business combinations in accordance with ASC Topic 805, *Business Combinations* ("ASC 805"). The purchase price for the business combinations was $13,550, which consisted of equipment and other assets of $72, goodwill of $7,341, and indefinite-lived intangible assets of $6,137 related to Medicare and Medicaid licenses. The Company anticipates that the total goodwill recognized will be fully deductible for tax purposes. There were no material acquisition costs that were expensed related to the business combinations during the nine months ended September 30, 2021.

Two of the hospice agencies were acquired Medicare licenses and are considered asset acquisitions. The fair value of assets for the hospice licenses acquired totaled $585 and was allocated to indefinite-lived intangible assets.

2020 Acquisitions

During the nine months ended September 30, 2020, the Company expanded its operations with the addition of four home health agency, five hospice agencies, and two senior living communities. The aggregate purchase price for these acquisitions was $14,493. In connection with the addition of the senior living communities, the Company entered into new long-term "triple-net" leases with subsidiaries of Ensign. The addition of these operations added a total of 164 operational senior living units to be operated by the Company's independent operating subsidiaries. A subsidiary of the Company entered into a separate operations transfer agreement with the prior operator of each acquired operation as part of each transaction.

The fair value of assets for all home health, hospice and home care acquisitions was concentrated in goodwill and as such, these transactions were classified as business combinations in accordance with ASC 805. The purchase price for the business combinations was $14,493, which mostly consisted of equipment of $78, goodwill of $7,860, indefinite-lived intangible assets of $6,636 related to Medicare and Medicaid licenses, net of assumed liabilities of $81. The majority of total goodwill recognized is fully deductible for tax purposes. There were no acquisition costs that were expensed related to the business combinations of home health, hospice, and home care during the nine months ended September 30, 2020.

8. PROPERTY AND EQUIPMENT—NET

Property and equipment, net consist of the following:

	September 30, 2021	December 31, 2020
Leasehold improvements	$ 11,844	$ 9,984
Equipment	24,729	22,420
Furniture and fixtures	1,199	1,186
	37,772	33,590
Less: accumulated depreciation	(19,263)	(15,706)
Property and equipment, net	$ 18,509	$ 17,884

Depreciation expense was $1,189 and $3,527 for the three and nine months ended September 30, 2021, respectively, and $1,209 and $3,424 for the three and nine months ended September 30, 2020, respectively.

The Company measures certain assets at fair value on a non-recurring basis, including long-lived assets, which are evaluated for impairment. Long-lived assets include assets such as property and equipment, operating lease assets and certain intangible assets. The inputs used to determine the fair value of long-lived assets and a reporting unit are considered Level 3 measurements due to their subjective nature. Management has evaluated its long-lived assets and determined there was no impairment during the three and nine months ended September 30, 2021 and 2020.

9. GOODWILL AND OTHER INDEFINITE-LIVED INTANGIBLE ASSETS

The following table represents activity in goodwill by segment for the nine months ended September 30, 2021:

	Home Health and Hospice Services	Senior Living Services	Total
December 31, 2020	$ 62,802	$ 3,642	$ 66,444
Additions	7,341	—	7,341
September 30, 2021	$ 70,143	$ 3,642	$ 73,785

Other indefinite-lived intangible assets consist of the following:

	September 30, 2021	December 31, 2020
Trade name	$ 1,355	$ 1,355
Medicare and Medicaid licenses	52,855	46,133
Total	$ 54,210	$ 47,488

As of September 30, 2021, we evaluated potential triggering events that might be indicators that our goodwill and indefinite lived intangibles were impaired. The Company concluded that the current economic and business conditions did not result in a triggering event requiring a quantitative goodwill or intangible asset impairment analysis. No goodwill or intangible asset impairments were recorded during the three and nine months ended September 30, 2021 and 2020.

10. OTHER ACCRUED LIABILITIES

Other accrued liabilities consist of the following:

	September 30, 2021	December 31, 2020
Refunds payable	$ 2,786	$ 2,664
Deferred revenue	1,366	1,271
Contract Liabilities (CARES Act advance payments)	13,359	22,771
Resident deposits	5,361	5,647
Property taxes	1,120	982
Accrued self-insurance liabilities - current portion	2,191	1,354
Other	2,957	3,586
Other accrued liabilities	$ 29,140	$ 38,275

Refunds payable includes payables related to overpayments, duplicate payments and credit balances from various payor sources. Deferred revenue occurs when the Company receives payments in advance of services provided. Resident deposits include refundable deposits to residents and a small portion consists of non-refundable deposits recognized into revenue over a period of time. The CARES Act also expanded the ability of CMS to provide accelerated or advance payments intended to increase the cash flow of healthcare providers and suppliers impacted by COVID-19. During the prior year the Company applied for and received $27,997 in funds under the AAP Program. On October 1, 2020, the Continuing Appropriations Act, 2021 and Other Extensions Act (the “CA Act”) was signed into law. Among other things, the CARES Act significantly changed the repayment terms for AAP. In April 2021 CMS began automatic recoupment of these amounts through offsets to new claims. Medicare will automatically recoup 25% of Medicare payments for 11 months. At the end of the 11 months and assuming full repayment has not occurred, recoupment will increase to 50% for another six months. Any balance outstanding after these two recoupment periods will be subject to repayment at a 4% interest rate. As of September 30, 2021, CMS had recouped $14,638 of the AAP. The Company anticipates completing repayment of the AAP within the allotted recoupment periods.

11. DEBT

Long-term debt, net consists of the following:

	September 30, 2021	December 31, 2020
Revolving Credit Facility	$ 45,000	$ 9,500
Less: unamortized debt issuance costs[(a)]	(2,258)	(1,223)
Long-term debt, net	$ 42,742	$ 8,277

(a) Amortization expense for debt issuance costs was $129 and $358 for the three and nine months ended September 30, 2021, respectively, and $86 and $248 for the three and nine months ended September 30, 2020, respectively, and is recorded in interest expense, net on the Condensed Consolidated Statements of Income.

On February 23, 2021, Pennant entered into an amendment to its existing credit agreement (as amended, the “Credit Agreement”), which provides for an increased revolving credit facility with a syndicate of banks with a borrowing capacity of $150,000 (the “Revolving Credit Facility”). The interest rates applicable to loans under the Revolving Credit Facility are, at the Company’s election, either (i) Adjusted LIBOR (as defined in the Credit Agreement) plus a margin ranging from 2.3% to 3.3% per annum or (ii) Base Rate plus a margin ranging from 1.3% to 2.3% per annum, in each case based on the ratio of Consolidated Total Net Debt to Consolidated EBITDA (each, as defined in the Credit Agreement). In addition, Pennant pays a commitment fee on the undrawn portion of the commitments under the Revolving Credit Facility which ranges from 0.35% to 0.50% per annum, depending on the Consolidated Total Net Debt to Consolidated EBITDA ratio of the Company and its subsidiaries. The Company is not required to repay any loans under the Credit Agreement prior to maturity in 2026, other than to the extent the outstanding borrowings exceed the aggregate commitments under the Credit Agreement. As of September 30, 2021, the Company’s weighted average interest rate on its outstanding debt was 2.97%. As of September 30, 2021, the Company had available borrowing on the Revolving Credit Facility of $101,664, which is net of outstanding letters of credit of $3,336.

The fair value of the Revolving Credit Facility approximates carrying value, due to the short-term nature and variable interest rates. The fair value of this debt is categorized within Level 2 of the fair value hierarchy based on the observable market borrowing rates.

The Credit Agreement is guaranteed, jointly and severally, by certain of the Company's independent operating subsidiaries, and is secured by a pledge of stock of the Company's material independent operating subsidiaries as well as a first lien on substantially all of each material operating subsidiary's personal property. The Credit Agreement contains customary covenants that, among other things, restrict, subject to certain exceptions, the ability of the Company and its independent operating subsidiaries to grant liens on their assets, incur indebtedness, sell assets, make investments, engage in acquisitions, mergers or consolidations, amend certain material agreements and pay certain dividends and other restricted payments. Financial covenants require compliance with certain levels of leverage ratios that impact the amount of interest. As of September 30, 2021, the Company was compliant with all such financial covenants.

12. OPTIONS AND AWARDS

Outstanding options held by employees of the Company under the Ensign stock plans (collectively the "Ensign Plans") and outstanding options and restricted stock awards under the Company Subsidiary Equity Plan (together with the Ensign Plans the "Pre-Spin Plans") were modified and replaced with Pennant awards under the Pennant Plans at the Spin-Off date. Additionally, in connection with the Spin-Off, the Company issued new options and restricted stock awards to Pennant and Ensign employees under the 2019 Omnibus Incentive Plan (the "OIP") and Long-Term Incentive Plan (the "LTIP", together referred to as the "Pennant Plans").

Under the Ensign Plans and the Pennant Plans, stock-based payment awards, including employee stock options, restricted stock awards ("RSA"), and restricted stock units ("RSU" and together with RSA, "Restricted Stock") are issued based on estimated fair value. The following disclosures represent share-based compensation expense relating to employees of the Company's subsidiaries and non-employee directors who have awards under the Ensign and Pennant Plans.

Total share-based compensation expense for all Plans for the three and nine months ended September 30, 2021 and 2020 was:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2021	2020	2021	2020
Share-based compensation expense related to stock options	$ 834	444	$ 2,216	$ 1,076
Share-based compensation expense related to Restricted Stock	1,547	1,558	4,597	4,643
Share-based compensation expense related to Restricted Stock to non-employee directors	187	100	670	298
Total share-based compensation	$ 2,568	$ 2,102	$ 7,483	$ 6,017

In future periods, the Company estimates it will recognize the following share-based compensation expense for unvested stock options and unvested Restricted Stock, which were unvested as of September 30, 2021:

	Unrecognized Compensation Expense	Weighted Average Recognition Period (in years)
Unvested Stock Options	$ 12,715	4.0
Unvested Restricted Stock	6,325	1.1
Total unrecognized share-based compensation expense	$ 19,040	

Stock Options

Under the Pennant Plans, options granted to employees of the subsidiaries of Pennant generally vest over five years at 20% per year on the anniversary of the grant date. Options expire ten years after the date of grant.

The Company uses the Black-Scholes option-pricing model to recognize the value of stock-based compensation expense for share-based payment awards under the Plans. Determining the appropriate fair-value model and calculating the fair value of stock-based awards at the grant date requires considerable judgment, including estimating stock price volatility and expected option life. The Company develops estimates based on historical data and market information, which can change significantly over time.

The fair value of each option is estimated on the grant date using a Black-Scholes option-pricing model with the following weighted average assumptions for stock options granted:

Grant Year	Options Granted	Risk-Free Interest Rate	Expected Life[(a)]	Expected Volatility[(b)]	Dividend Yield	Weighted Average Fair Value of Options
2021	364	1.0 %	6.5	38.2 %	— %	$ 14.82
2020	494	0.5 %	6.5	35.8 %	— %	$ 9.81

(a) Under the midpoint method, the expected option life is the midpoint between the contractual option life and the average vesting period for the options being granted. This resulted in an expected option life of 6.5 years for the options granted.

(b) Because the Company's equity shares have been traded for a relatively short period of time, expected volatility assumption was based on the volatility of related industry stocks.

The following table represents the employee stock option activity during the nine months ended September 30, 2021:

	Number of Options Outstanding	Weighted Average Exercise Price	Number of Options Vested	Weighted Average Exercise Price of Options Vested
December 31, 2020	1,982	$ 17.48	615	$ 7.52
Granted	364	37.70		
Exercised	(92)	7.48		
Forfeited & Expired	(63)	22.49		
September 30, 2021	2,191	$ 21.12	683	$ 10.16

Restricted Stock

A summary of the status of Pennant's non-vested Restricted Stock, and changes during the nine months ended September 30, 2021, is presented below:

	Non-Vested Restricted Stock	Weighted Average Grant Date Fair Value
December 31, 2020	1,635	$ 14.80
Granted	15	44.67
Vested	(143)	16.26
Forfeited	(4)	14.30
September 30, 2021	1,503	$ 14.96

13. LEASES

The Company's independent operating subsidiaries lease 54 senior living communities and its administrative offices under non-cancelable operating leases, most of which have initial lease terms ranging from five to 21 years. Most of these leases contain renewal options, most involve rent increases and none contain purchase options. The lease term excludes lease renewals because the renewal rents are not at a bargain, there are no economic penalties for the Company to renew the lease, and it is not reasonably certain that the Company will exercise the extension options. As of September 30, 2021, the Company's independent operating subsidiaries leased 31 communities from subsidiaries of Ensign (the "Ensign Leases") under a master lease arrangement. The existing leases with subsidiaries of Ensign are generally for initial terms of between 14 to 20 years. In

addition to rent, each of the operating companies are required to pay the following: (1) all impositions and taxes levied on or with respect to the leased properties (other than taxes on the income of the lessor); (2) all utilities and other services necessary or appropriate for the leased properties and the business conducted on the leased properties; (3) all insurance required in connection with the leased properties and the business conducted on the leased properties; (4) all community maintenance and repair costs; and (5) all fees in connection with any licenses or authorizations necessary or appropriate for the leased properties and the business conducted on the leased properties.

Fifteen of the Company's affiliated senior living communities, excluding the communities that are operated under the Ensign Leases (as defined herein), are operated under two separate master lease arrangements. Under these master leases, a breach at a single community could subject one or more of the other communities covered by the same master lease to the same default risk. Failure to comply with Medicare and Medicaid provider requirements is a default under several of the Company's leases and master leases. With an indivisible lease, it is difficult to restructure the composition of the portfolio or economic terms of the master lease without the consent of the landlord.

The components of operating lease cost, are as follows:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2021	2020	2021	2020
Operating Lease Costs:				
Facility Rent—cost of services	$ 9,052	$ 8,876	$ 26,844	$ 26,624
Office Rent—cost of services	1,282	914	3,611	2,713
Sublease Income	—	(69)	—	(143)
Rent—cost of services	$ 10,334	$ 9,721	$ 30,455	$ 29,194
General and administrative expense	$ 51	$ 76	$ 192	$ 218
Variable lease cost [(a)]	$ 1,609	$ 1,299	$ 4,598	$ 3,975

(a) Represents variable lease cost for operating leases, which costs include property taxes and insurance, common area maintenance, and consumer price index increases, incurred as part of our triple net lease, and which is included in cost of services for the three and nine months ended September 30, 2021 and 2020.

The following table shows the lease maturity analysis for all leases as of September 30, 2021, for the years ended December 31:

Year	Amount
2021 (Remainder)	$ 9,778
2022	38,645
2023	37,686
2024	36,645
2025	35,681
Thereafter	356,306
Total lease payments	514,741
Less: present value adjustments	(212,103)
Present value of total lease liabilities	302,638
Less: current lease liabilities	(15,399)
Long-term operating lease liabilities	$ 287,239

Operating lease liabilities are based on the net present value of the remaining lease payments over the remaining lease term. In determining the present value of lease payments, the Company used its incremental borrowing rate based on the information available at each lease's commencement date to determine each lease's operating lease liability. As of September 30, 2021, the weighted average remaining lease term is 14.3 years and the weighted average discount rate is 8.1%.

14. INCOME TAXES

The Company recorded income tax expense of $69 and $1,013 or 5.8% and 18.4% of earnings before income taxes for the three and nine months ended September 30, 2021, respectively and income tax expense of $104 and $2,430 or 2.3% and 17.2% of earnings before income taxes for the three and nine months ended September 30, 2020, respectively. The effective tax rate for both three and nine month periods includes excess tax benefits from share-based compensation which were offset by non-deductible expenses including non-deductible compensation.

15. COMMITMENTS AND CONTINGENCIES

Regulatory Matters - The Company provides services in complex and highly regulated industries. The Company's compliance with applicable U.S. federal, state and local laws and regulations governing these industries may be subject to governmental review and adverse findings may result in significant regulatory action, which could include sanctions, damages, fines, penalties (many of which may not be covered by insurance), and even exclusion from government programs. The Company is a party to various regulatory and other governmental audits and investigations in the ordinary course of business and cannot predict the ultimate outcome of any federal or state regulatory survey, audit or investigation. While governmental audits and investigations are the subject of administrative appeals, the appeals process, even if successful, may take several years to resolve. The Department of Justice, CMS, or other federal and state enforcement and regulatory agencies may conduct additional investigations related to the Company's businesses. The Company believes that it is presently in compliance in all material respects with all applicable laws and regulations.

Cost-Containment Measures - Government and third-party payors have instituted cost-containment measures designed to limit payments made to providers of healthcare services, and there can be no assurance that future measures designed to limit payments made to providers will not adversely affect the Company.

Indemnities - From time to time, the Company enters into certain types of contracts that contingently require the Company to indemnify parties against third-party claims. These contracts primarily include (i) certain real estate leases, under which the Company may be required to indemnify property owners or prior operators for post-transfer environmental or other liabilities and other claims arising from the Company's use of the applicable premises, (ii) operations transfer agreements, in which the Company agrees to indemnify past operators of agencies and communities the Company acquires against certain liabilities arising from the transfer of the operation and/or the operation thereof after the transfer, (iii) certain Ensign lending agreements, and (iv) certain agreements with management, directors and employees, under which the subsidiaries of the Company may be required to indemnify such persons for liabilities arising out of their employment relationships. The terms of such obligations vary by contract and, in most instances, a specific or maximum dollar amount is not explicitly stated therein. Generally, amounts under these contracts cannot be reasonably estimated until a specific claim is asserted. Consequently, because no claims have been asserted, no liabilities have been recorded for these obligations on the Company's Condensed Consolidated Balance Sheets for any of the periods presented.

Litigation - The Company's businesses involve a significant risk of liability given the age and health of the patients and residents served by its independent operating subsidiaries. The Company, its operating companies, and others in the industry may be subject to a number of claims and lawsuits, including professional liability claims, alleging that services provided have resulted in personal injury, elder abuse, wrongful death or other related claims. Healthcare litigation (including class action litigation) is common and is filed based upon a wide variety of claims and theories, and the Company is routinely subjected to these claims in the ordinary course of business, including potential claims related to patient care and treatment, and professional negligence, as well as employment related claims. If there were a significant increase in the number of these claims or an increase in amounts owing should plaintiffs be successful in their prosecution of these claims, this could materially adversely affect the Company's business, financial condition, results of operations and cash flows. In addition, the defense of these lawsuits may result in significant legal costs, regardless of the outcome, and may result in large settlement amounts or damage awards.

In addition to the potential lawsuits and claims described above, the Company is also subject to potential lawsuits under the False Claims Act (the "FCA") and comparable state laws alleging submission of fraudulent claims for services to any healthcare program (such as Medicare) or payor. A violation may provide the basis for exclusion from federally funded healthcare programs. Such exclusions could have a correlative negative impact on the Company's financial performance. Some states, including California, Arizona and Texas, have enacted similar whistleblower and false claims laws and regulations. In addition, the Deficit Reduction Act of 2005 created incentives for states to enact anti-fraud legislation modeled on the FCA. As

such, the Company could face increased scrutiny, potential liability and legal expenses and costs based on claims under state false claims acts in markets in which it conducts business.

Under the Fraud Enforcement and Recovery Act ("FERA") and its associated rules, healthcare providers face significant penalties for the knowing retention of government overpayments, even if no false claim was involved. Providers have an obligation to proactively exercise "reasonable diligence" to identify overpayments and return those overpayments to CMS within 60 days of "identification" or the date any corresponding cost report is due, whichever is later. Retention of overpayments beyond this period may create liability under the FCA. In addition, FERA protects whistleblowers (including employees, contractors, and agents) from retaliation.

The Company cannot predict or provide any assurance as to the possible outcome of any litigation. If any litigation were to proceed, and the Company and its operating companies are subjected to, alleged to be liable for, or agree to a settlement of, claims or obligations under federal Medicare statutes, the FCA, or similar state and federal statutes and related regulations, the Company's business, financial condition and results of operations and cash flows could be materially and adversely affected. Among other things, any settlement or litigation could involve the payment of substantial sums to settle any alleged civil violations, and may also include the assumption of specific procedural and financial obligations by the Company or its independent operating subsidiaries going forward under a corporate integrity agreement and/or other arrangement with the government.

Medicare Revenue Recoupments - The Company is subject to probe reviews relating to Medicare services, billings and potential overpayments by Unified Program Integrity Contractors ("UPIC"), Recovery Audit Contractors ("RAC"), Zone Program Integrity Contractors ("ZPIC"), Program Safeguard Contractors ("PSC"), Supplemental Medical Review Contractors ("SMRC") and Medicaid Integrity Contributors ("MIC") programs, each of the foregoing collectively referred to as "Reviews." As of September 30, 2021, eight of the Company's independent operating subsidiaries had Reviews scheduled, on appeal or in dispute resolution process, both pre- and post-payment. If an operation fails an initial or subsequent Review, the operation could then be subject to extended Review, suspension of payment, or extrapolation of the identified error rate to all billing in the same time period. As of September 30, 2021, and through the filing of this Quarterly Report on Form 10-Q, the Company's independent operating subsidiaries have responded to the Reviews that are currently ongoing, on appeal or in dispute resolution process and the Company.

One hospice provider number is subject to a Medicare payment suspension imposed by a Uniform Program Integrity Contractor (UPIC). The UPIC is reviewing 42 patient records covering a 4-month period to determine whether, in its view, a Medicare overpayment was made. Medicare payments to that provider number are suspended pending the conclusion of the UPIC's review. The payments suspended as of September 30, 2021 total $2.7 million. The suspended amounts represent all Medicare payments due to the provider number since the start of the suspension and are not an overpayment finding. If the UPIC concludes that an overpayment exists, it will recover the overpayment from the suspended funds and release the excess funds, if any, to the provider. The UPIC has not specified when the payment suspension will end or when it will reach an over-payment determination.

Insurance - The Company retains risk for a substantial portion of potential claims for general and professional liability, workers' compensation and automobile liability. The Company does not retain risk related to its employee health plans.

The Company recognizes obligations associated with these costs, up to specified deductible limits in the period in which a claim is incurred, including with respect to both reported claims and claims incurred but not reported. The general and professional liability insurance has a retention limit of $150 per claim with a $500 corridor as an additional out-of-pocket retention we must satisfy for claims within the policy year before the carrier will reimburse losses. The workers' compensation insurance has a retention limit of $250 per claim, except for policies held in Texas and Washington which are subject to state insurance and possess their own limits.

Concentrations

Credit Risk - The Company has significant accounts receivable balances, the collectability of which is dependent on the availability of funds from certain governmental programs, primarily Medicare and Medicaid. These receivables represent the only significant concentration of credit risk for the Company. The Company does not believe there are significant credit risks associated with these governmental programs. The Company believes that an appropriate allowance has been recorded for the possibility of these receivables proving uncollectible, and continually monitors and adjusts these allowances as necessary. The Company's gross receivables from the Medicare and Medicaid programs accounted for approximately 73.2% and 75.7% of

its total gross accounts receivable as of September 30, 2021 and December 31, 2020, respectively. Revenue from reimbursement under the Medicare and Medicaid programs accounted for 62.2% and 62.6% for the three and nine months ended September 30, 2021, and 60.4% and 59.3% of the Company's revenue for the three and nine months ended September 30, 2020.

Item 2. ***Management's Discussion and Analysis of Financial Condition and Results of Operations***

You should read the following discussion and analysis in conjunction with the Interim Financial Statements and the related notes thereto contained in Part I, Item 1 of this Quarterly Report on Form 10-Q (this "Quarterly Report"). The information contained in this Quarterly Report is not a complete description of our business or the risks associated with an investment in our common stock. We urge you to carefully review and consider the various disclosures made by us in this Quarterly Report and in our other reports filed with the Securities and Exchange Commission ("SEC"), including our Annual Report on Form 10-K for the year ended December 31, 2020 (the "2020 Annual Report"), which discusses our business and related risks in greater detail, as well as subsequent reports we may file from time to time on Form 10-K, Form 10-Q and 8-K, for additional information. The section entitled "Risk Factors" filed within our 2020 Annual Report describes some of the important risk factors that may affect our business, financial condition, results of operations and/or liquidity. You should carefully consider those risks, in addition to the other information in this Quarterly Report and in our other filings with the SEC, before deciding to purchase, hold or sell our common stock.

Special Note About Forward-Looking Statements

This Quarterly Report contains "forward-looking statements" within the meaning of the safe harbor provisions of the U.S. Private Securities Litigation Reform Act of 1995, that are based on our management's beliefs and assumptions and on information currently available to our management. Forward-looking statements include all statements that are not historical facts and can be identified by the use of forward-looking terminology such as the words "outlook," "believes," "expects," "potential," "continues," "may," "might," "will," "should," "could," "seeks," "approximately," "goals," "future," "projects," "predicts," "guidance," "target," "intends," "plans," "estimates," "anticipates", the negative version of these words or other comparable words. Forward-looking statements include, but are not limited to, statements related to our expectations regarding the performance of our business, our financial results, our liquidity and capital resources, the benefits resulting from the Spin-Off, the effects of competition and the effects of future legislation or regulations and other non-historical statements. Additionally, many of these risks and uncertainties are currently amplified by and will continue to be amplified by, or in the future may be amplified by, the COVID-19 outbreak. The developments with respect to the spread of COVID-19 and its impacts have occurred rapidly, and because of the unprecedented nature of the pandemic, we are unable to predict the extent and duration of the adverse financial impact of COVID-19 on our business, financial condition and results of operations.

The risk factors discussed in this Quarterly Report and the 2020 Annual Report under the heading "Risk Factors," could cause our results to differ materially from those expressed in forward-looking statements. Factors that could cause actual results to differ materially from those in the forward-looking statements include, but are not limited to:

- uncertainties related to the COVID-19 outbreak;
- uncertainties regarding the implementation of state and federal vaccination mandates and potential affects upon our workforce and ability to maintain staffing, retain work;
- additional regulations relating to COVID-19 imposed by state and federal authorities and payors;
- federal and state changes to, or delays receiving, reimbursement and other aspects of Medicaid and Medicare;
- changes in the regulation of the healthcare services industry;
- increases in the federal income tax rate;
- increased competition and increased cost of acquisition or retention for, or a shortage of, skilled personnel;
- government reviews, audits and investigations of our business;
- changes in federal and state employment related laws;
- compliance with state and federal employment, immigration, licensing and other laws;
- competition from other healthcare providers;
- actions of national labor unions;
- the leases of our affiliated senior living communities;
- inability to complete future community or business acquisitions and failure to successfully integrate acquired communities and businesses into our operations;
- general economic conditions;
- security breaches and other cyber security incidents;
- the performance of the financial and credit markets;
- uncertainties related to our ability to realize the anticipated benefits of the Spin-Off; and

- uncertainties related to our ability to obtain financing or the terms of such financing.

Forward-looking statements involve risks, uncertainties and assumptions. Actual results may differ materially from those expressed in these forward-looking statements. You should not place undue reliance on any forward-looking statements in this Quarterly Report. Although we may from time to time voluntarily update our prior forward-looking statements, we disclaim any commitment to do so except as required by applicable securities laws.

Overview

We are a leading provider of high-quality healthcare services to patients of all ages, including the growing senior population, in the United States. We strive to be the provider of choice in the communities we serve through our innovative operating model. We operate in multiple lines of businesses including home health, hospice and senior living services across Arizona, California, Colorado, Idaho, Iowa, Montana, Nevada, Oklahoma, Oregon, Texas, Utah, Washington, Wisconsin and Wyoming. As of September 30, 2021, our home health and hospice business provided home health, hospice and home care services from 88 agencies operating across these 14 states, and our senior living business operated 54 senior living communities throughout seven states.

The following table summarizes our affiliated home health and hospice agencies and senior living communities as of:

	December 31,								September 30,
	2013	2014	2015	2016	2017	2018	2019	2020	2021
Home health and hospice agencies	16	25	32	39	46	54	63	76	88
Senior living communities	12	15	36	36	43	50	52	54	54
Senior living units	1,256	1,587	3,184	3,184	3,434	3,820	3,963	4,127	4,127
Total number of home health, hospice, and senior living operations	28	40	68	75	89	104	115	130	142

COVID-19

We have been, and we expect to continue to be, impacted by several factors related to the viral disease known as COVID-19 ("COVID-19") that may cause actual results to differ from our historical results or current expectations. Due to the COVID-19 pandemic, the results presented in this report are not necessarily indicative of future operating results. The situation surrounding COVID-19 remains fluid. We are actively managing our response in collaboration with government officials, team members and business partners, and we are assessing potential impacts to our financial position and operating results, as well as adverse developments in our business.

Home Health and Hospice

During the third quarter, the labor challenges experienced throughout the year were exacerbated as COVID-19 cases rose sharply, leading to further wage pressure, increased overtime and greater use of agency and registry staffing. Home health admissions during the quarter were impacted as more and more staff entered the quarantine protocol and by a significant decline in elective procedures, particularly in a few key markets and states that re-imposed temporary halts on such procedures.

Senior Living

COVID-19 continues to impact all aspects of our senior living business and geographies, including impacts on our residents, team members, vendors and business partners. For much of the third quarter of 2021, we saw a continuation of increased occupancy that began in the second quarter, although our occupancy began to decline in September and our overall senior living occupancy has decreased since the onset of the COVID-19 pandemic due to a greater number of move outs net of move ins. We cannot be sure if or when the occupancy levels in our senior living communities will improve over multiple measurement periods or return to pre-pandemic levels.

Labor

We have experienced and expect to continue to see increased labor costs due to increased overtime and premium pay and the increased need for temporary labor to supplement our existing staffing. We are monitoring the ongoing impact of our COVID-19 response actions on our revenue and expenses, including labor acquisition and turnover costs that may be imposed by existing and anticipated state and federal vaccination mandates imposed for skilled workers in home health agencies, senior

living communities and other health care service providers. However, the extent to which COVID-19 will continue to impact our operations will depend on future developments, which remain uncertain and cannot be predicted with confidence, including the pace of spread and impact of the B.1.617.2 variant of COVID-19 (the "Delta variant") and other potential variant strains, and the actions taken to contain COVID-19 or treat its impact, among others.

Recent Activities

Acquisitions. During the nine months ended September 30, 2021, we expanded our operations with the addition of five home health, four hospice and two home care agencies. We entered into a separate operations transfer agreement with each respective prior operator as a part of each transaction. The aggregate purchase price for these acquisitions was $14.1 million. For further discussion of our acquisitions, see Note 7, *Acquisitions*, in the Notes to the Interim Financial Statements.

Trends

Since the pandemic began and until the first quarter of 2021, we experienced a steady decline in senior living occupancy as move-ins declined relative to move-outs due to the pandemic. Beginning in the second quarter of 2021, and continuing into the third quarter, we have experienced a slight increase in our senior living occupancy. We cannot be sure when the occupancy levels in our senior living communities will return to pre-pandemic levels. As uncertainty regarding the COVID-19 pandemic persists, if there is a resurgence in cases, or if variant strains aggressively emerge, we could see a more prolonged recovery.

When we acquire turnaround or start-up operations, we expect that our combined metrics may be impacted. We expect these metrics to vary from period to period based upon the maturity of the operations within our portfolio. We have generally experienced lower occupancy rates and higher costs at our senior living communities and lower census and higher costs at our home health and hospice agencies for recently acquired operations; as a result, we generally anticipate lower and/or fluctuating consolidated and segment margins during years of acquisition growth. We established one start-up hospice agency in Washington during the three months ended September 30, 2021.

Government Regulation

We have disclosed under the heading "Government Regulation" in the 2020 Annual Report a summary of regulations that we believe materially affect our business, financial condition or results of operations. Since the time of the filing of the 2020 Annual Report, the following regulations have been updated.

The Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act") was enacted on March 27, 2020 in the United States and subsequent regulatory actions. The CARES Act contained provisions for accelerated or advance Medicare payments ("AAP") to provide supporting cash flow to providers and suppliers combating the effects of the COVID-19 pandemic. We applied for and received $28.0 million in the prior year. These funds are subject to automatic recoupment through offsets to new claims beginning one year after payment were issued. In April, 2021, CMS began to automatically recoup 25% of Medicare payments, which will continue for 11 months. At the end of the 11 months, assuming full repayment has not occurred, recoupment will increase to 50% for another six months. Any balance outstanding after these two recoupment periods will be subject to repayment at a 4% interest rate. We anticipate completing repayment of the AAP within the allotted recoupment periods.

The CARES Act temporarily suspended the 2% sequestration payment adjustment on Medicare fee-for-service payment beginning May 1, 2020 until December 31, 2020. The suspension was initially extended to go through March 31, 2021, and in April 2021 was extended through December 31, 2021. We recognized $0.9 million and $2.7 million in revenue related to the suspension of sequestration for the three and nine months ended September 30, 2021, respectively, and $1.1 million and $1.7 million for the three and nine months ended September 30, 2020, respectively, exclusive of our start-up operations. Further, the CARES Act payroll tax deferral program allowed employers to defer the deposit and payment of the employer's portion of social security taxes that otherwise would be due between March 27, 2020, and December 31, 2020. The CARES Act permits employers to deposit half of these deferred payments by the end of 2021 and the other half by the end of 2022. We deferred approximately $7.8 million of the employer-paid portion of social security taxes, of which $3.9 million is included in other long-term liabilities and the current portion of $3.9 million in accrued wages and related liabilities.

The American Rescue Plan Act of 2021 (the "ARP Act") was enacted on March 11, 2021 in the United States. The ARP Act was designed to assist the country with the effects of the COVID-19 pandemic and included a number of tax components. The ARP Act's primary tax impact on us is a new revenue raising provision that requires us to include the next five highest paid employees to the list of covered officers already subject to the IRC Section 162(m) wage limitation beginning

in the 2027 tax year. We will continue to assess the effect of the ARP Act and ongoing other government legislation related to the COVID-19 pandemic that may be issued.

During the third quarter of 2021, President Biden directed the Department of Labor, Occupational Safety and Health Administration ("OSHA") to implement a rule requiring employers with more than 100 employees to require its employees to be fully vaccinated for COVID-19 or submit to weekly testing for the virus. This OSHA regulation has not yet been announced and is expected in the fourth quarter of 2021. Similarly, during the third quarter the Department of Health and Human Services, Centers for Medicare and Medicaid Services ("CMS") announced that it would be issuing a rule requiring workers at home health agencies, and potentially other health care provider services, to be fully vaccinated for COVID-19 without an option for testing in lieu of vaccination. This CMS regulation also has not yet been announced and is expected in the fourth quarter of 2021.

Segments

We have two reportable segments: (1) home health and hospice services, which includes our home health, home care and hospice businesses; and (2) senior living services, which includes the operation of assisted living, independent living and memory care communities. Our Chief Executive Officer, who is our Chief Operating Decision Maker ("CODM"), reviews financial information at the operating segment level. We also report an "all other" category that includes general and administrative expense from our Service Center.

Key Performance Indicators

We manage the fiscal aspects of our business by monitoring key performance indicators that affect our financial performance. These indicators and their definitions include the following:

Home Health and Hospice Services

- ***Total home health admissions***. The total admissions of home health patients, including new acquisitions, new admissions and readmissions.
- ***Total Medicare home health admissions***. Total admissions of home health patients, who are receiving care under Medicare reimbursement programs, including new acquisitions, new admissions and readmissions.
- ***Average Medicare revenue per completed 60-day home health episode***. The average amount of revenue for each completed 60-day home health episode generated from patients who are receiving care under Medicare reimbursement programs.
- ***Total hospice admissions***. Total admissions of hospice patients, including new acquisitions, new admissions and recertifications.
- ***Average hospice daily census***. The average number of patients who are receiving hospice care during any measurement period divided by the number of days during such measurement period.
- ***Hospice Medicare revenue per day***. The average daily Medicare revenue recorded during any measurement period for services provided to hospice patients.

The following table summarizes our overall home health and hospice statistics for the periods indicated:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2021	2020	2021	2020
Home health services:				
Total home health admissions	9,213	6,771	28,079	18,166
Total Medicare home health admissions	4,211	3,418	13,115	8,686
Average Medicare revenue per 60-day completed episode[(a)]	$ 3,404	$ 3,448	$ 3,382	$ 3,311
Hospice services:				
Total hospice admissions	2,219	2,133	6,420	5,763
Average hospice daily census	2,337	2,177	2,313	1,934
Hospice Medicare revenue per day	$ 174	$ 164	$ 173	$ 164

(a) The year to date average Medicare revenue per 60-day completed episode includes post period claim adjustments for prior quarters.

Senior Living Services

- ***Occupancy***. The ratio of actual number of days our units are occupied during any measurement period to the number of units available for occupancy during such measurement period.
- ***Average monthly revenue per occupied unit***. The revenue for senior living services during any measurement period divided by actual occupied senior living units for such measurement period divided by the number of months for such measurement period.

The following table summarizes our senior living statistics for the periods indicated:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2021	2020	2021	2020
Occupancy	73.7 %	76.8 %	72.8 %	78.5 %
Average monthly revenue per occupied unit	$ 3,174	$ 3,173	$ 3,179	$ 3,195

Revenue Sources

Home Health and Hospice Services

Home Health. We derive the majority of our home health revenue from Medicare and managed care. The Medicare payment is adjusted for differences between estimated and actual payment amounts, an inability to obtain appropriate billing documentation or authorizations acceptable to the payor and other reasons unrelated to credit risk. For Medicare episodes that began prior to January 1, 2020, home health agencies were reimbursed under the Medicare HH PPS, while Medicare periods of care that began on or after that date are reimbursed under the Patient-Driven Groupings Model ("PDGM") methodology. Under PDGM, Medicare provides agencies with payments for each 30-day period of care provided to beneficiaries. If a beneficiary is still eligible for care after the end of the first 30-day payment period, a second 30-day payment period can begin. There are no limits to the number of periods of care a beneficiary who remains eligible for the home health benefit can receive. While payment for each 30-day period of care is adjusted to reflect the beneficiary's health condition and needs, a special outlier provision exists to ensure appropriate payment for those beneficiaries that have the most expensive care needs. The payment under the Medicare program is also adjusted for certain variables including, but not limited to: (a) a low utilization payment adjustment if the number of visits is below an established threshold that varies based on the diagnosis of a beneficiary; (b) a partial payment if the patient transferred to another provider or the Company received a patient from another provider before completing the period of care; (c) adjustment to the admission source of claim if it is determined that the patient had a qualifying stay in a post-acute care setting within 14 days prior to the start of a 30-day payment period; (d) the timing of the 30-day payment period provided to a patient in relation to the admission date, regardless of whether the same home health provider provided care for the entire series of episodes; (e) changes to the acuity of the patient during the previous 30-day period of care; (f) changes in the base payments established by the Medicare program; (g) adjustments to the base payments for case mix and geographic wages; and (h) recoveries of overpayments. For further detail regarding PDGM see the *Government Regulation* section of our 2020 Annual Report.

Hospice. We derive the majority of our hospice business revenue from Medicare reimbursement. The estimated payment rates are calculated as daily rates for each of the levels of care we deliver. Rates are set based on specific levels of care, are adjusted by a wage index to reflect healthcare labor costs across the country and are established annually through federal legislation. The following are the four levels of care provided under the hospice benefit:

- ***Routine Home Care ("RHC").*** Care that is not classified under any of the other levels of care, such as the work of nurses, social workers or home health aides.
- ***General Inpatient Care.*** Pain control or acute or chronic symptom management that cannot be managed in a setting other than an inpatient Medicare-certified facility, such as a hospital, skilled nursing facility or hospice inpatient facility.
- ***Continuous Home Care.*** Care for patients experiencing a medical crisis that requires nursing services to achieve palliation and symptom control, if the agency provides a minimum of eight hours of care within a 24-hour period.
- ***Inpatient Respite Care.*** Short-term, inpatient care to give temporary relief to the caregiver who regularly provides care to the patient.

CMS has established a two-tiered payment system for RHC. Hospices are reimbursed at a higher rate for RHC services provided from days of service one through 60 and a lower rate for all subsequent days of service. CMS also provides for a Service Intensity Add-On, which increases payments for certain RHC services provided by registered nurses and social workers to hospice patients during the final seven days of life.

Medicare reimbursement is adjusted for an inability to obtain appropriate billing documentation or authorizations acceptable to the payor and other reasons unrelated to credit risk. Additionally, as Medicare hospice revenue is subject to an inpatient cap limit and an overall payment cap, we monitor our provider numbers and estimate amounts due back to Medicare to the extent that the cap has been exceeded.

Senior Living Services. As of September 30, 2021, we provided assisted living, independent living and memory care services in 54 communities. Within our senior living operations, we generate revenue primarily from private pay sources, with a portion earned from Medicaid or other state-specific programs.

Primary Components of Expense

Cost of Services (excluding rent, general and administrative expense and depreciation and amortization). Our cost of services represents the costs of operating our independent operating subsidiaries, which primarily consists of payroll and related benefits, supplies, purchased services, and ancillary expenses such as the cost of pharmacy and therapy services provided to patients. Cost of services also includes the cost of general and professional liability insurance and other general cost of services specifically attributable to our operations.

Rent—Cost of Services. Rent—cost of services consists solely of base minimum rent amounts payable under lease agreements to our landlords. Our subsidiaries lease and operate but do not own the underlying real estate at our operations, and these amounts do not include taxes, insurance, impounds, capital reserves or other charges payable under the applicable lease agreements.

General and Administrative Expense. General and administrative expense consists primarily of payroll and related benefits and travel expenses for our Service Center personnel, including training and other operational support. General and administrative expense also includes professional fees (including accounting and legal fees), costs relating to information systems, stock-based compensation and rent for our Service Center offices.

Depreciation and Amortization. Property and equipment are recorded at their original historical cost. Depreciation is computed using the straight-line method over the estimated useful lives of the depreciable assets (ranging from three to 15 years). Leasehold improvements are amortized on a straight-line basis over the shorter of their estimated useful lives or the remaining lease term.

Critical Accounting Policies and Estimates

Our discussion and analysis of our financial condition and results of operations are based on Interim Financial Statements, which have been prepared in accordance with U.S. generally accepted accounting principles ("GAAP"). The preparation of the Interim Financial Statements and related disclosures requires us to make judgments, estimates and

assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. On an ongoing basis we review our judgments and estimates, including but not limited to those related to revenue, cost allocations, leases, intangible assets, goodwill, and income taxes. We base our estimates and judgments upon our historical experience, knowledge of current conditions and our belief of what could occur in the future considering available information, including assumptions that we believe to be reasonable under the circumstances. By their nature, these estimates and judgments are subject to an inherent degree of uncertainty, and actual results could differ materially from the amounts reported. While we believe that our estimates, assumptions, and judgments are reasonable, they are based on information available when the estimate was made. Refer to Note 2, *Basis of Presentation and Summary of Significant Accounting Policies*, within the 2020 Annual Report for further information on our critical accounting estimates and policies, which are as follows:

- ***Revenue recognition*** - The estimate of variable considerations to arrive at the transaction price, including methods and assumptions used to determine settlements with Medicare and Medicaid payors or retroactive adjustments due to audits and reviews;
- ***Leases*** - We use our estimated incremental borrowing rate based on the information available at lease commencement date in determining the present value of future lease payments;
- ***Acquisition accounting*** - The assumptions used to allocate the purchase price paid for assets acquired and liabilities assumed in connection with our acquisitions; and
- ***Income taxes*** - The estimation of valuation allowance or the need for and magnitude of liabilities for uncertain tax position.

Recent Accounting Pronouncements

Information concerning recently issued accounting pronouncements are included in Note 2, *Basis of Presentation and Summary of Significant Accounting Policies* in the Interim Financial Statements.

Results of Operations

The following table sets forth details of our revenue, expenses and earnings as a percentage of total revenue for the periods indicated:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2021	2020	2021	2020
Total revenue	100.0 %	100.0 %	100.0 %	100.0 %
Expense:				
Cost of services	80.1	76.7	79.3	75.6
Rent—cost of services	9.2	9.9	9.3	10.3
General and administrative expense	8.1	7.6	8.2	7.7
Depreciation and amortization	1.1	1.2	1.1	1.2
Total expenses	98.5	95.4	97.9	94.8
Income from operations	1.5	4.6	2.1	5.2
Other income (expense):				
Other income	—	0.2	—	0.1
Interest expense, net	(0.4)	(0.2)	(0.4)	(0.3)
Other expense, net	(0.4)	—	(0.4)	(0.2)
Income before provision for income taxes	1.1	4.6	1.7	5.0
Provision for income taxes	0.1	0.1	0.3	0.9
Net income	1.0	4.5	1.4	4.1
Less: net loss attributable to noncontrolling interest	(0.1)	—	(0.1)	—
Net income attributable to Pennant	1.1 %	4.5 %	1.5 %	4.1 %

The following table presents our consolidated GAAP Financial measures for the three and nine months ended September 30, 2021 and 2020:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2021	2020	2021	2020
	(In thousands)			
Consolidated GAAP Financial Measures:				
Total revenue	$ 111,921	$ 98,397	$ 327,929	$ 282,986
Total expenses	$ 110,219	$ 93,919	$ 321,045	$ 268,161
Income from operations	$ 1,702	$ 4,478	$ 6,884	$ 14,825

The following tables present certain financial information regarding our reportable segments. General and administrative expenses are not allocated to the reportable segments and are included in “All Other”:

	Home Health and Hospice Services	Senior Living Services	All Other	Total
	(In thousands)			
Segment GAAP Financial Measures:				
Three Months Ended September 30, 2021				
Revenue	$ 79,003	$ 32,918	$ —	$ 111,921
Segment Adjusted EBITDAR from Operations	$ 14,409	$ 9,106	$ (6,783)	$ 16,732
Three Months Ended September 30, 2020				
Revenue	$ 64,379	$ 34,018	$ —	$ 98,397
Segment Adjusted EBITDAR from Operations	$ 13,530	$ 11,684	$ (6,857)	$ 18,357

	Home Health and Hospice Services	Senior Living Services	All Other	Total
	(In thousands)			
Segment GAAP Financial Measures:				
Nine Months Ended September 30, 2021				
Revenue	$ 231,715	$ 96,214	$ —	$ 327,929
Segment Adjusted EBITDAR from Operations	$ 43,131	$ 27,692	$ (19,249)	$ 51,574
Nine Months Ended September 30, 2020				
Revenue	$ 179,125	$ 103,861	$ —	$ 282,986
Segment Adjusted EBITDAR from Operations	$ 34,681	$ 37,673	$ (15,638)	$ 56,716

The table below provides a reconciliation of Segment Adjusted EBITDAR from Operations to Condensed Consolidated Income from operations:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2021	2020	2021	2020
	(In thousands)			
Segment Adjusted EBITDAR from Operations[a]	$ 16,732	$ 18,357	$ 51,574	$ 56,716
Less: Depreciation and amortization	1,200	1,212	3,545	3,434
Rent—cost of services	10,334	9,721	30,455	29,194
Other Expense	—	225	(24)	225
Adjustments to Segment EBITDAR from Operations:				
Less: Costs at start-up operations[b]	532	717	991	1,422
Share-based compensation expense[c]	2,568	2,102	7,483	6,017
Acquisition related costs[d]	36	—	73	—
Transition services costs[e]	236	209	1,825	746
Net COVID-19 related costs[f]	—	(307)	—	853
Add: Net loss attributable to noncontrolling interest	(124)	—	(342)	—
Condensed Consolidated Income from Operations	$ 1,702	$ 4,478	$ 6,884	$ 14,825

) Segment Adjusted EBITDAR from Operations is net income (loss) attributable to the Company's reportable segments excluding interest expense, provision for income taxes, depreciation and amortization expense, rent, and, in order to view the operations performance on a comparable basis from period to period, certain adjustments including: (1) costs at start-up operations, (2) share-based compensation, (3) acquisition related costs, (4) redundant and nonrecurring costs associated with the Transition Services Agreement, and (5) net loss attributable to noncontrolling interest. General and administrative expenses are not allocated to the reportable segments, and are included as “All Other”, accordingly the segment earnings measure reported is before allocation of corporate general and administrative expenses. The Company's segment measures may be different from the calculation methods used by other companies and, therefore, comparability may be limited.

) Represents results related to start-up operations. This amount excludes rent and depreciation and amortization expense related to such operations.

) Share-based compensation expense incurred which is included in cost of services and general and administrative expense.

) Acquisition related costs related to business combinations during the periods.

) A portion of the costs incurred under the Transition Services Agreement identified as redundant or nonrecurring that are included in general and administrative expense. Fees incurred under the Transition Services Agreement, net of the Company’s payroll reimbursement, were $706 and $2,441 for the three and nine months ended September 30, 2021, and $1,502 and $4,583 for the three and nine months ended September 30, 2020, respectively. During the fourth quarter of fiscal 2020, we updated our Transition service costs adjustment to include duplicate software costs. The prior year transition service costs adjustment has been recast to reflect the change. The adjustment to the prior year transition service costs was $113 and $333 for the duplicative software costs for the three and nine months ended September 30, 2020 that were included in the 2020 full year amount in the Company’s as filed Form 10-K.

) Beginning in the first quarter of fiscal year 2021, we updated our definition of Segment Adjusted EBITDAR to no longer include an adjustment for COVID-19 expenses offset by the amount of sequestration relief. COVID-19 expenses continue to be part of daily operations for which less specific identification is visible. Furthermore, the sequestration relief has been extended through December 31, 2021. Sequestration relief was $867 and $2,685 for the three and nine months ended September 30, 2021, respectively.

The 2020 amounts represent incremental costs incurred as part of the Company's response to COVID-19 including direct medical supplies, labor, and other expenses, net of $1,121 and $1,675 in increased revenue related to the 2% payment increase in Medicare reimbursements for sequestration relief for the three and nine months ended September 30, 2020, respectively.

Performance and Valuation Measures:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2021	2020	2021	2020
	(In thousands)			
Consolidated Non-GAAP Financial Measures:				
Performance Metrics				
Consolidated EBITDA	$ 3,026	$ 5,915	$ 10,747	$ 18,484
Consolidated Adjusted EBITDA	$ 6,495	$ 8,684	$ 21,415	$ 27,619
Valuation Metric				
Consolidated Adjusted EBITDAR	$ 16,732		$ 51,574	

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2021	2020	2021	2020
	(In thousands)			
Segment Non-GAAP Measures:[(a)]				
Segment Adjusted EBITDA from Operations				
Home health and hospice services	$ 13,194	$ 12,702	$ 39,836	$ 32,158
Senior living services	$ 84	$ 2,839	$ 828	$ 11,099

(a) General and administrative expenses are not allocated to any segment for purposes of determining segment profit or loss.

The tables below reconcile Consolidated Net Income to the consolidated Non-GAAP financial measures, Consolidated EBITDA and Consolidated Adjusted EBITDA, and to the Non-GAAP valuation measure, Consolidated Adjusted EBITDAR, for the periods presented:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2021	2020	2021	2020
	(In thousands)			
Consolidated Net income	$ 1,121	$ 4,407	$ 4,503	$ 11,724
Less: Net loss attributable to noncontrolling interest	(124)	—	(342)	—
Add: Provision for income taxes	69	104	1,013	2,430
Interest expense, net	512	192	1,344	896
Depreciation and amortization	1,200	1,212	3,545	3,434
Consolidated EBITDA	3,026	5,915	10,747	18,484
Adjustments to Consolidated EBITDA				
Add: Costs at start-up operations[(a)]	532	717	991	1,422
Share-based compensation expense[(b)]	2,568	2,102	7,483	6,017
Acquisition related costs[(c)]	36	—	73	—
Transition services costs[(d)]	236	209	1,825	746
Net COVID-19 related costs[(e)]	—	(307)	—	853
Rent related to item (a) above	97	48	296	97
Consolidated Adjusted EBITDA	6,495	8,684	21,415	27,619
Rent—cost of services	10,334	9,721	30,455	29,194
Rent related to item (a) above	(97)	(48)	(296)	(97)
Adjusted rent—cost of services	10,237	9,673	30,159	29,097
Consolidated Adjusted EBITDAR	$ 16,732		$ 51,574	

(a) Represents results related to start-up operations. This amount excludes rent and depreciation and amortization expense related to such operations.

(b) Share-based compensation expense incurred which is included in cost of services and general and administrative expense.

(c) Acquisition related costs related to business combinations during the periods.

(d) A portion of the costs incurred under the Transition Services Agreement identified as redundant or nonrecurring that are included in general and administrative expense. Fees incurred under the Transition Services Agreement, net of the Company's payroll reimbursement, were $706 and $2,441 for the three and nine months ended September 30, 2021, and $1,502 and $4,583 for the three and nine months ended September 30, 2020, respectively. During the fourth quarter of fiscal 2020, we updated our Transition service costs adjustment to include duplicate software costs. The prior year transition service costs adjustment has been recast to reflect the change. The adjustment to the prior year transition service costs was $113 and $333 for the duplicative software costs for the three and nine months ended September 30, 2020 that were included in the 2020 full year amount in the Company's as filed Form 10-K.

(e) Beginning in the first quarter of fiscal year 2021, we updated our definition of Segment Adjusted EBITDAR to no longer include an adjustment for COVID-19 expenses offset by the amount of sequestration relief. COVID-19 expenses continue to be part of daily operations for which less specific identification is visible. Furthermore, the sequestration relief has been extended through December 31, 2021. Sequestration relief was $867 and $2,685 for the three and nine months ended September 30, 2021, respectively.

The 2020 amounts represent incremental costs incurred as part of the Company's response to COVID-19 including direct medical supplies, labor, and other expenses, net of $1,121 and $1,675 in increased revenue related to the 2% payment increase in Medicare reimbursements for sequestration relief for the three and nine months ended September 30, 2020, respectively.

The tables below reconcile Segment Adjusted EBITDAR from Operations to Segment Adjusted EBITDA from Operations for the periods presented:

	Three Months Ended September 30,			
	Home Health and Hospice		Senior Living	
	2021	2020	2021	2020
	(In thousands)			
Segment Adjusted EBITDAR from Operations	$ 14,409	$ 13,530	$ 9,106	$ 11,684
Less: Rent—cost of services	1,282	846	9,052	8,875
Rent related to start-up operations	(67)	(18)	(30)	(30)
Segment Adjusted EBITDA from Operations	$ 13,194	$ 12,702	$ 84	$ 2,839

	Nine Months Ended September 30,			
	Home Health and Hospice		Senior Living	
	2021	2020	2021	2020
	(In thousands)			
Segment Adjusted EBITDAR from Operations	$ 43,131	$ 34,681	$ 27,692	$ 37,673
Less: Rent—cost of services	3,611	2,570	26,844	26,624
Rent related to start-up operations	(316)	(47)	20	(50)
Segment Adjusted EBITDA from Operations	$ 39,836	$ 32,158	$ 828	$ 11,099

The following discussion includes references to certain performance and valuation measures, which are non-GAAP financial measures, including Consolidated EBITDA, Consolidated Adjusted EBITDA, Segment Adjusted EBITDA from Operations, and Consolidated Adjusted EBITDAR (collectively, “Non-GAAP Financial Measures”). Non-GAAP Financial Measures are used in addition to, and in conjunction with, results presented in accordance with GAAP and should not be relied upon to the exclusion of GAAP financial measures. Non-GAAP Financial Measures reflect an additional way of viewing aspects of our operations and company that, when viewed with our GAAP results and the accompanying reconciliations to corresponding GAAP financial measures, we believe can provide a more comprehensive understanding of factors and trends affecting our business.

We believe these Non-GAAP Financial Measures are useful to investors and other external users of our financial statements regarding our results of operations because:

- they are widely used by investors and analysts in our industry as a supplemental measure to evaluate the overall performance of companies in our industry without regard to items such as interest expense, rent expense and depreciation and amortization, which can vary substantially from company to company depending on the book value of assets, the method by which assets were acquired, and differences in capital structures;
- they help investors evaluate and compare the results of our operations from period to period by removing the impact of our asset base and capital structure from our operating results; and
- Consolidated Adjusted EBITDAR is used by investors and analysts in our industry to value the companies in our industry without regard to capital structures.

We use Non-GAAP Financial Measures:

- as measurements of our operating performance to assist us in comparing our operating performance on a consistent basis from period to period;
- to allocate resources to enhance the financial performance of our business;
- to assess the value of a potential acquisition;
- to assess the value of a transformed operation’s performance;

- to evaluate the effectiveness of our operational strategies; and
- to compare our operating performance to that of our competitors.

We typically use Non-GAAP Financial Measures to compare the operating performance of each operation from period to period. We find that Non-GAAP Financial Measures are useful for this purpose because they do not include such costs as interest expense, income taxes, depreciation and amortization expense, which may vary from period-to-period depending upon various factors, including the method used to finance operations, the date of acquisition of a community or business, and the tax law of the state in which a business unit operates.

We also establish compensation programs and bonuses for our leaders that are partially based upon the achievement of Consolidated Adjusted EBITDAR targets.

Non-GAAP Financial Measures have no standardized meaning defined by GAAP. Therefore, our Non-GAAP Financial Measures have limitations as analytical tools, and they should not be considered in isolation, or as a substitute for analysis of our results as reported in accordance with GAAP. Some of these limitations are:

- they do not reflect our current or future cash requirements for capital expenditures or contractual commitments;
- they do not reflect changes in, or cash requirements for, our working capital needs;
- they do not reflect the net interest expense, or the cash requirements necessary to service interest or principal payments, on our debt;
- in the case of Consolidated Adjusted EBITDAR, it does not reflect rent expenses, which are normal and recurring operating expenses that are necessary to operate our leased operations;
- they do not reflect any income tax payments we may be required to make;
- although depreciation and amortization are non-cash charges, the assets being depreciated and amortized will often have to be replaced in the future, and do not reflect any cash requirements for such replacements; and
- other companies in our industry may calculate the same Non-GAAP Financial Measures differently than we do, which may limit their usefulness as comparative measures.

We compensate for these limitations by using Non-GAAP Financial Measures only to supplement net income on a basis prepared in accordance with GAAP in order to provide a more complete understanding of the factors and trends affecting our business.

We strongly encourage investors to review the Interim Financial Statements, included in this Quarterly Report in their entirety and to not rely on any single financial measure. Because these Non-GAAP Financial Measures are not standardized, it may not be possible to compare these financial measures with other companies' non-GAAP financial measures having the same or similar names. These Non-GAAP Financial Measures should not be considered a substitute for, nor superior to, financial results and measures determined or calculated in accordance with GAAP. We strongly urge you to review the reconciliation of income from operations to the Non-GAAP Financial Measures in the table presented above, along with the Interim Financial Statements and related notes included elsewhere in this Quarterly Report.

We believe the following Non-GAAP Financial Measures are useful to investors as key operating performance measures and valuation measures:

Performance Measures:

Consolidated EBITDA

We believe Consolidated EBITDA is useful to investors in evaluating our operating performance because it helps investors evaluate and compare the results of our operations from period to period by removing the impact of our asset base (depreciation and amortization expense) from our operating results.

We calculate Consolidated EBITDA as net income, adjusted for net income (loss) attributable to noncontrolling interest prior to the Spin-Off, before (a) interest expense (b) provision for income taxes and (c) depreciation and amortization.

Consolidated Adjusted EBITDA

We adjust Consolidated EBITDA when evaluating our performance because we believe that the exclusion of certain additional items described below provides useful supplemental information to investors regarding our ongoing operating performance. We believe that the presentation of Consolidated Adjusted EBITDA, when considered with Consolidated EBITDA and GAAP net income is beneficial to an investor's complete understanding of our operating performance.

We calculate Consolidated Adjusted EBITDA by adjusting Consolidated EBITDA to exclude the effects of non-core business items, which for the reported periods includes, to the extent applicable:

- costs at start-up operations;
- share-based compensation expense;
- acquisition related costs;
- Spin-Off related transaction costs;
- redundant or nonrecurring costs incurred as part of the Transition Services Agreement (as defined in Note 3, *Related Party Transactions*).

Segment Adjusted EBITDA from Operations

We calculate Segment Adjusted EBITDA from Operations by adjusting Segment Adjusted EBITDAR from Operations to include rent-cost of services. We believe that the inclusion of rent-cost of services provides useful supplemental information to investors regarding our ongoing operating performance for each segment.

***Valuation Measure*:**

Consolidated Adjusted EBITDAR

We use Consolidated Adjusted EBITDAR as one measure in determining the value of prospective acquisitions. It is also a measure commonly used by us, research analysts and investors to compare the enterprise value of different companies in the healthcare industry, without regard to differences in capital structures. Additionally, we believe the use of Consolidated Adjusted EBITDAR allows us, research analysts and investors to compare operational results of companies with operating and finance leases. A significant portion of finance lease expenditures are recorded in interest, whereas operating lease expenditures are recorded in rent expense.

This measure is not displayed as a performance measure as it excludes rent expense, which is a normal and recurring operating expense and, as such, does not reflect our cash requirements for leasing commitments. Our presentation of Consolidated Adjusted EBITDAR should not be construed as a financial performance measure.

The adjustments made and previously described in the computation of Consolidated Adjusted EBITDA are also made when computing Consolidated Adjusted EBITDAR. We calculate Consolidated Adjusted EBITDAR by excluding rent-cost of services and rent related to start up operations from Consolidated Adjusted EBITDA.

Three Months Ended September 30, 2021 Compared to the Three Months Ended September 30, 2020

Revenue

	Three Months Ended September 30,			
	2021		2020	
	Revenue Dollars	Revenue Percentage	Revenue Dollars	Revenue Percentage
	(In thousands)			
Home health and hospice services				
Home health	$ 34,228	30.6 %	$ 25,162	25.5 %
Hospice	39,069	34.9	33,440	34.0
Home care and other[(a)]	5,706	5.1	5,777	5.9
Total home health and hospice services	79,003	70.6	64,379	65.4
Senior living services	32,918	29.4	34,018	34.6
Total revenue	$ 111,921	100.0 %	$ 98,397	100.0 %

(a) Home care and other revenue is included with home health revenue in other disclosures in this Quarterly Report.

Our total revenue increased $13.5 million, or 13.7% during the three months ended September 30, 2021. Quarter-to-date revenue from acquired operations between September 30, 2020 and September 30, 2021 resulted in adding $10.5 million or 10.6%. We experienced growth of $4.1 million from increased operational performance in our Home Health and Hospice segment as detailed below. The growth in Home Health and Hospice segment revenue was offset by a decrease in Senior Living segment revenue of $1.1 million driven primarily by a decrease in occupancy.

Home Health and Hospice Services

	Three Months Ended September 30,			
	2021	2020	Change	% Change
	(In thousands)			
Home health and hospice revenue				
Home health services	$ 34,228	$ 25,162	$ 9,066	36.0 %
Hospice services	39,069	33,440	5,629	16.8
Home care and other	5,706	5,777	(71)	(1.2)
Total home health and hospice revenue	$ 79,003	$ 64,379	$ 14,624	22.7 %

	Three Months Ended September 30,			
	2021	2020	Change	% Change
Home health services:				
Total home health admissions	9,213	6,771	2,442	36.1 %
Total Medicare home health admissions	4,211	3,418	793	23.2
Average Medicare revenue per 60-day completed episode	$ 3,404	$ 3,448	$ (44)	(1.3)
Hospice services:				
Total hospice admissions	2,219	2,133	86	4.0
Average daily census	2,337	2,177	160	7.3
Hospice Medicare revenue per day	$ 174	$ 164	$ 10	6.1
Number of home health and hospice agencies at period end	88	72	16	22.2

Home health and hospice revenue increased $14.6 million, or 22.7%. Revenue grew due to an increase in certain key performance indicators, including an increase of 36.1% in total home health admissions, an increase of 23.2% in Medicare home health admissions, an increase of 7.3% in hospice average daily census, and an increase of 6.1% in hospice Medicare

revenue per day, during the three months ended September 30, 2021 in comparison to the prior year's quarter. Included in the key performance indicators, growth was partially driven by the addition of sixteen home health, hospice and home care operations between September 30, 2020 and September 30, 2021, adding $10.5 million or 16.2% in revenue, as well as additional revenue of $0.9 million due to the sequestration suspension in the current year.

Senior Living Services

	Three Months Ended September 30,			
	2021	2020	Change	% Change
Revenue (in thousands)	$ 32,918	$ 34,018	$ (1,100)	(3.2)%
Number of communities at period end	54	54	—	—
Occupancy	73.7 %	76.8 %	(3.1)%	
Average monthly revenue per occupied unit	$ 3,174	$ 3,173	$ 1	—

Senior living revenue decreased $1.1 million, or 3.2%, for the three months ended September 30, 2021 compared to the same period in the prior year due primarily to a 3.1% decrease in occupancy between September 30, 2020 and September 30, 2021.

Cost of Services

The following table sets forth total cost of services by each of our reportable segments for the periods indicated:

	Three Months Ended September 30,			
	2021	2020	Change	% Change
	(In thousands)			
Home Health and Hospice	$ 65,606	$ 52,594	$ 13,012	24.7 %
Senior Living	24,013	22,892	1,121	4.9
Total cost of services	$ 89,619	$ 75,486	$ 14,133	18.7 %

Total consolidated cost of services increased $14.1 million or 18.7% for the three months ended September 30, 2021 when compared to the three months ended September 30, 2020. Cost of services as a percentage of revenue increased by 3.4% from 76.7% to 80.1% for the three months ended September 30, 2021 when compared to the three months ended September 30, 2020.

Home Health and Hospice Services

	Three Months Ended September 30,			
	2021	2020	Change	% Change
	(In thousands)			
Cost of service	$ 65,606	$ 52,594	$ 13,012	24.7 %
Cost of services as a percentage of revenue	83.0 %	81.7 %	1.3 %	

Cost of services related to our Home Health and Hospice services segment increased $13.0 million, or 24.7%, primarily due to increased volume of services provided and increased labor costs. Cost of services as a percentage of revenue for the three months ended September 30, 2021 increased 1.3% from 81.7% to 83.0% for the three months ended September 30, 2021 when compared to the three months ended September 30, 2020. Wage costs increased over the prior year from increases in per hour wages and overtime due to the staffing environment, resulting in higher overtime and per hour wages.

Senior Living Services

	Three Months Ended September 30,			
	2021	2020	Change	% Change
	(In thousands)			
Cost of service	$ 24,013	$ 22,892	$ 1,121	4.9 %
Cost of services as a percentage of revenue	72.9 %	67.3 %	5.6 %	

Cost of services related to our Senior Living services segment increased $1.1 million, or 4.9%. As a percentage of revenue, costs of service increased by 5.6% from 67.3% to 72.9% for the three months ended September 30, 2021 when compared to the three months ended September 30, 2020, primarily as a result of a decrease in occupancy while experiencing increased wage pressures. Fixed costs have remained consistent with prior periods.

Rent—Cost of Services. Rent expense increased 6.3% from $9.7 million to $10.3 million in the three months ended September 30, 2021 compared to the three months ended September 30, 2020, primarily as a result of acquisitions and CPI adjustments. Rent as a percentage of total revenue decreased 0.7% from 9.9% to 9.2% in the three months ended September 30, 2021 compared to the three months ended September 30, 2020.

General and Administrative Expense. Our general and administrative expense increased $1.6 million or 20.9% from $7.5 million to $9.1 million for the three months ended September 30, 2021 when compared to the three months ended September 30, 2020. General and administrative expense as a percentage of revenue increased 0.5% from 7.6% to 8.1%. The primary driver of the increase in general and administrative expense was an increase of $1.5 million in wage and benefits related to increased headcount during the three months ended September 30, 2021 when compared to the three months ended September 30, 2020.

Depreciation and Amortization. Depreciation and amortization expense decreased slightly as a percentage of total revenue.

Provision for Income Taxes. Our effective tax rate for the three months ended September 30, 2021 was 5.8% of earnings before income taxes compared with an effective tax rate of 2.3% for the three months ended September 30, 2020. See Note 14, *Income Taxes*, to the Interim Financial Statements included elsewhere in this Quarterly Report for further discussion.

Nine Months Ended September 30, 2021 Compared to the Nine Months Ended September 30, 2020

Revenue

	Nine Months Ended September 30,			
	2021		2020	
	Revenue Dollars	Revenue Percentage	Revenue Dollars	Revenue Percentage
	(In thousands)			
Home health and hospice services				
Home health	$ 102,719	31.3 %	$ 67,430	23.8 %
Hospice	112,821	34.4	96,503	34.1
Home care and other[(a)]	16,175	5.0	15,192	5.4
Total home health and hospice services	231,715	70.7	179,125	63.3
Senior living services	96,214	29.3	103,861	36.7
Total revenue	$ 327,929	100.0 %	$ 282,986	100.0 %

(a) Home care and other revenue is included with home health revenue in other disclosures in this Quarterly Report.

Our total revenue increased $44.9 million, or 15.9% during the nine months ended September 30, 2021. This increase was primarily the result of revenue from acquired home health and hospice operations of $29.6 million or 10.4% since September 30, 2020. The remaining increase in revenue were driven by growth from operational performance in our home health and hospice segment, offset by a decrease of $7.6 million in our senior living segment.

Home Health and Hospice Services

	Nine Months Ended September 30,			
	2021	2020	Change	% Change
	(In thousands)			
Home health and hospice revenue				
Home health services	$ 102,719	$ 67,430	$ 35,289	52.3 %
Hospice services	112,821	96,503	16,318	16.9
Home care and other	16,175	15,192	983	6.5
Total home health and hospice revenue	$ 231,715	$ 179,125	$ 52,590	29.4 %

	Nine Months Ended September 30,			
	2021	2020	Change	% Change
Home health services:				
Total home health admissions	28,079	18,166	9,913	54.6 %
Total Medicare home health admissions	13,115	8,686	4,429	51.0
Average Medicare revenue per 60-day completed episode	$ 3,382	$ 3,311	$ 71	2.1
Hospice services:				
Total hospice admissions	6,420	5,763	657	11.4
Average daily census	2,313	1,934	379	19.6
Hospice Medicare revenue per day	$ 173	$ 164	$ 9	5.5
Number of home health and hospice agencies at period end	88	72	16	22.2

Home health and hospice revenue increased $52.6 million, or 29.4% during the nine months ended September 30, 2021. Revenue grew primarily due to an increase of 54.6% in home health admissions (inclusive of an increase in total Medicare home health admissions of 51.0%), an increase of 11.4% in total hospice admissions, and an increase of 19.6% in hospice average daily census during the nine months ended September 30, 2021 when compared to the nine months ended September 30, 2020. Growth occurred from the addition of $29.6 million in revenue from the acquisition of sixteen home health, hospice and home care operations from September 30, 2020 through September 30, 2021, as well as growth due to an increase in operational performance metrics compared to the prior year.

Senior Living Services

	Nine Months Ended September 30,			
	2021	2020	Change	% Change
Revenue (in thousands)	$ 96,214	$ 103,861	$ (7,647)	(7.4)%
Number of communities at period end	54	54	—	—
Occupancy	72.8 %	78.5 %	(5.7)%	
Average monthly revenue per occupied unit	$ 3,179	$ 3,195	$ (16)	(0.5)

Senior living revenue decreased $7.6 million, or 7.4%, for the nine months ended September 30, 2021 compared to the same period in the prior year primarily due to a 5.7% decrease in occupancy in occupancy between September 30, 2020 and September 30, 2021.

Cost of Services

	Nine Months Ended September 30,			
	2021	2020	Change	% Change
	(In thousands)			
Home Health and Hospice	$ 191,200	$ 146,093	$ 45,107	30.9 %
Senior Living	68,708	67,741	967	1.4
Total cost of services	$ 259,908	$ 213,834	$ 46,074	21.5 %

Consolidated cost of services increased $46.1 million or 21.5% during the nine months ended September 30, 2021. Cost of services as a percentage of revenue for the nine months ended September 30, 2021 increased by 3.7% to 79.3% from 75.6% compared to the nine months ended September 30, 2020.

Home Health and Hospice Services

	Nine Months Ended September 30,			
	2021	2020	Change	% Change
Cost of service (in thousands)	$ 191,200	$ 146,093	$ 45,107	30.9 %
Cost of services as a percentage of revenue	82.5 %	81.6 %	0.9 %	

Cost of services related to our Home Health and Hospice services segment increased $45.1 million, or 30.9%, primarily due to increased volume of services from acquisitions and organic growth. Cost of services as a percentage of revenue for the nine months ended September 30, 2021 increased 0.9% compared to the nine months ended September 30, 2020. Wage costs increased over the prior year in per hour wages and overtime due to the staffing environment, resulting in higher overtime and per hour wages.

Senior Living Services

	Nine Months Ended September 30,			
	2021	2020	Change	% Change
Cost of service (in thousands)	$ 68,708	$ 67,741	$ 967	1.4 %
Cost of services as a percentage of revenue	71.4 %	65.2 %	6.2 %	

Cost of services related to our Senior Living services segment increased $1.0 million, or 1.4% during the nine months ended September 30, 2021. As a percentage of revenue, costs of service increased by 6.2% from 65.2% to 71.4% during the nine months ended September 30, 2021 when compared to the nine months ended September 30, 2020, as a result of a decrease in occupancy while experiencing higher wage costs. Fixed costs remained consistent with the prior year.

Rent—Cost of Services. Rent increased 4.3% from $29.2 million to $30.5 million in the nine months ended September 30, 2021 compared to the same period in the prior year, primarily as a result of acquisitions and CPI adjustments. As a percentage of revenue, rent—cost of services decreased 1.0% when compared to the nine months ended September 30, 2020.

General and Administrative Expense. Our general and administrative expense increased $5.4 million or 25.1% from $21.7 million to $27.1 million for the nine months ended September 30, 2021 when compared to the nine months ended September 30, 2020. The increase in general and administrative expense was primarily due to an increase of $4.2 million in wage and benefits during the nine months ended September 30, 2021 when compared to the nine months ended September 30, 2020.

Depreciation and Amortization. Depreciation and amortization expense decreased slightly as a percentage of total revenue.

Provision for Income Taxes. Our effective tax rate for the nine months ended September 30, 2021 was 18.4% of earnings before income taxes compared with an effective tax rate of 17.2% for the nine months ended September 30, 2020. The

increase in the effective tax rate was due to an increase in non-deductible expenses including non-deductible compensation. See Note 14, *Income Taxes*, to the Interim Financial Statements included elsewhere in this Quarterly Report for further discussion.

Liquidity and Capital Resources

Our primary sources of liquidity are net cash provided by operating activities and borrowings under our revolving credit facility.

Revolving Credit Facility

On February 23, 2021, Pennant entered into an amendment to its existing credit agreement (as amended, the "Credit Agreement"), which provides for an increased revolving credit facility with a syndicate of banks with a borrowing capacity of $150.0 million (the "Revolving Credit Facility"). The Revolving Credit Facility is not subject to interim amortization and the Company will not be required to repay any loans under the Revolving Credit Facility prior to maturity in 2026. The Company is permitted to prepay all or any portion of the loans under the Revolving Credit Facility prior to maturity without premium or penalty, subject to reimbursement of any LIBOR breakage costs of the lenders.

The Credit Agreement contains customary covenants that, among other things, restrict, subject to certain exceptions, the ability of the Company and its independent operating subsidiaries to grant liens on their assets, incur indebtedness, sell assets, make investments, engage in acquisitions, mergers or consolidations, amend certain material agreements and pay certain dividends and other restricted payments. Financial covenants require compliance with certain levels of leverage ratios that impact the amount of interest. As of September 30, 2021, the Company was compliant with all such financial covenants.

As of September 30, 2021, we had $3.7 million of cash and $101.7 million of available borrowing capacity on our Revolving Credit Facility.

We believe that our existing cash, generated through operations and our access to financing facilities, together with funding through third-party sources such as commercial banks, will be sufficient to fund our operating activities and growth needs, and provide adequate liquidity for the next twelve months.

The following table presents selected data from our Condensed Consolidated Statement of Cash Flows for the periods presented:

	Nine Months Ended September 30,	
	2021	2020
	(In thousands)	
Net cash (used in) provided by operating activities	$ (13,065)	$ 53,087
Net cash used in investing activities	(18,066)	(27,578)
Net cash provided by (used in) financing activities	34,795	(17,591)
Net increase in cash	3,664	7,918
Cash at beginning of year	43	402
Cash at end of year	$ 3,707	$ 8,320

Nine Months Ended September 30, 2021 Compared to the Nine Months Ended September 30, 2020

Our net cash flow from operating activities for the nine months ended September 30, 2021 decreased by $66.2 million when compared to the nine months ended September 30, 2020. The primary driver of this difference can be attributed to the $42.6 million change in cash flows related to the AAP. We received $28.0 million in AAP in the nine months ended September 30, 2020, and CMS recouped $14.6 million of those funds during the nine months ended September 30, 2021. Exclusive of the repayment of AAP, our net cash flow from operations would have been $1.6 million positive for the nine months ended September 30, 2021. Other factors that contributed to the net cash used in operating activities were a decrease of $7.2 million in net income, an increase of $3.8 million in prepaid expenses, and a decrease of $6.8 million in accrued wages when compared to the nine months ended September 30, 2020.

Our net cash used in investing activities for the nine months ended September 30, 2021 decreased by $9.5 million compared to the nine months ended September 30, 2020, primarily due to a decrease of $3.5 million in capital expenditures

combined with a decrease of $5.3 million in escrow deposits related to acquisitions that occurred during the period from September 30, 2020 to September 30, 2021.

Our net cash provided by financing activities increased by approximately $52.4 million for the nine months ended September 30, 2021 compared to the nine months ended September 30, 2020. This increase was primarily due to the financing of our acquisitions and the recoupment of the AAP.

Contractual Obligations, Commitments and Contingencies

Other than certain draws and payments made on our Revolving Credit Facility, as described in Note 11, *Debt*, to the Interim Financial Statements in Part I of this Quarterly Report, there have been no material changes to our total obligations during the period covered by this Quarterly Report outside of the normal course of our business.

Item 3. *Quantitative and Qualitative Disclosures About Market Risk*

Interest Rate Risk. We are exposed to risks associated with market changes in interest rates. Our Revolving Credit Facility exposes us to variability in interest payments due to changes in LIBOR. We manage our exposure to this market risk by monitoring available financing alternatives.

Item 4. *Controls and Procedures*

Evaluation of Disclosure Controls and Procedures

Under the supervision and with the participation of our management, including the Chief Executive Officer and Chief Financial Officer, we have evaluated the effectiveness of our disclosure controls and procedures (as such term is defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended (the "Exchange Act")), as of the end of the period covered by this Quarterly Report. Based on that evaluation, the Chief Executive Officer and Chief Financial Officer have concluded that these disclosure controls and procedures were effective to provide reasonable assurance that information we are required to disclose in reports that we file or submit under the Exchange Act is recorded, processed, summarized, and reported within the time periods specified in SEC rules and forms, and that such information is accumulated and communicated to our management, including our Chief Executive Officer and Chief Financial Officer, as appropriate, to allow timely decisions regarding required disclosure.

Changes in Internal Control over Financial Reporting

There were no material changes in our internal control over financial reporting (as such term is defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act) that occurred during our most recent fiscal quarter that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

PART II. OTHER INFORMATION

Item 1. ***Legal Proceedings***

We are involved in various claims and lawsuits arising in the ordinary course of business, none of which, in the opinion of management, is expected to have a material adverse effect on our results of operations or financial condition. However, the results of such matters cannot be predicted with certainty and we cannot assure you that the ultimate resolution of any legal or administrative proceeding or dispute will not have a material adverse effect on our business, financial condition, results of operations and cash flows. See Note 15, *Commitments and Contingencies*, to the Interim Financial Statements for a description of claims and legal actions arising in the ordinary course of our business.

Item 1A. ***Risk Factors***

We have disclosed under the heading "Risk Factors" in the 2020 Annual Report risk factors that materially affect our business, financial condition or results of operations. You should carefully consider the risk factors set forth in the 2020 Annual Report and the other information set forth elsewhere in this Quarterly Report. You should be aware that these risk factors and other information may not describe every risk facing our Company. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial also may materially adversely affect our business, financial condition and/or operating results. Since the filing of our 2020 Annual Report on February 24, 2021, the following additions have been made to the risk factors previously disclosed.

Rules mandating COVID-19 vaccination may subject us to penalties and exacerbate staffing challenges. Various federal, state and local governments have issued, or indicated an intention to issue, COVID-19 vaccination requirements for health care workers and other workers. On September 9, 2021, President Biden directed CMS to issue a rule mandating staff vaccination for providers who are reimbursed by government payors, such as Medicare and Medicaid.

States where we operate have imposed their own vaccine mandates as well. California, the most populous state, issued an order on August 5, 2021, requiring workers in home care, home health, and adult and senior care facilities to receive at least one vaccine dose by September 30, 2021.On August 20, 2021, the State of Washington's governor issued a proclamation requiring workers in almost any healthcare setting—including employees, contractors, and volunteers—to be fully vaccinated against COVID-19 (including both shots of the two-shot Pfizer and Moderna vaccination course) by October 18, 2021. On August 30, 2021, the Colorado State Board of Health approved a COVID-19 vaccine requirement for employees, contractors, and other individuals working in certain health care facilities including home care agencies, hospices, assisted living facilities, and similar facilities or services, mandating that these workers receive one vaccine shot by September 30, 2021, and be fully vaccinated by October 31, 2021. None of these state mandates allow for regular COVID-19 testing as an alternative to vaccination. On October 11, 2021, Texas issued an executive order banning the practice of mandating vaccination, including by private employers

The Company may be subject to fines, penalties or judgments, or may otherwise be negatively impacted, if it is found not to have complied with any such current or future vaccination requirements. Current or prospective employees may oppose vaccination, making it more difficult to recruit or retain staff.

Additionally, in October of 2021, the FDA and CDC approved the use of COVID-19 vaccine booster shots for certain individuals who work in high-risk environments. The Company may be subject to fines, penalties, judgments, or otherwise be negatively impacted based on loss of skilled workers or increased competition and cost to acquire skilled workers in the event of worker hesitancy or aversion to vaccine booster shots, or a change in the definition or understanding of "fully vaccinated" under CMS, OSHA or other state regulations that currently, or may in the future, require employees to have received booster shots to maintain their fully vaccinated status.

Expiration of Certain Waivers and Changes in CMS Reporting Practices. In response to the COVID-19 pandemic, CMS issued numerous blanket waivers effective March 20, 2020, to ease reporting requirements and other administrative burdens on health care providers during the COVID-19 public health emergency. Certain of these waivers have begun to expire, and more waivers may expire in the fourth quarter of 2021 and in 2022. The expiration of these waivers may affect our operating costs due to the reinstitution of reporting regarding staffing data and other information that was not required to be reported during the COVID-19 public health emergency until the expiration of those waivers; the expiration of these waivers may additionally affect our ability to use certain billing codes when seeking reimbursement from Medicare or Medicaid, which may affect our financial performance.

Item 6. Exhibits

EXHIBIT INDEX

Exhibit	Description
3.1	Amended and Restated Certificate of Incorporation of The Pennant Group, Inc., effective as of September 27, 2019 (incorporated by reference to Exhibit 3.1 to The Pennant Group, Inc.'s Current Report on Form 8-K (File No. 001-38900) filed with the SEC on October 3, 2019).
3.2	Amended and Restated By-laws of The Pennant Group, Inc. (incorporated by reference to Exhibit 3.2 to The Pennant Group, Inc.'s Current Report on Form 8-K (File No. 001-38900) filed with the SEC on October 3, 2019).
31.1	Certification of Chief Executive Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
31.2	Certification of Chief Financial Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1	Certification of Chief Executive Officer pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
32.2	Certification of Chief Financial Officer pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
101.INS	XBRL Instance Document - the instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document.
101.SCH	Inline XBRL Taxonomy Extension Schema Document
101.CAL	Inline XBRL Taxonomy Extension Calculation Linkbase Document
101.DEF	Inline XBRL Taxonomy Extension Definition Linkbase Document
101.LAB	Inline XBRL Taxonomy Extension Label Linkbase Document
101.PRE	Inline XBRL Taxonomy Extension Presentation Linkbase Document

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

The Pennant Group, Inc.

Dated: November 8, 2021

BY: /s/ JENNIFER L. FREEMAN

Jennifer L. Freeman

Chief Financial Officer (Principal Financial Officer and Duly Authorized Officer)

EXHIBIT 31.1

I, Daniel H Walker, certify that:

1. I have reviewed this quarterly report on Form 10-Q of The Pennant Group, Inc;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) for the registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: November 8, 2021

/s/ DANIEL H WALKER

Name: Daniel H Walker

Title: Chairman and Chief Executive Officer
(Principal Executive Officer)

EXHIBIT 31.2

I, Jennifer L. Freeman, certify that:

1. I have reviewed this quarterly report on Form 10-Q of The Pennant Group, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) for the registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: November 8, 2021

/s/ JENNIFER L. FREEMAN

Name: Jennifer L. Freeman

Title: *Chief Financial Officer (Principal Financial Officer, Principal Accounting Officer and Duly Authorized Officer)*

EXHIBIT 32.1

CERTIFICATION PURSUANT TO
18 U.S.C. §1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Quarterly Report of The Pennant Group, Inc. (the Company) on Form 10-Q for the period ended September 30, 2021, as filed with the Securities and Exchange Commission on the date hereof (the Report), I, Daniel H Walker, Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that to my knowledge:

1 The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

2 The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ DANIEL H WALKER

Name:	Daniel H Walker
Title:	Chairman and Chief Executive Officer (Principal Executive Officer)

November 8, 2021

A signed original of this written statement required by 18 U.S.C. Section 1350 has been provided to the Company and will be retained by the Company and furnished to the Securities and Exchange Commission or its staff upon request.

EXHIBIT 32.2

CERTIFICATION PURSUANT TO
18 U.S.C. §1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Quarterly Report of The Pennant Group, Inc. (the Company) on Form 10-Q for the period ended September 30, 2021, as filed with the Securities and Exchange Commission on the date hereof (the Report), I, Jennifer L. Freeman, Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that to my knowledge:

1 The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

2 The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ JENNIFER L. FREEMAN

Name: Jennifer L. Freeman

Title: *Chief Financial Officer (Principal Financial Officer, Principal Accounting Officer and Duly Authorized Officer)*

November 8, 2021

A signed original of this written statement required by 18 U.S.C. Section 1350 has been provided to the Company and will be retained by the Company and furnished to the Securities and Exchange Commission or its staff upon request.

EXHIBIT 10

SYMBOL HEALTHCARE, INC. 2021-2022

Hospice assumptions and calculations

	2021	2022	2023	Estimated 2024	Estimated 2025	Estimated 2026	
KING COUNTY UNMET NEED ADC	**(8)**	**39**	**85**				WA DOH Numeric Need Methodology 11/10/21
NUMERIC NEED OF 2	**2**	**2**	**2**				WA DOH Numeric Need Methodology 11/10/21
TOTAL ADC PER AGENCY	(4)	20	43	66	89	112	WA DOH Numeric Need Methodology 11/10/21

KING COUNTY UNMET NEED PATIENT DAYS	**-2759**	**14070**	**30899**				WA DOH Numeric Need Methodology 11/10/21
Numeric need	2	2	2				WA DOH Numeric Need Methodology 11/10/21
unmet patient days	-1380	7035	15450	23864	32279	40693	WA DOH Numeric Need Methodology 11/10/21

ALOS IN WASHINGTON STATE	**62.12**	**62.12**	**62.12**	**62.12**	**62.12**	**62.12**	WA DOH Numeric Need Methodology 11/10/21

KING County unduplicated admissions calculation

Unmet annual admits	(22.21)	113.25	248.70	384.16	519.62	655.07	
Monthly admits	(1.85)	9.44	20.73	32.01	43.30	54.59	*Unduplicated Admissions required to cover 100% of unmet need

Assumptions and Projections

					2023	2024	2025	2026
Assumes 1/1/23 start date	**2023**	**2024**	**2025**	**2026**	40%	45%	50%	55%
Patient Days	**6180**	**10739**	**16139**	**22381**	Projected service for 40% in 2023, 45% in 2024, 50% in 2025, 55% in 2026			
Annual admissions - Unduplicated Patients with ALOS of 62.12	**99**	**173**	**260**	**360**				
Monthly Unduplicated Patient admissions	**8**	**14**	**22**	**30**				
Average Daily Census (ADC)	**17**	**29**	**44**	**61**				

National Hospice and Palliative Care Organization (NHPCO)
2017 Facts and Figures updated as of April 2018
Table 10: Level of Care by Percentage of Days of Care

	DOC %
Routine Home Care (RHC)	**98.0%**
Inpatient Respite Care (IRC)	**1.5%**
Continuous Home Care (CHC)	**0.2%**
General InPatient Care (GIP)	**0.3%**

CMS WA percentages of care
PIERCE County- Days of Care (DOC)

	2023	2024	2025	2026	
Routine Home Care (RHC)	6,056	10,524	15,816	21,934	Level of Care Percentage x Projected service of unmet days
Inpatient Respite Care (IRC)	93	161	242	336	Level of Care Percentage x Projected service of unmet days
Continuous Home Care (CHC)	12	21	32	45	Level of Care Percentage x Projected service of unmet days
General InPatient Care (GIP)	19	32	48	67	Level of Care Percentage x Projected service of unmet days
Total Days of Care	6,180	10,739	16,139	22,381	

Referral resources based on Cornerstone averages

	# of Referrals by Source				Avg referral %
Physician Referral	2.7	4.7	7.1	9.9	32.9%
Clinic Referral	3.0	5.3	7.9	11.0	36.5%
Transfer from Hospital	1.0	1.8	2.6	3.7	12.2%
Transfer from SNF	1.4	2.4	3.6	5.0	16.7%
All other	0.1	0.2	0.4	0.5	1.7%
Subtotal Referrals	8.3	14.4	21.7	30.0	

Per Diem Rates - 2022

KING County	Days 1-60	Days > 60		
Routine Home Care	**$ 241.05**	**$ 190.49**	**$ 201.55**	Blended rate of 30% Tier 1 and 70% Tier 2 based on
Inpatient Respite	**$ 561.44**		Per Day	Cornerstone averages, includes 2% sequestration
Continuous Home Care	**$ 68.91**		Per Hour	Per Hour, minimum 8 hours required
General InPatient	**$ 1,266.02**		Per Day	

REVENUE

Gross revenue by type of care

KING County	2023	2024	2025	2026	
Routine Home Care	1,220,608	2,121,082	3,187,756	4,420,630	Days of Care x Per Diem Rates
Inpatient Respite	52,044	90,438	135,919	188,485	Days of Care x Per Diem Rates
Continuous Home Care	6,814	11,841	17,795	24,678	Days of Care x Per Diem Rates: Assumes one 8 hour shift per each unmet day
General InPatient	23,471	40,787	61,298	85,005	Days of Care x Per Diem Rates
Gross revenue subtotal	1,302,937	2,264,148	3,402,768	4,718,798	

Payor Mix

Medicare	94.6%	94.6%	94.6%	94.6%	Based on total Cornerstone averages
Medicaid	4.0%	4.0%	4.0%	4.0%	Based on total Cornerstone averages
Commercial	1.2%	1.2%	1.2%	1.2%	Based on total Cornerstone averages
self pay	0.2%	0.2%	0.2%	0.2%	Based on total Cornerstone averages
Subtotal	100%	100%	100%	100%	

Gross revenue by Payor Mix

KING County	2023	2024	2025	2026	
Medicare	1,232,578	2,141,884	3,219,018	4,463,983	Gross revenue by Type of Care x Payor Mix
Medicaid	52,117	90,566	136,111	188,752	Gross revenue by Type of Care x Payor Mix
Commercial	15,635	27,170	40,833	56,626	Gross revenue by Type of Care x Payor Mix
self pay	2,606	4,528	6,806	9,438	Gross revenue by Type of Care x Payor Mix
Gross revenue subtotal	**1,302,937**	**2,264,148**	**3,402,768**	**4,718,798**	

Adjustments to revenue	2023	2024	2025	2026	
Contractual adjustments					
Medicare Managed Care,					
Medicaid Managed Care, Private					
Pay, Third Party Ins	(26,059)	(45,283)	(68,055)	(94,376)	Assumed 2%
Charity Care	(65,147)	(113,207)	(170,138)	(235,940)	Assumed 5%
Provisions for Bad Debt	(13,029)	(22,641)	(34,028)	(47,188)	Assumed 1%
Total Adjustments to Revenue	(104,235)	(181,132)	(272,221)	(377,504)	
Total Net Revenue	**1,198,702**	**2,083,016**	**3,130,546**	**4,341,294**	

EXPENSES

PATIENT CARE COSTS

Clinical Staff by FTE	2023	2024	2025	2026	Annual Comp/FTE	Note
Registered Nurse	2.5	4.4	6.6	9.2	80,000	1 RN/12 ADC and .8 RN/12 ADC for weekend/night/call rotation
Certified Nursing Assistant	1.7	2.9	4.4	6.1	31,200	1 CNA/10 ADC
Licensed Clinical Social Worker	0.6	1.0	1.5	2.0	71,000	1 LCSW/30 ADC; Also covers Volunteer Coordinator until ADC of 60
Spiritual Care Coordinator	0.6	1.0	1.5	2.0	56,000	1 SCC/30 ADC; Also covers Bereavement Coordinator until ADC of 60
Director of Clinical Services	0.4	0.7	1.1	1.5	110,000	1/DPS/40 ADC includes QAPI
Total	**5.8**	**10.1**	**15.1**	**21.0**		

Clinical Staffing	2023	2024	2025	2026	Note
Compensation and Benefits					
Registered Nurse	203,172	353,056	530,605	735,819	FTE x Annual Compensation
Certified Nursing Assistant	52,825	91,795	137,957	191,313	FTE x Annual Compensation
Licensed Clinical Social Worker	40,070	69,631	104,647	145,120	FTE x Annual Compensation
Spiritual Care Coordinator	31,604	54,920	82,539	114,461	FTE x Annual Compensation
Director of Clinical Services	46,560	80,909	121,597	168,625	FTE x Annual Compensation
Payroll Taxes & Benefits	112,269	195,093	293,204	406,601	30% of Base Compensation
Total	**486,500**	**845,403**	**1,270,550**	**1,761,938**	

Contracted Patient Care	2023	2024	2025	2026	Note	
Medical Director	28,952	50,311	75,611	104,854	MD rate of $190/hr. per contract.	Assumption of .75hrs/ADC
Physical Therapist	646	1,122	1,687	2,339	$42.38/hr	1.5 hours/20 ADC/Month
Occupational Therapist	598	1,040	1,562	2,167	$39.26/hr	1.5 hours/20 ADC/Month
Speech Therapist	542	941	1,415	1,962	$35.55/hr	1.5 hours/20 ADC/Month
Dietitian	507	881	1,325	1,837	$33.29/hr	1.5 hours/20 ADC/Month
Total	**31,245**	**54,295**	**81,600**	**113,159**		

Direct Patient Care Costs	2023	2024	2025	2026	Note
DME	37,326	64,862	97,481	135,182	$6.04/PPD based on Cornerstone averages
Pharmacy	43,815	76,138	114,427	158,682	$7.09/PPD based on Cornerstone averages
General Inpatient Costs	23,471	40,787	61,298	85,005	$1180.67 per General Inpatient DOC
Medical Supplies	16,006	27,813	41,801	57,967	$2.59/PPD based on Cornerstone averages
Inpatient Respite	52,044	90,438	135,919	188,485	$520.36 per Inpatient Respite DOC
Room and Board	2,781	4,832	7,263	10,072	$.45/PPD based on Cornerstone averages
Mileage	22,247	38,660	58,101	80,572	Estimate 8 miles/DOC reimbursed at $.45/mile based on existing local agency
Subtotal	**197,690**	**343,531**	**516,289**	**715,966**	
Total Direct Patient Care Costs	**715,435**	**1,243,229**	**1,868,439**	**2,591,062**	

ADMINISTRATIVE COSTS

Administrative Staff by FTE	2023	2024	2025	2026	Annual Comp/FTE	Note
Administrator	0.5	0.5	0.5	0.5	100,000	
Business Office Manager, Medical						
Records, Scheduling	0.6	1.0	1.5	2.0	50,000	1 BOM/30 ADC
Intake	1.0	1.0	1.0	1.0	52,000	
Community Liaison	0.6	1.0	1.5	2.0	65,000	1 CL/30 ADC
Total	**2.6**	**3.5**	**4.4**	**5.6**		

Administrative Compensation and Benefits	2023	2024	2025	2026	Note
Administrator	50,000	50,000	50,000	50,000	FTE x Annual Compensation, represents 50% of HH Administrator
Business Office Manager, Medical					
Records, Scheduling	28,218	49,036	73,695	102,197	FTE x Annual Compensation
Intake	52,000	52,000	52,000	52,000	FTE x Annual Compensation
Community Liaison	36,684	63,746	95,804	132,856	FTE x Annual Compensation
Payroll Taxes & Benefits	50,071	64,435	81,450	101,116	30% of Base Compensation
Total	**216,973**	**279,216**	**352,949**	**438,169**	

Administration Costs	2023	2024	2025	2026	Note
Advertising	15,987	20,830	31,305	43,413	$4,000 launch plus 1% of revenue
Allocated Costs	65,147	113,207	170,138	235,940	5% Allocation to Cornerstone Service Center for support; Legal, HR, Accounting, IT, and Clinical
B & O Taxes	19,544	33,962	51,042	70,782	1.5% of Gross Revenue
Dues & Subscriptions	4,500	4,500	4,500	4,500	$375/month, primarily Medbridge
Education and trainings	10,000	10,000	10,000	10,000	$10,000/year, Continuing education including Clinical education and compliance
Information					
Technology/Computer/Software					
Maintenance	15,000	15,000	15,000	15,000	$1250/month
Insurance	1,200	1,200	1,200	1,200	Liability and property content
Legal and professional	-	-	-	-	Included in Allocated Costs to Cornerstone Service Center
Licenses and Fees	13,883		2,383		First year Accreditation $3,100, Survey $7,500, initial State License $3,283, bi-annual state lic based on FTE $2,383
Postage	6,000	6,000	6,000	6,000	$500/month
Purchased services	12,000	12,000	12,000	12,000	$1000/month; bank fees, system access: HCHB, SHP, Workday
Repairs and Maintenance	1,800	1,800	1,800	1,800	$150/month
Cleaning	2,520	2,520	2,520	2,520	$210/month
Office supplies	3,000	3,000	3,000	3,000	$250/month
Equipment lease & maintenance	6,000	6,000	6,000	6,000	$500/month, copier and postage machines
Building rent or lease	25,455	26,091	26,742	27,544	Lease is 25% of Puget Sound HH lease
Lease NNN or Common Area					
Maintenance charges					No NNN costs
Recruitment	5,000	3,000	3,000	3,000	$5,000 startup and $250/month following
Telephones	8,553	11,919	15,907	20,515	$55/FTE/month + $250/month for landlines
Travel	6,500	5,000	5,000	5,000	First year $6,500 support and launch, $5,000 thereafter

Subtotal	**222,089**	**276,030**	**367,537**	**468,214**
Total Administrative Expense	**439,061**	**555,246**	**720,486**	**906,383**
TOTAL COSTS	**1,154,496**	**1,798,476**	**2,588,924**	**3,497,446**
EBITDA	44,206	284,540	541,622	843,848
EBITDA Margin %	3.7%	13.7%	17.3%	19.4%
Depreciation	1,333	1,333	1,334	-
Amortization	-	-	-	-
EBIT	42,873	283,207	540,288	843,848
Interest Expense	-	-	-	
Earnings before Taxes	42,873	283,207	540,288	843,848

YEAR	MO LEASE	25%	LEASE PER YR
2023	$ 8,485.00	$ 2,121.25	25,455.00
2024	$ 8,697.00	$ 2,174.25	26,091.00
2025	$ 8,914.00	$ 2,228.50	26,742.00
2026	$ 9,181.42	$ 2,295.36	27,544.26

SYMBOL HEALTHCARE, INC. 2021-2022 BALANCE SHEET-HOSPICE ONLY KING CO	2023	2024	2025	2026
Assets				
Current Assets				
Cash	(50,512)	173,601	645,986	1,409,365
Accounts Receivable	135,946	236,237	355,039	492,352
Allowance for Bad Debt	(5,438)	(9,449)	(14,202)	(19,694)
Prepaid Assets	2,121	2,174	2,229	2,295
Total Current Assets	82,118	402,563	989,052	1,884,318
Property and Equipment				
Leasehold Improvements	-	-	-	-
Furniture & Equipment	5,000	5,000	5,000	5000
Accumulated Deprciation/Amortization	(1,333)	(2,666)	(4,000)	(4,000)
Total Property and Equipment	3,667	2,334	1,000	1,000
Other Assets				
Security Deposit	6,363.75	6,522.75	6,685.50	6,886.07
Start Up Costs	15,500	15,500	15,500	15,500
Other Assets	-	-	-	-
Total Other Assets	21,864	22,023	22,186	22,386
Total Assets	**107,648**	**426,920**	**1,012,238**	**1,907,704**
Liabilities				
Current Liabilities				
Accounts Payable/Credit Card Payable	35,464	53,980	78,224	105,816
Payroll Liabilities	29,311	46,859	67,646	91,671
Total Current Liabilities	64,775	100,840	145,869	197,487
Long Term Liabilities				
Other Liabilities	-	-	-	
Hospice CAP				
Total Long Term Liabilities	-	-	-	
Total Liabilities	**64,775**	**100,840**	**145,869**	**197,487**
Equity				
Retained Earnings	-	42,873	326,080	866,369
Net Income	42,873	283,207	540,288	843,848
Total Equity	42,873	326,080	866,369	1,710,217
Total Liabilities and Equity	**107,648**	**426,920**	**1,012,238**	**1,907,704**
	-	-	-	-

SYMBOL HEALTHCARE, INC. 2021-2022
PRO FORMA-HOSPICE ONLY
KING CO
REVENUE

Gross revenue by type of care

KING County	**2023**	**2024**	**2025**	**2026**	
Routine Home Care	1,220,608	2,121,082	3,187,756	4,420,630	Days of Care x Per Diem Rates
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Adjustments to revenue	**2023**	**2024**	**2025**	**2026**	
Contractual adjustments Medicare Managed Care, Medicaid Managed Care, Private Pay, Third Party Ins	(26,059)	(45,283)	(68,055)	(94,376)	Assumed 2%
Charity Care	(65,147)	(113,207)	(170,138)	(235,940)	Assumed 5%
Provisions for Bad Debt	(13,029)	(22,641)	(34,028)	(47,188)	Assumed 1%
Total Adjustments to Revenue	(104,235)	(181,132)	(272,221)	(377,504)	
Total Net Revenue	**1,198,702**	**2,083,016**	**3,130,546**	**4,341,294**	

EXPENSES

Clinical Staffing	**2023**	**2024**	**2025**	**2026**	**Note**
Compensation and Benefits					
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Physical Therapist	646	1,122	1,687	2,339	$42.38/hr	1.5 hours/20 ADC/Month
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Medical Supplies	16,006	27,813	41,801	57,967	$2.59/PPD based on Cornerstone averages
Inpatient Respite	52,044	90,438	135,919	188,485	$520.36 per Inpatient Respite DOC
Room and Board	2,781	4,832	7,263	10,072	$.45/PPD based on Cornerstone averages
Mileage	22,247	38,660	58,101	80,572	Estimate 8 miles/DOC reimbursed at $.45/mile based on existing local agency
Subtotal	**197,690**	**343,531**	**516,289**	**715,966**	

Total Direct Patient Care Costs	**715,435**	**1,243,229**	**1,868,439**	**2,591,062**	

ADMINISTRATIVE COSTS

Administrative Compensation and Benefits	**2023**	**2024**	**2025**	**2026**	**Note**
Administrator	50,000	50,000	50,000	50,000	FTE x Annual Compensation, represents 50% of HH Administrator
Business Office Manager, Medical Records, Scheduling	28,218	49,036	73,695	102,197	FTE x Annual Compensation
Intake	52,000	52,000	52,000	52,000	FTE x Annual Compensation
Community Liaison	36,684	63,746	95,804	132,856	FTE x Annual Compensation
Payroll Taxes & Benefits	50,071	64,435	81,450	101,116	30% of Base Compensation
Total	**216,973**	**279,216**	**352,949**	**438,169**	

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B & O Taxes	19,544	33,962	51,042	70,782	1.5% of Gross Revenue
Dues & Subscriptions	4,500	4,500	4,500	4,500	$375/month, primarily Medbridge
Education and trainings	10,000	10,000	10,000	10,000	$10,000/year, Continuing education including Clinical education and compliance
Information Technology/Computer/Software Maintenance	15,000	15,000	15,000	15,000	$1250/month
Insurance	1,200	1,200	1,200	1,200	Liability and property content
Legal and professional	-	-	-	-	Included in Allocated Costs to Cornerstone Service Center
Licenses and Fees	13,883	-	2,383		First year Accreditation $3,100, Survey $7,500, initial State License $3,283, bi-annual state lic based on FTE $2,383
Postage	6,000	6,000	6,000	6,000	$500/month
Purchased services	12,000	12,000	12,000	12,000	$1000/month; bank fees, system access: HCHB, SHP, Workday
Repairs and Maintenance	1,800	1,800	1,800	1,800	$150/month
Cleaning	2,520	2,520	2,520	2,520	$210/month
Office supplies	3,000	3,000	3,000	3,000	$250/month
Equipment lease & maintenance	6,000	6,000	6,000	6,000	$500/month, copier and postage machines
Building rent or lease	25,455	26,091	26,742	27,544	Lease is 25% of Puget Sound HH lease
Lease NNN or Common Area Maintenance charges	-	-	-	-	No NNN costs
Recruitment	5,000	3,000	3,000	3,000	$5,000 startup and $250/month following
Telephones	8,553	11,919	15,907	20,515	$55/FTE/month + $250/month for landlines
Travel	6,500	5,000	5,000	5,000	First year $6,500 support and launch, $5,000 thereafter
Subtotal	**222,089**	**276,030**	**367,537**	**468,214**	

Total Administrative Expense	**439,061**	**555,246**	**720,486**	**906,383**
TOTAL COSTS	**1,154,496**	**1,798,476**	**2,588,924**	**3,497,446**
EBITDA	44,206	284,540	541,622	843,848
EBITDA Margin %	3.7%	13.7%	17.3%	19.4%
Depreciation	1,333	1,333	1,334	-
Amortization	-	-	-	
EBIT	42,873	283,207	540,288	843,848
Interest Expense	-	-	-	

Earnings before Taxes	42,873	283,207	540,288	843,848

CORNERSTONE HEALTHCARE INC +
KING COUNTY CN BS
For the Ten Months Ending
October 31, 2021

	12/31/2020	12/31/2021	12/31/2022	12/31/2023	12/31/2024	12/31/2025	12/31/2026
ASSETS							
CURRENT ASSETS							
CASH							
CN Cash				**(50,512)**	**173,601**	**645,986**	**1,409,365**
Petty Cash	2,762	2,762	2,762	2,762	2,762	2,762	2,762
TOTAL CASH	2,762	2,762	2,762	(47,750)	176,363	648,748	1,412,127
ACCOUNTS RECEIVABLE							
Medicare A	29,508,467	31,487,407.99	31,487,407.99	31,487,407.99	31,487,407.99	31,487,407.99	31,487,407.99
A/R 606 Contra - Medicare	(1,085,759)	372,984.56	372,984.56	372,984.56	372,984.56	372,984.56	372,984.56
Medicare B	33,974	(1,678,842.29)	(1,678,842.29)	(1,678,842.29)	(1,678,842.29)	(1,678,842.29)	(1,678,842.29)
Medicaid	4,684,902	(2,793,065.33)	(2,793,065.33)	(2,793,065.33)	(2,793,065.33)	(2,793,065.33)	(2,793,065.33)
A/R 606 Contra - Medicaid	(1,639,877)	(1,534,251.38)	(1,534,251.38)	(1,534,251.38)	(1,534,251.38)	(1,534,251.38)	(1,534,251.38)
Private	276,277	(4,351,846.48)	(4,351,846.48)	(4,351,846.48)	(4,351,846.48)	(4,351,846.48)	(4,351,846.48)
A/R 606 Contra - Private	(583,722)	7,057,788.35	7,057,788.35	7,057,788.35	7,057,788.35	7,057,788.35	7,057,788.35
HMO/Managed Care	9,490,332	969,480.38	969,480.38	969,480.38	969,480.38	969,480.38	969,480.38
A/R 606 Contra - Managed Care	(1,900,581)	13,825,868.92	13,825,868.92	13,825,868.92	13,825,868.92	13,825,868.92	13,825,868.92
Veterans	638,613	1,014,831.93	1,014,831.93	1,014,831.93	1,014,831.93	1,014,831.93	1,014,831.93
Miscellaneous	872,404	177,134.28	177,134.28	177,134.28	177,134.28	177,134.28	177,134.28
Prebilled A/R	2,113,273	2,279,557.00	2,279,557.00	2,279,557.00	2,279,557.00	2,279,557.00	2,279,557.00
Hospice Intercompany	581	1,271.85	1,271.85	1,271.85	1,271.85	1,271.85	1,271.85
Clearing - Adjustments - Cornerstone	788,291	2,963,185.18	2,963,185.18	2,963,185.18	2,963,185.18	2,963,185.18	2,963,185.18
Medicaid R&B A/R	-	-	-	-	-	-	-
CN Accounts Receivable				**135,946**	**236,237**	**355,039**	**492,352**
TOTAL ACCOUNTS RECEIVABLE	43,197,174	49,791,505	49,791,505	49,927,451	50,027,742	50,146,544	50,283,857

ALLOWANCE FOR DOUBTFUL ACCOUNTS							
Medicaid	116,325	(340,534.59)	(340,534.59)	(340,534.59)	(340,534.59)	(340,534.59)	(340,534.59)
CN Allowance for Bad Debt				**(5,438)**	**(9,449)**	**(14,202)**	**(19,694)**
TOTAL ALLOWANCE FOR DOUBTFUL ACCOUNTS	116,325	(340,535)	(340,535)	(345,972)	(349,984)	(354,736)	(360,229)
ACCOUNTS RECEIVABLE NET OF ALLOWANCE	43,313,499	49,450,970	49,450,970	49,581,479	49,677,758	49,791,808	49,923,628
PREPAID EXPENSES							
Prepaid Liability Insurance	0	0	0	0	0	0	0
Prepaid - One Time							
Prepaid Other <$1,000	47,409	3,905.91	3,905.91	3,905.91	3,905.91	3,905.91	3,905.91
Prepaid Other	678,830	501,545.17	501,545.17	501,545.17	501,545.17	501,545.17	501,545.17
CN Prepaid Expenses				**2,121**	**2,174**	**2,229**	**2,295**
Prepaid License							
Prepaid Rent	80,172	38,981	38,981	38,981	38,981	38,981	38,981
TOTAL PREPAID EXPENSES	806,411	544,432	544,432	546,553	546,606	546,660	546,727
OTHER CURRENT ASSETS							
SUPPLIES							
INTERCOMPANY BALANCES							
Inter Company - SC due from Facility	20,490,756	(10,068,495)	(10,068,495)	(10,068,495)	(10,068,495)	(10,068,495)	(10,068,495)
Spin Interco	2,710,000	2,710,000	2,710,000	2,710,000	2,710,000	2,710,000	2,710,000
NET INTERCOMPANY BALANCES	23,200,756	(7,358,495)	(7,358,495)	(7,358,495)	(7,358,495)	(7,358,495)	(7,358,495)
Deposits - Other	4,333	4,333	4,333	4,333	4,333	4,333	4,333
PREPAID EXPENSES AND OTHER CURRENT ASSETS	24,011,500	(6,809,730)	(6,809,730)	(6,807,609)	(6,807,556)	(6,807,501)	(6,807,435)
TOTAL CURRENT ASSETS	67,327,761	42,644,002	42,644,002	42,726,120	43,046,565	43,633,055	44,528,320
FIXED ASSETS							
Leasehold improvements	1,031,823	1,065,449.91	1,065,449.91	1,065,449.91	1,065,449.91	1,065,449.91	1,065,449.91

Fixed Equipment	428,363	431,864.58	431,864.58	431,864.58	431,864.58	431,864.58	431,864.58
Minor Moveable	307,741	313,045.82	313,045.82	313,045.82	313,045.82	313,045.82	313,045.82
Furniture and Fixtures **(INCLUDES CN)**	839,182	894,807.19	894,807.19	**899,807**	**899,807**	**899,807**	**899,807**
Computer Equipment	1,765,763	1,881,141.97	1,881,141.97	1,881,141.97	1,881,141.97	1,881,141.97	1,881,141.97
Computer Software	4,942,497	5,087,496.95	5,087,496.95	5,087,496.95	5,087,496.95	5,087,496.95	5,087,496.95
Vehicles	365,538	479,114.41	479,114.41	479,114.41	479,114.41	479,114.41	479,114.41
	9,680,907	10,152,921	10,152,921	10,157,921	10,157,921	10,157,921	10,157,921
ACCUMLATED DEPRECIATION							
Leasehold Improvements	(354,755)	(487,390.15)	(487,390.15)	(487,390.15)	(487,390.15)	(487,390.15)	(487,390.15)
Fixed Equipment	(254,393)	(290,005.72)	(290,005.72)	(290,005.72)	(290,005.72)	(290,005.72)	(290,005.72)
Minor Equipment	(222,350)	(249,436.46)	(249,436.46)	(249,436.46)	(249,436.46)	(249,436.46)	(249,436.46)
Furniture & Fixtures **(INCLUDES CN)**	(268,653)	(369,596.06)	(369,596.06)	**(370,929)**	**(372,262)**	**(373,596)**	**(373,596)**
Computer Equipment	(1,208,446)	(1,519,251.16)	(1,519,251.16)	(1,519,251.16)	(1,519,251.16)	(1,519,251.16)	(1,519,251.16)
Computer Software	(3,960,027)	(4,460,100.97)	(4,460,100.97)	(4,460,100.97)	(4,460,100.97)	(4,460,100.97)	(4,460,100.97)
Vehicles	(273,222)	(321,096.94)	(321,096.94)	(321,096.94)	(321,096.94)	(321,096.94)	(321,096.94)
TOTAL ACCUMLATED DEPRECIATION	(6,541,847)	(7,696,877)	(7,696,877)	(7,698,210)	(7,699,543)	(7,700,877)	(7,700,877)
FIXED ASSETS NET	3,139,061	2,456,043	2,456,043	2,459,710	2,458,377	2,457,043	2,457,043
ROU ASSETS							
ROU Asset-Op Lease (R/E)	13,153,355	15,659,055.57	15,659,055.57	15,659,055.57	15,659,055.57	15,659,055.57	15,659,055.57
ROU Asset A/D-Op Lease (R/E)	(3,693,370)	(6,094,178.69)	(6,094,178.69)	(6,094,178.69)	(6,094,178.69)	(6,094,178.69)	(6,094,178.69)
Op Lease Clearing	297,025	403,180.58	403,180.58	403,180.58	403,180.58	403,180.58	403,180.58
TOTAL ROU ASSETS	9,757,010	9,968,057	9,968,057	9,968,057	9,968,057	9,968,057	9,968,057
Customer Relationships	30,952	52,797.40	52,797.40	52,797.40	52,797.40	52,797.40	52,797.40
Goodwill	62,769,380	70,533,768.54	70,533,768.54	70,533,768.54	70,533,768.54	70,533,768.54	70,533,768.54
Tradename	1,355,498	1,355,497.67	1,355,497.67	1,355,497.67	1,355,497.67	1,355,497.67	1,355,497.67
MCare License	46,132,099	53,175,274.87	53,175,274.87	53,175,274.87	53,175,274.87	53,175,274.87	53,175,274.87
INTANGIBLE AND OTHER ASSETS, NET	110,287,929	125,117,338	125,117,338	125,117,338	125,117,338	125,117,338	125,117,338
L/T Prepaid	38,089	16,891.61	16,891.61	16,891.61	16,891.61	16,891.61	16,891.61

Deposits Utilities	6,782	7,379.00	7,379.00	7,379.00	7,379.00	7,379.00	7,379.00
Deposits Rent	292,992	321,637.82	321,637.82	321,637.82	321,637.82	321,637.82	321,637.82
CN Security Deposit				**6,364**	**6,523**	**6,686**	**6,886**
CN Start Up Costs				**15,500**	**15,500**	**15,500**	**15,500**
Escrow Deposits	562,500						
Other Long Term Assets	6,951,366	6,951,366	6,951,366	6,951,366	6,951,366	6,951,366	6,951,366
Restricted & Other Assets	7,851,729	7,297,275	7,297,275	7,319,138	7,319,297	7,319,460	7,319,661
TOTAL OTHER LONG TERM ASSETS	131,035,729	144,838,714	144,838,714	144,864,245	144,863,071	144,861,899	144,862,100
TOTAL ASSETS	198,363,491	187,482,716	187,482,716	187,590,365	187,909,636	188,494,954	189,390,420.2
LIABILITIES AND STOCKHOLDERS' EQUITY							
CURRENT LIABILITIES							
TRADE ACCOUNTS PAYABLE							
Accounts payable - trade **(INCLUDES CN)**	452,260	643,623.48	643,623.48	**679,088**	**697,604**	**721,847**	**749,440**
Accrued AP	2,890,140	3,093,246.01	3,093,246.01	3,093,246.01	3,093,246.01	3,093,246.01	3,093,246.01
Patient Refunds	(3,980)	20,556.95	20,556.95	20,556.95	20,556.95	20,556.95	20,556.95
Due:Prior Owners	(3,206,074)	(14,526,230.98)	(14,526,230.98)	(14,526,230.98)	(14,526,230.98)	(14,526,230.98)	(14,526,230.98)
TOTAL TRADE PAYABLES	132,347	(10,768,805)	(10,768,805)	(10,733,340)	(10,714,824)	(10,690,581)	(10,662,988)
ACCRUED WAGES AND RELATED LIABILITIES							
Accrued Payroll	11,060,599	7,493,818.26	7,493,818.26	7,493,818.26	7,493,818.26	7,493,818.26	7,493,818.26
Payroll Clearing	(167,785)	(160,771.58)	(160,771.58)	(160,771.58)	(160,771.58)	(160,771.58)	(160,771.58)
Garnishments Payable	10,118	21,060.73	21,060.73	21,060.73	21,060.73	21,060.73	21,060.73
Federal Payroll Taxes Payable	4,370,213	4,443,877.60	4,443,877.60	4,443,877.60	4,443,877.60	4,443,877.60	4,443,877.60
Deferred Payroll FICA Emergency	2,834,460	2,631,097.82	2,631,097.82	2,631,097.82	2,631,097.82	2,631,097.82	2,631,097.82
CN Payroll Liabilities				**29,311**	**46,859**	**67,646**	**91,671**
401K Employee W/H							
Due:EEF - Payroll Deductions							

Due:Ensign Foundation - Payroll Deductions							
Due:Finding Home Foundation - Payroll deduction	410	590	590	590	590	590	590
Accrued Vacation	2,747,710	3,412,947	3,412,947	3,412,947	3,412,947	3,412,947	3,412,947
TOTAL ACCRUED WAGES AND RELATED LIABILITIES	20,855,725	17,842,620	17,842,620	17,871,932	17,889,479	17,910,266	17,934,291
Accrued Workers Comp							
TOTAL ACCRUED INSURANCE	-	-	-	-	-	-	-
OTHER ACCRUED LIABILITIES							
Accrued Other	158,810	273,196.43	273,196.43	273,196.43	273,196.43	273,196.43	273,196.43
Accrued HSA Plan							
Deferred Revenue	28,067,542	11,027,346	11,027,346	11,027,346	11,027,346	11,027,346	11,027,346
Accrued Insurance Premiums	66,811	27,764	27,764	27,764	27,764	27,764	27,764
Real Property Taxes	7,989	10,339	10,339	10,339	10,339	10,339	10,339
Personal Property Taxes	1,505	3,944	3,944	3,944	3,944	3,944	3,944
Unprocessed Patient Refunds	2,042,371	2,202,572	2,202,572	2,202,572	2,202,572	2,202,572	2,202,572
Sales/Excise/B&O taxes	55,976	107,808	107,808	107,808	107,808	107,808	107,808
Hospice CAP Accrued	1,889,305	469,843	469,843	469,843	469,843	469,843	469,843
Facility Fund	157,595	224,185	224,185	224,185	224,185	224,185	224,185
TOTAL OTHER ACCRUED LIABILITIES	32,447,904	14,346,997	14,346,997	14,346,997	14,346,997	14,346,997	14,346,997
TOTAL CURRENT LIABILITIES	53,435,977	21,420,813	21,420,813	21,485,588	21,521,653	21,566,682	21,618,300
LONG TERM DEBT							
Deferred Rent Liability							
Op Lease Liability ST	3,123,194						
OP Lease Liability LT	11,634,419	17,858,252.22	17,858,252.22	17,858,252.22	17,858,252.22	17,858,252.22	17,858,252.22
Op Lease Liability A/D	(4,300,255)	(7,411,219.35)	(7,411,219.35)	(7,411,219.35)	(7,411,219.35)	(7,411,219.35)	(7,411,219.35)
TOTAL LONG TERM LIABILITIES	10,457,357	10,447,033	10,447,033	10,447,033	10,447,033	10,447,033	10,447,033
TOTAL LIABILITIES	63,893,334	31,867,846	31,867,846	31,932,621	31,968,686	32,013,715	32,065,333

STOCKHOLDERS' EQUITY							
Additional Paid-In-Capital	12,151,918	12,151,917.90	12,151,917.90	12,151,917.90	12,151,917.90	12,151,917.90	12,151,917.90
Spin RE Adjust - Adj	37,049,632	37,049,631.63	37,049,631.63	37,049,631.63	37,049,631.63	37,049,631.63	37,049,631.63
	54,655,908	54,655,908.11	54,655,908.11	54,655,908.11	54,655,908.11	54,655,908.11	54,655,908.11
Retained Earnings, Prior Year **(INCLUDES CN)**	103,857,458	103,857,458	103,857,458	103,857,458	103,857,458	103,857,458	103,857,458
Current Year Income **(INCLUDES CN)**	4,380,987	30,615,789	30,615,789	**30,615,789**	**30,658,662**	**30,941,869**	**31,482,157**
Total Stockholders' Equity	26,231,712	21,141,624	21,141,624	**21,184,497**	**21,424,831**	**21,681,912**	**21,985,472**
TOTAL LIABILITIES AND STOCKHOLDERS' EQUITY	134,470,157	155,614,870	155,614,870	155,657,743	155,940,950	156,481,239	157,325,087
	198,363,491	187,482,716	187,482,716	187,590,365	187,909,636	188,494,954	189,390,420.2
	-	-	-	-	-	-	-

CORNERSTONE HEALTHCARE INC +
KING COUNTY CN IS

For the Ten Months Ending
October 31, 2021

	2020	2021	2022	2023	2024	2025	2026
Total Net Home Health Revenue	98,267,134.16	136,834,182.79	136,834,182.79	136,834,182.79	136,834,182.79	136,834,182.79	136,834,182.79
Total Net Hospice Revenue	133,854,590.06	152,937,081.32	152,937,081.32	152,937,081.32	152,937,081.32	152,937,081.32	152,937,081.32
TOTAL NET CN HOSPICE REVENUE				**1,198,701.98**	**2,083,015.76**	**3,130,546.44**	**4,341,294.02**
Total Net Other Revenue	21,921,770.56	21,867,362.25	21,867,362.25	21,867,362.25	21,867,362.25	21,867,362.25	21,867,362.25
TOTAL NET REVENUE	254,043,494.78	311,638,626.36	311,638,626.36	312,837,328.34	313,721,642.12	314,769,172.80	315,979,920.38
DIRECT COSTS							
HH- Therapy Wages	19,220,438.70	27,422,607.70	27,422,607.70	27,422,607.70	27,422,607.70	27,422,607.70	27,422,607.70
HH- Therapy Benefits	4,478,498.13	6,495,684.93	6,495,684.93	6,495,684.93	6,495,684.93	6,495,684.93	6,495,684.93
HH- Therapy Mileage	1,155,452.80	1,528,945.62	1,528,945.62	1,528,945.62	1,528,945.62	1,528,945.62	1,528,945.62
HH - Therapy Other	1,937,682.70	2,916,598.27	2,916,598.27	2,916,598.27	2,916,598.27	2,916,598.27	2,916,598.27
Total Home Health Therapy	26,792,072.33	38,363,836.52	38,363,836.52	38,363,836.52	38,363,836.52	38,363,836.52	38,363,836.52
HH- CNA Wages	1,546,551.53	2,039,445.30	2,039,445.30	2,039,445.30	2,039,445.30	2,039,445.30	2,039,445.30
HH- CNA Benefits	504,052.83	657,154.16	657,154.16	657,154.16	657,154.16	657,154.16	657,154.16
HH- CNA Mileage	395,039.55	404,858.68	404,858.68	404,858.68	404,858.68	404,858.68	404,858.68
HH - CNA Other	22,119.35	21,780.41	21,780.41	21,780.41	21,780.41	21,780.41	21,780.41
Total Home Health CNA	2,467,763.26	3,123,238.55	3,123,238.55	3,123,238.55	3,123,238.55	3,123,238.55	3,123,238.55
HH- Nursing Wages	18,256,116.93	24,592,249.20	24,592,249.20	24,592,249.20	24,592,249.20	24,592,249.20	24,592,249.20
HH- Nursing Benefits	4,608,601.36	6,551,000.18	6,551,000.18	6,551,000.18	6,551,000.18	6,551,000.18	6,551,000.18
HH- Nursing Mileage	1,322,150.05	1,630,556.08	1,630,556.08	1,630,556.08	1,630,556.08	1,630,556.08	1,630,556.08
HH - Nursing Other	168,974.08	638,276.75	638,276.75	638,276.75	638,276.75	638,276.75	638,276.75
Total Home Health Skilled Nursing	24,355,842.42	33,412,082.21	33,412,082.21	33,412,082.21	33,412,082.21	33,412,082.21	33,412,082.21
HH - SS Wages	1,126,096.76	1,516,491.54	1,516,491.54	1,516,491.54	1,516,491.54	1,516,491.54	1,516,491.54
HH - SS Benefits	280,997.42	412,631.79	412,631.79	412,631.79	412,631.79	412,631.79	412,631.79
HH - SS Mileage	56,258.77	85,029.00	85,029.00	85,029.00	85,029.00	85,029.00	85,029.00
HH - SS Other	9,592.05	8,823.14	8,823.14	8,823.14	8,823.14	8,823.14	8,823.14

Total Home Health Social Services	1,472,945.00	2,022,975.47	2,022,975.47	2,022,975.47	2,022,975.47	2,022,975.47	2,022,975.47
HH - Supplies	1,686,752.72	2,641,839.34	2,641,839.34	2,641,839.34	2,641,839.34	2,641,839.34	2,641,839.34
HH - Other Direct Costs	29,135.98	25,453.35	25,453.35	25,453.35	25,453.35	25,453.35	25,453.35
TOTAL DIRECT COSTS - HOME HEALTH	56,804,511.71	79,589,425.44	79,589,425.44	79,589,425.44	79,589,425.44	79,589,425.44	79,589,425.44
Hospice- CNA Wages	4,205,846.34	5,474,276.98	5,474,276.98	5,474,276.98	5,474,276.98	5,474,276.98	5,474,276.98
Hospice- CNA Benefits	1,119,301.42	1,457,306.56	1,457,306.56	1,457,306.56	1,457,306.56	1,457,306.56	1,457,306.56
Hospice- CNA Mileage	695,464.48	892,375.42	892,375.42	892,375.42	892,375.42	892,375.42	892,375.42
Hospice - CNA Other	53,255.16	20,759.73	20,759.73	20,759.73	20,759.73	20,759.73	20,759.73
Total Hospice CNA	6,073,867.40	7,844,718.69	7,844,718.69	7,844,718.69	7,844,718.69	7,844,718.69	7,844,718.69
Hospice- Nursing Wages	19,283,933.72	22,911,050.71	22,911,050.71	22,911,050.71	22,911,050.71	22,911,050.71	22,911,050.71
Hospice- Nursing Benefits	4,094,054.55	5,205,467.13	5,205,467.13	5,205,467.13	5,205,467.13	5,205,467.13	5,205,467.13
Hospice- Nursing Mileage	919,030.13	1,107,907.51	1,107,907.51	1,107,907.51	1,107,907.51	1,107,907.51	1,107,907.51
Hospice - Nursing Other	149,864.59	281,344.18	281,344.18	281,344.18	281,344.18	281,344.18	281,344.18
Total Hospice Skilled Nursing	24,446,882.99	29,505,769.53	29,505,769.53	29,505,769.53	29,505,769.53	29,505,769.53	29,505,769.53
Hospice - SS Wages	3,665,257.39	4,447,027.34	4,447,027.34	4,447,027.34	4,447,027.34	4,447,027.34	4,447,027.34
Hospice - SS Benefits	750,588.97	994,695.11	994,695.11	994,695.11	994,695.11	994,695.11	994,695.11
Hospice - SS Mileage	166,859.40	223,168.08	223,168.08	223,168.08	223,168.08	223,168.08	223,168.08
Hospice - SS Other	7,004.76	2,894.58	2,894.58	2,894.58	2,894.58	2,894.58	2,894.58
Total Hospice Social Services	4,589,710.52	5,667,785.11	5,667,785.11	5,667,785.11	5,667,785.11	5,667,785.11	5,667,785.11
Hospice - Chaplain Wages	2,222,288.47	2,761,314.79	2,761,314.79	2,761,314.79	2,761,314.79	2,761,314.79	2,761,314.79
Hospice - Chaplain Benefits	464,210.10	561,487.87	561,487.87	561,487.87	561,487.87	561,487.87	561,487.87
Hospice - Chaplain Mileage	152,189.39	188,900.40	188,900.40	188,900.40	188,900.40	188,900.40	188,900.40
Hospice - Chaplain Other	2,195.45	1,862.69	1,862.69	1,862.69	1,862.69	1,862.69	1,862.69
Total Hospice Chaplain	2,840,883.41	3,513,565.75	3,513,565.75	3,513,565.75	3,513,565.75	3,513,565.75	3,513,565.75
Hospice - Volunteer Wages	511,478.36	692,949.08	692,949.08	692,949.08	692,949.08	692,949.08	692,949.08
Hospice - Volunteer Benefits	134,607.66	176,635.91	176,635.91	176,635.91	176,635.91	176,635.91	176,635.91
Hospice - Volunteer Mileage	12,571.02	25,939.32	25,939.32	25,939.32	25,939.32	25,939.32	25,939.32
Hospice - Volunteer Other	14,241.08	14,322.93	14,322.93	14,322.93	14,322.93	14,322.93	14,322.93
Total Hospice Volunteer	672,898.12	909,847.24	909,847.24	909,847.24	909,847.24	909,847.24	909,847.24
Hospice - Pharmacy	4,845,509.55	5,404,824.45	5,404,824.45	5,404,824.45	5,404,824.45	5,404,824.45	5,404,824.45
Hospice - Supplies	2,039,624.35	2,576,434.55	2,576,434.55	2,576,434.55	2,576,434.55	2,576,434.55	2,576,434.55

Hospice - DME	4,594,836.62	5,239,062.36	5,239,062.36	5,239,062.36	5,239,062.36	5,239,062.36	5,239,062.36
Hospice- Room and Board	10,425,330.43	9,269,751.82	9,269,751.82	9,269,751.82	9,269,751.82	9,269,751.82	9,269,751.82
Hospice - Respite and GIP	541,917.41	647,001.97	647,001.97	647,001.97	647,001.97	647,001.97	647,001.97
Hospice - Other Direct Costs	264,946.39	340,086.74	340,086.74	340,086.74	340,086.74	340,086.74	340,086.74
TOTAL DIRECT COSTS - HOSPICE	61,336,407.19	70,918,848.21	70,918,848.21	70,918,848.21	70,918,848.21	70,918,848.21	70,918,848.21
Palliative - Nursing Wages	110,088.59	251,189.55	251,189.55	251,189.55	251,189.55	251,189.55	251,189.55
Palliative - Nursing Benefits	26,766.22	54,318.04	54,318.04	54,318.04	54,318.04	54,318.04	54,318.04
Palliative - Supplies	3,202.86	7,563.05	7,563.05	7,563.05	7,563.05	7,563.05	7,563.05
Total Palliative Nursing	140,057.67	313,070.64	313,070.64	313,070.64	313,070.64	313,070.64	313,070.64
TOTAL DIRECT COSTS - PALLIATIVE	140,057.67	313,070.64	313,070.64	313,070.64	313,070.64	313,070.64	313,070.64
PD - Wages	9,236,224.76	9,738,899.99	9,738,899.99	9,738,899.99	9,738,899.99	9,738,899.99	9,738,899.99
PD - Benefits	1,554,567.51	1,736,129.54	1,736,129.54	1,736,129.54	1,736,129.54	1,736,129.54	1,736,129.54
PD - Mileage	264,257.21	306,908.91	306,908.91	306,908.91	306,908.91	306,908.91	306,908.91
PD - Supplies	9,579.54	11,964.90	11,964.90	11,964.90	11,964.90	11,964.90	11,964.90
PD - Other	95,720.18	629,508.55	629,508.55	629,508.55	629,508.55	629,508.55	629,508.55
TOTAL DIRECT COSTS - PRIVATE DUTY	11,160,349.20	12,423,411.89	12,423,411.89	12,423,411.89	12,423,411.89	12,423,411.89	12,423,411.89
Finding Home - Wages	2,020,499.53	1,664,163.48	1,664,163.48	1,664,163.48	1,664,163.48	1,664,163.48	1,664,163.48
Finding Home - Benefits	352,492.08	358,994.97	358,994.97	358,994.97	358,994.97	358,994.97	358,994.97
Finding Home - Mileage	13,706.25	20,276.65	20,276.65	20,276.65	20,276.65	20,276.65	20,276.65
Finding Home - Supplies	4,194.74	8,244.10	8,244.10	8,244.10	8,244.10	8,244.10	8,244.10
Finding Home - Other	145,903.14	358,572.78	358,572.78	358,572.78	358,572.78	358,572.78	358,572.78
TOTAL DIRECT COSTS - FINDING HOME	2,536,795.74	2,410,251.98	2,410,251.98	2,410,251.98	2,410,251.98	2,410,251.98	2,410,251.98
HOSPICE CN							
Registered Nurse				203,171.51	353,056.44	530,605.48	735,818.63
Certified Nursing Assistant				52,824.59	91,794.67	137,957.42	191,312.84
Licensed Clinical Social Worker				40,069.94	69,630.58	104,647.19	145,119.79
Spiritual Care Coordinator				31,604.46	54,919.89	82,538.63	114,460.68
Director of Clinical Services				46,560.14	80,908.77	121,597.09	168,625.10
Payroll Taxes & Benefits				112,269.19	195,093.10	293,203.74	406,601.11
Medical Director				28,951.94	50,310.54	75,611.28	104,854.15
Physical Therapist				645.78	1,122.19	1,686.53	2,338.80
Occupational Therapist				598.24	1,039.57	1,562.37	2,166.62

Speech Therapist				541.71	941.34	1,414.73	1,961.88
Dietitian				507.27	881.49	1,324.79	1,837.16
DME				37,325.99	64,862.35	97,481.07	135,182.15
Pharmacy				43,814.78	76,138.09	114,427.28	158,682.35
General Inpatient Costs				23,471.23	40,786.56	61,297.77	85,004.86
Medical Supplies				16,005.68	27,813.49	41,800.66	57,967.18
Inpatient Respite				52,043.91	90,438.06	135,918.58	188,485.47
Room and Board				2,780.91	4,832.46	7,262.66	10,071.52
Mileage				22,247.28	38,659.68	58,101.30	80,572.14
TOTAL DIRECT COSTS-CN HOSPICE				**715,434.53**	**1,243,229.28**	**1,868,438.58**	**2,591,062.42**
TOTAL DIRECT COSTS	131,978,121.51	165,655,008.16	165,655,008.16	166,370,442.68	166,898,237.44	167,523,446.73	168,246,070.57
HCHB	1,239,592.36	2,629,033.19	2,629,033.19	2,629,033.19	2,629,033.19	2,629,033.19	2,629,033.19
Administration-Wages	29,854,653.97	39,428,283.42	39,428,283.42	39,428,283.42	39,428,283.42	39,428,283.42	39,428,283.42
Administration-Benefits	6,086,692.64	8,246,761.72	8,246,761.72	8,246,761.72	8,246,761.72	8,246,761.72	8,246,761.72
Administration-Purchased Services	8,523,237.32	10,516,638.62	10,516,638.62	10,516,638.62	10,516,638.62	10,516,638.62	10,516,638.62
Administration-Insurance	905,226.10	1,343,431.91	1,343,431.91	1,343,431.91	1,343,431.91	1,343,431.91	1,343,431.91
Administration-Other	15,049,557.96	12,971,020.47	12,971,020.47	12,971,020.47	12,971,020.47	12,971,020.47	12,971,020.47
Total Administration	60,419,367.99	72,506,136.13	72,506,136.13	72,506,136.13	72,506,136.13	72,506,136.13	72,506,136.13
Marketing - Wages	8,775,534.56	10,706,065.55	10,706,065.55	10,706,065.55	10,706,065.55	10,706,065.55	10,706,065.55
Marketing - Benefits	1,677,793.94	2,065,164.39	2,065,164.39	2,065,164.39	2,065,164.39	2,065,164.39	2,065,164.39
Marketing - Mileage	212,013.89	303,164.21	303,164.21	303,164.21	303,164.21	303,164.21	303,164.21
Marketing - Activity Programs	1,316.75	3,179.19	3,179.19	3,179.19	3,179.19	3,179.19	3,179.19
Marketing - Other	883,718.94	1,178,120.21	1,178,120.21	1,178,120.21	1,178,120.21	1,178,120.21	1,178,120.21
Total Marketing	11,550,378.08	14,255,693.55	14,255,693.55	14,255,693.55	14,255,693.55	14,255,693.55	14,255,693.55
Occupancy - Utilities	257,465.42	308,838.18	308,838.18	308,838.18	308,838.18	308,838.18	308,838.18
Occupancy - Other	10,297.44	16,516.57	16,516.57	16,516.57	16,516.57	16,516.57	16,516.57
Total Occupancy	267,762.86	325,354.75	325,354.75	325,354.75	325,354.75	325,354.75	325,354.75
HOSPICE CN							
Administrator				50,000.00	50,000.00	50,000.00	50,000.00
Business Office Manager, Medical Records, Scheduling				28,218.26	49,035.62	73,695.21	102,197.03
Intake				52,000.00	52,000.00	52,000.00	52,000.00
Community Liaison				36,683.74	63,746.30	95,803.77	132,856.14
Payroll Taxes & Benefits				50,070.60	64,434.58	81,449.69	101,115.95

Advertising				15,987.02	20,830.16	31,305.46	43,412.94
Allocated Costs				65,146.85	113,207.38	170,138.39	235,939.89
B & O Taxes				19,544.05	33,962.21	51,041.52	70,781.97
Dues & Subscriptions				4,500.00	4,500.00	4,500.00	4,500.00
Education and trainings				10,000.00	10,000.00	10,000.00	10,000.00
Information Technology/Computer/Software Maintenance				15,000.00	15,000.00	15,000.00	15,000.00
Insurance				1,200.00	1,200.00	1,200.00	1,200.00
Legal and professional				0.00	0.00	0.00	0.00
Licenses and Fees				13,883.00	0.00	2,383.00	0.00
Postage				6,000.00	6,000.00	6,000.00	6,000.00
Purchased services				12,000.00	12,000.00	12,000.00	12,000.00
Repairs and Maintenance				1,800.00	1,800.00	1,800.00	1,800.00
Cleaning				2,520.00	2,520.00	2,520.00	2,520.00
Office supplies				3,000.00	3,000.00	3,000.00	3,000.00
Equipment lease & maintenance				6,000.00	6,000.00	6,000.00	6,000.00
Building rent or lease				25,455.00	26,091.00	26,742.00	27,544.26
Lease NNN or Common Area Maintenance charges				0.00	0.00	0.00	0.00
Recruitment				5,000.00	3,000.00	3,000.00	3,000.00
Telephones				8,552.89	11,919.06	15,906.51	20,515.26
Travel				6,500.00	5,000.00	5,000.00	5,000.00
TOTAL INDIRECT COST-CN HOSPICE				**439,061.43**	**555,246.30**	**720,485.56**	**906,383.45**
TOTAL INDIRECT COSTS	73,477,101.29	89,716,217.62	89,716,217.62	90,155,279.05	90,271,463.92	90,436,703.18	90,622,601.07
TOTAL COSTS	205,455,222.79	255,371,225.78	255,371,225.78	256,525,721.73	257,169,701.36	257,960,149.91	258,868,671.64
Bad Debt	(222.47)	11,753.13	11,753.13	11,753.13	11,753.13	11,753.13	11,753.13
TOTAL OPERATING EXPENSES	205,455,000.32	255,382,978.91	255,382,978.91	256,537,474.86	257,181,454.49	257,971,903.04	258,880,424.77
Service Center Allocation	12,554,525.42	16,494,849.70	16,494,849.70	16,494,849.70	16,494,849.70	16,494,849.70	16,494,849.70
EBITDAR	36,033,969.04	39,760,797.75	39,760,797.75	39,805,003.78	40,045,337.93	40,302,420.06	40,604,645.91
EBITDAR Margin	14.18%	12.76%	12.76%	12.72%	12.76%	12.80%	12.85%
Occupancy- Rent	3,750,368.09	4,970,311.46	4,970,311.46	4,970,311.46	4,970,311.46	4,970,311.46	4,970,311.46
Property Taxes	16,524.46	19,880.01	19,880.01	19,880.01	19,880.01	19,880.01	19,880.01
Total Property Expenses	3,766,892.55	4,990,191.47	4,990,191.47	4,990,191.47	4,990,191.47	4,990,191.47	4,990,191.47
EBITDA	32,267,076.49	34,770,606.28	34,770,606.28	34,814,812.31	35,055,146.46	35,312,228.59	35,614,454.44
EBITDA MARGIN	12.70%	11.16%	11.16%	11.13%	11.17%	11.22%	11.27%
Depreciation and Amortization	1,462,469.74	1,419,460.01	1,419,460.01	1,420,793.01	1,420,793.01	1,420,794.01	1,420,793.01

Gain or loss on disposal	318.71	(770.83)	(770.83)	(770.83)	(770.83)	(770.83)	(770.83)
Other income(expense) net	(225,000.00)	23,608.32	23,608.32	23,608.32	23,608.32	23,608.32	23,608.32
Earnings Before Interest & Tax	31,029,288.04	33,328,308.78	33,328,308.78	33,371,181.81	33,611,515.96	33,868,597.09	34,170,823.94
Interest	4,774,062.39	7,985,061.99	7,985,061.99	7,985,061.99	7,985,061.99	7,985,061.99	7,985,061.99
Earnings Before Income Taxes	26,255,225.65	25,343,246.79	25,343,246.79	25,386,119.82	25,626,453.97	25,883,535.10	26,185,761.95
NET INCOME	1,600.00	1,600.00	1,600.00	1,600.00	1,600.00	1,600.00	1,600.00
	26,253,625.65	25,341,646.79	25,341,646.79	25,384,519.82	25,624,853.97	25,881,935.10	26,184,161.95

SYMBOL HEALTHCARE, INC. 2021-2022 BALANCE SHEET-HOSPICE ONLY	2023	2024	2025	2026
KING COUNTY + PIERCE COUNTY				
Assets				
Current Assets				
Cash	(105,896)	257,167	984,960	2,135,520
Accounts Receivable	280,244	432,541	610,181	813,162
Allowance for Bad Debt	(11,210)	(17,302)	(24,407)	(32,526)
Prepaid Assets	4,243	4,349	4,457	4,591
Total Current Assets	167,381	676,755	1,575,190	2,920,747
Property and Equipment				
Leasehold Improvements	-	-	-	-
Furniture & Equipment	5,000	5,000	5,000	5000
Accumulated Deprciation/Amortization	(1,333)	(2,666)	(4,000)	(4,000)
Total Property and Equipment	3,667	2,334	1,000	1,000
Other Assets				
Security Deposit	12,727.50	13,045.50	13,371.00	13,772.13
Start Up Costs	15,500	15,500	15,500	15,500
Other Assets	-	-	-	-
Total Other Assets	28,228	28,546	28,871	29,272
Total Assets	**199,276**	**707,634**	**1,605,061**	**2,951,019**
Liabilities				
Current Liabilities				
Accounts Payable/Credit Card Payable	53,800	82,518	120,300	161,187
Payroll Liabilities	60,713	87,587	118,924	154,726
Total Current Liabilities	114,512	170,105	239,225	315,914
Long Term Liabilities				
Other Liabilities	-	-	-	
Hospice CAP				
Total Long Term Liabilities	-	-	-	
Total Liabilities	**114,512**	**170,105**	**239,225**	**315,914**
Equity				
Retained Earnings	-	84,764	537,530	1,365,837
Net Income	84,764	452,766	828,307	1,269,269
Total Equity	84,764	537,530	1,365,837	2,635,106
Total Liabilities and Equity	**199,276**	**707,634**	**1,605,061**	**2,951,019**

SYMBOL HEALTHCARE, INC. 2021-2022

PRO FORMA-HOSPICE ONLY

KING COUNTY + PIERCE COUNTY

REVENUE

Gross revenue by type of care

	2023	2024	2025	2026	
Routine Home Care	2,516,204	3,883,616	5,478,569	7,301,062	Days of Care x Per Diem Rates
Inpatient Respite	107,285	165,588	233,594	311,300	Days of Care x Per Diem Rates
Continuous Home Care	14,047	21,680	30,584	40,758	Days of Care x Per Diem Rates: Assumes one 8 hour shift per each unmet day
General InPatient	48,384	74,679	105,348	140,393	Days of Care x Per Diem Rates
Gross revenue subtotal	2,685,920	4,145,563	5,848,094	7,793,514	

Adjustments to revenue	**2023**	**2024**	**2025**	**2026**	
Contractual adjustments Medicare Managed Care, Medicaid Managed Care, Private Pay, Third Party Ins	(53,718)	(82,911)	(116,962)	(155,870)	Assumed 2%
Charity Care	(134,296)	(207,278)	(292,405)	(389,676)	Assumed 5%
Provisions for Bad Debt	(26,859)	(41,456)	(58,481)	(77,935)	Assumed 1%
Total Adjustments to Revenue	(214,874)	(331,645)	(467,848)	(623,481)	

Total Net Revenue	**2,471,046**	**3,813,918**	**5,380,246**	**7,170,033**	

EXPENSES

Clinical Staffing	**2023**	**2024**	**2025**	**2026**	**Note**
Compensation and Benefits					
Registered Nurse	424,196	653,739	921,411	1,227,212	FTE x Annual Compensation
Certified Nursing Assistant	110,291	169,972	239,567	319,075	FTE x Annual Compensation
Licensed Clinical Social Worker	83,661	128,932	181,723	242,033	FTE x Annual Compensation
Spiritual Care Coordinator	65,986	101,693	143,331	190,900	FTE x Annual Compensation
Director of Clinical Services	97,212	149,815	211,157	281,236	FTE x Annual Compensation
Payroll Taxes & Benefits	234,404	361,245	509,156	678,137	30% of Base Compensation
Total	**1,015,749**	**1,565,397**	**2,206,344**	**2,938,592**	

Contracted Patient Care	**2023**	**2024**	**2025**	**2026**	**Note**	-
Medical Director	60,448	93,158	131,301	174,878	MD rate of $190/hr. p	-
Physical Therapist	1,348	2,078	2,929	3,901	$42.38/hr	1.5 hours/20 ADC/Month
Occupational Therapist	1,249	1,925	2,713	3,614	$39.26/hr	1.5 hours/20 ADC/Month
Speech Therapist	1,131	1,743	2,457	3,272	$35.55/hr	1.5 hours/20 ADC/Month
Dietitian	1,059	1,632	2,301	3,064	$33.29/hr	1.5 hours/20 ADC/Month
Total	**65,235**	**100,536**	**141,700**	**188,728**		

Direct Patient Care Costs	**2023**	**2024**	**2025**	**2026**	**Note**
DME	77,932	120,103	169,279	225,459	$6.04/PPD based on Cornerstone averages
Pharmacy	91,480	140,982	198,706	264,653	$7.09/PPD based on Cornerstone averages
General Inpatient Costs	48,384	74,679	105,348	140,393	$1180.67 per General Inpatient DOC
Medical Supplies	33,418	51,501	72,588	96,679	$2.59/PPD based on Cornerstone averages
Inpatient Respite	107,285	165,588	233,594	311,300	$520.36 per Inpatient Respite DOC
Room and Board	5,806	8,948	12,612	16,797	$.45/PPD based on Cornerstone averages
Mileage	46,449	71,584	100,895	134,380	Estimate 8 miles/DOC reimbursed at $.45/mile based on existing local agency
Subtotal	**410,755**	**633,385**	**893,021**	**1,189,662**	

Total Direct Patient Care Costs	**1,491,740**	**2,299,317**	**3,241,065**	**4,316,982**	

ADMINISTRATIVE COSTS

Administrative Compensation and Benefits	**2023**	**2024**	**2025**	**2026**	**Note**
Administrator	100,000	100,000	100,000	100,000	FTE x Annual Compensation, represents 50% of HH Administrator
Business Office Manager, Medical Records, Scheduling	58,916	90,797	127,974	170,446	FTE x Annual Compensation
Intake	104,000	104,000	104,000	104,000	FTE x Annual Compensation
Community Liaison	76,591	118,036	166,366	221,580	FTE x Annual Compensation
Payroll Taxes & Benefits	101,852	123,850	149,502	178,808	30% of Base Compensation
Total	**441,359**	**536,683**	**647,841**	**774,834**	

Administration Costs	**2023**	**2024**	**2025**	**2026**	**Note**
Advertising	30,710	44,139	59,802	77,700	$6000 launch + 1% revenue
Allocated Costs	134,296	207,278	292,405	389,676	5% Allocation to Cornerstone Service Center for support; Legal, HR, Accounting, IT, and Clinical
B & O Taxes	40,289	62,183	87,721	116,903	1.5% of Gross Revenue
Dues & Subscriptions	4,500	4,500	4,500	4,500	$375/month, primarily Medbridge
Education and trainings	10,000	10,000	10,000	10,000	$10,000/year, Continuing education including Clinical education and compliance
Information Technology/Computer/Software Maintenance	15,000	15,000	15,000	15,000	$1250/month
Insurance	1,200	1,200	1,200	1,200	Liability and property content
Legal and professional	-	-	-	-	Included in Allocated Costs to Cornerstone Service Center
Licenses and Fees	13,883	-	2,383	-	First year Accreditation $3,100, Survey $7,500, initial State License $3,283, bi-annual state lic based on FTE $2,383
Postage	6,000	6,000	6,000	6,000	$500/month
Purchased services	12,000	12,000	12,000	12,000	$1000/month; bank fees, system access: HCHB, SHP, Workday
Repairs and Maintenance	1,800	1,800	1,800	1,800	$150/month
Cleaning	2,520	2,520	2,520	2,520	$210/month
Office supplies	3,000	3,000	3,000	3,000	$250/month
Equipment lease & maintenance	6,000	6,000	6,000	6,000	$500/month, copier and postage machines
Building rent or lease	25,455	26,091	26,742	27,544	Lease is 25% of Puget Sound HH lease
Lease NNN or Common Area Maintenance charges	-	-	-	-	No NNN costs
Recruitment	5,000	3,000	3,000	3,000	$5,000 startup and $250/month following
Telephones	17,507	22,662	28,673	35,541	$55/FTE/month + $250/month for landlines
Travel	6,500	5,000	5,000	5,000	First year $6,500 support and launch, $5,000 thereafter
Subtotal	**335,660**	**432,374**	**567,747**	**717,384**	adjust the totals when any change is made

Total Administrative Expense	**777,019**	**969,057**	**1,215,588**	**1,492,218**
TOTAL COSTS	**2,268,759**	**3,268,374**	**4,456,653**	**5,809,200**
EBITDA	202,288	545,543	923,593	1,360,833
EBITDA Margin %	8.2%	14.3%	17.2%	19.0%
Depreciation	1,333	1,333	1,334	-
Amortization	-	-	-	
EBIT	200,955	544,210	922,259	1,360,833
Interest Expense	-	-	-	
Earnings before Taxes	200,955	544,210	922,259	1,360,833

YEAR	**MO LEASE**	**25%**	**LEASE PER YR**
2023	$ 8,485.00	$ 2,121.25	25,455.00
2024	$ 8,697.00	$ 2,174.25	26,091.00
2025	$ 8,914.00	$ 2,228.50	26,742.00
2026	$ 9,181.42	$ 2,295.36	27,544.26

CORNERSTONE HEALTHCARE INC +
ALL FOUR COUNTIES BS
For the Ten Months Ending
October 31, 2021

	12/31/2020	12/31/2021	12/31/2022	12/31/2023	12/31/2024	12/31/2025	12/31/2026
ASSETS							
CURRENT ASSETS							
CASH							
CN Cash				**(309,272)**	**91,780**	**1,011,504**	**2,532,627**
Petty Cash	2,762	2,762	2,762	2,762	2,762	2,762	2,762
TOTAL CASH	2,762	2,762	2,762	(306,510)	94,542	1,014,266	2,535,389
ACCOUNTS RECEIVABLE							
Medicare A	29,508,467	31,487,407.99	31,487,407.99	31,487,407.99	31,487,407.99	31,487,407.99	31,487,407.99
A/R 606 Contra - Medicare	(1,085,759)	372,984.56	372,984.56	372,984.56	372,984.56	372,984.56	372,984.56
Medicare B	33,974	(1,678,842.29)	(1,678,842.29)	(1,678,842.29)	(1,678,842.29)	(1,678,842.29)	(1,678,842.29)
Medicaid	4,684,902	(2,793,065.33)	(2,793,065.33)	(2,793,065.33)	(2,793,065.33)	(2,793,065.33)	(2,793,065.33)
A/R 606 Contra - Medicaid	(1,639,877)	(1,534,251.38)	(1,534,251.38)	(1,534,251.38)	(1,534,251.38)	(1,534,251.38)	(1,534,251.38)
Private	276,277	(4,351,846.48)	(4,351,846.48)	(4,351,846.48)	(4,351,846.48)	(4,351,846.48)	(4,351,846.48)
A/R 606 Contra - Private	(583,722)	7,057,788.35	7,057,788.35	7,057,788.35	7,057,788.35	7,057,788.35	7,057,788.35
HMO/Managed Care	9,490,332	969,480.38	969,480.38	969,480.38	969,480.38	969,480.38	969,480.38
A/R 606 Contra - Managed Care	(1,900,581)	13,825,868.92	13,825,868.92	13,825,868.92	13,825,868.92	13,825,868.92	13,825,868.92
Veterans	638,613	1,014,831.93	1,014,831.93	1,014,831.93	1,014,831.93	1,014,831.93	1,014,831.93
Miscellaneous	872,404	177,134.28	177,134.28	177,134.28	177,134.28	177,134.28	177,134.28
Prebilled A/R	2,113,273	2,279,557.00	2,279,557.00	2,279,557.00	2,279,557.00	2,279,557.00	2,279,557.00
Hospice Intercompany	581	1,271.85	1,271.85	1,271.85	1,271.85	1,271.85	1,271.85
Clearing - Adjustments - Cornerstone	788,291	2,963,185.18	2,963,185.18	2,963,185.18	2,963,185.18	2,963,185.18	2,963,185.18
Medicaid R&B A/R	-	-	-	-	-	-	-
CN Accounts Receivable				**457,900**	**702,481**	**987,358**	**1,312,529**
TOTAL ACCOUNTS RECEIVABLE	43,197,174	49,791,505	49,791,505	50,249,405	50,493,986	50,778,863	51,104,033

ALLOWANCE FOR DOUBTFUL ACCOUNTS							
Medicaid	116,325	(340,534.59)	(340,534.59)	(340,534.59)	(340,534.59)	(340,534.59)	(340,534.59)
CN Allowance for Bad Debt				**(18,316)**	**(28,099)**	**(39,494)**	**(52,501)**
TOTAL ALLOWANCE FOR DOUBTFUL ACCOUNTS	116,325	(340,535)	(340,535)	(358,851)	(368,634)	(380,029)	(393,036)
ACCOUNTS RECEIVABLE NET OF ALLOWANCE	43,313,499	49,450,970	49,450,970	49,890,554	50,125,353	50,398,834	50,710,998
PREPAID EXPENSES							
Prepaid Liability Insurance	0	0	0	0	0	0	0
Prepaid - One Time							
Prepaid Other <$1,000	47,409	3,905.91	3,905.91	3,905.91	3,905.91	3,905.91	3,905.91
Prepaid Other	678,830	501,545.17	501,545.17	501,545.17	501,545.17	501,545.17	501,545.17
CN Prepaid Expenses				**5,918**	**6,091**	**6,269**	**6,475**
Prepaid License							
Prepaid Rent	80,172	38,981	38,981	38,981	38,981	38,981	38,981
TOTAL PREPAID EXPENSES	806,411	544,432	544,432	550,349	550,522	550,701	550,907
OTHER CURRENT ASSETS							
SUPPLIES							
INTERCOMPANY BALANCES							
Inter Company - SC due from Facility	20,490,756	(10,068,495)	(10,068,495)	(10,068,495)	(10,068,495)	(10,068,495)	(10,068,495)
Spin Interco	2,710,000	2,710,000	2,710,000	2,710,000	2,710,000	2,710,000	2,710,000
NET INTERCOMPANY BALANCES	23,200,756	(7,358,495)	(7,358,495)	(7,358,495)	(7,358,495)	(7,358,495)	(7,358,495)
Deposits - Other	4,333	4,333	4,333	4,333	4,333	4,333	4,333
PREPAID EXPENSES AND OTHER CURRENT ASSETS	24,011,500	(6,809,730)	(6,809,730)	(6,803,812)	(6,803,639)	(6,803,461)	(6,803,255)
TOTAL CURRENT ASSETS	67,327,761	42,644,002	42,644,002	42,780,232	43,416,255	44,609,638	46,443,131
FIXED ASSETS							
Leasehold improvements	1,031,823	1,065,449.91	1,065,449.91	1,065,449.91	1,065,449.91	1,065,449.91	1,065,449.91

Fixed Equipment	428,363	431,864.58	431,864.58	431,864.58	431,864.58	431,864.58	431,864.58
Minor Moveable	307,741	313,045.82	313,045.82	313,045.82	313,045.82	313,045.82	313,045.82
Furniture and Fixtures **(INCLUDES CN)**	839,182	894,807.19	894,807.19	**914,807**	**914,807**	**914,807**	**914,807**
Computer Equipment	1,765,763	1,881,141.97	1,881,141.97	1,881,141.97	1,881,141.97	1,881,141.97	1,881,141.97
Computer Software	4,942,497	5,087,496.95	5,087,496.95	5,087,496.95	5,087,496.95	5,087,496.95	5,087,496.95
Vehicles	365,538	479,114.41	479,114.41	479,114.41	479,114.41	479,114.41	479,114.41
	9,680,907	10,152,921	10,152,921	10,172,921	10,172,921	10,172,921	10,172,921
ACCUMLATED DEPRECIATION							
Leasehold Improvements	(354,755)	(487,390.15)	(487,390.15)	(487,390.15)	(487,390.15)	(487,390.15)	(487,390.15)
Fixed Equipment	(254,393)	(290,005.72)	(290,005.72)	(290,005.72)	(290,005.72)	(290,005.72)	(290,005.72)
Minor Equipment	(222,350)	(249,436.46)	(249,436.46)	(249,436.46)	(249,436.46)	(249,436.46)	(249,436.46)
Furniture & Fixtures **(INCLUDES CN)**	(268,653)	(369,596.06)	(369,596.06)	**(374,928)**	**(380,260)**	**(385,596)**	**(385,596)**
Computer Equipment	(1,208,446)	(1,519,251.16)	(1,519,251.16)	(1,519,251.16)	(1,519,251.16)	(1,519,251.16)	(1,519,251.16)
Computer Software	(3,960,027)	(4,460,100.97)	(4,460,100.97)	(4,460,100.97)	(4,460,100.97)	(4,460,100.97)	(4,460,100.97)
Vehicles	(273,222)	(321,096.94)	(321,096.94)	(321,096.94)	(321,096.94)	(321,096.94)	(321,096.94)
TOTAL ACCUMLATED DEPRECIATION	(6,541,847)	(7,696,877)	(7,696,877)	(7,702,209)	(7,707,541)	(7,712,877)	(7,712,877)
FIXED ASSETS NET	3,139,061	2,456,043	2,456,043	2,470,711	2,465,379	2,460,043	2,460,043
ROU ASSETS							
ROU Asset-Op Lease (R/E)	13,153,355	15,659,055.57	15,659,055.57	15,659,055.57	15,659,055.57	15,659,055.57	15,659,055.57
ROU Asset A/D-Op Lease (R/E)	(3,693,370)	(6,094,178.69)	(6,094,178.69)	(6,094,178.69)	(6,094,178.69)	(6,094,178.69)	(6,094,178.69)
Op Lease Clearing	297,025	403,180.58	403,180.58	403,180.58	403,180.58	403,180.58	403,180.58
TOTAL ROU ASSETS	9,757,010	9,968,057	9,968,057	9,968,057	9,968,057	9,968,057	9,968,057
Customer Relationships	30,952	52,797.40	52,797.40	52,797.40	52,797.40	52,797.40	52,797.40
Goodwill	62,769,380	70,533,768.54	70,533,768.54	70,533,768.54	70,533,768.54	70,533,768.54	70,533,768.54
Tradename	1,355,498	1,355,497.67	1,355,497.67	1,355,497.67	1,355,497.67	1,355,497.67	1,355,497.67
MCare License	46,132,099	53,175,274.87	53,175,274.87	53,175,274.87	53,175,274.87	53,175,274.87	53,175,274.87
INTANGIBLE AND OTHER ASSETS, NET	110,287,929	125,117,338	125,117,338	125,117,338	125,117,338	125,117,338	125,117,338
L/T Prepaid	38,089	16,891.61	16,891.61	16,891.61	16,891.61	16,891.61	16,891.61

Deposits Utilities	6,782	7,379.00	7,379.00	7,379.00	7,379.00	7,379.00	7,379.00
Deposits Rent	292,992	321,637.82	321,637.82	321,637.82	321,637.82	321,637.82	321,637.82
CN Security Deposit				**17,753**	**18,272**	**18,807**	**19,424**
CN Start Up Costs				**62,000**	**62,000**	**62,000**	**62,000**
Escrow Deposits	562,500						
Other Long Term Assets	6,951,366	6,951,366	6,951,366	6,951,366	6,951,366	6,951,366	6,951,366
Restricted & Other Assets	7,851,729	7,297,275	7,297,275	7,377,027	7,377,546	7,378,082	7,378,699
TOTAL OTHER LONG TERM ASSETS	131,035,729	144,838,714	144,838,714	144,933,134	144,928,321	144,923,521	144,924,138
TOTAL ASSETS	198,363,491	187,482,716	187,482,716	187,713,366	188,344,577	189,533,159	191,367,269.4
LIABILITIES AND STOCKHOLDERS' EQUITY							
CURRENT LIABILITIES							
TRADE ACCOUNTS PAYABLE							
Accounts payable - trade **(INCLUDES CN)**	452,260	643,623.48	643,623.48	**764,129**	**808,627**	**867,951**	**934,475**
Accrued AP	2,890,140	3,093,246.01	3,093,246.01	3,093,246.01	3,093,246.01	3,093,246.01	3,093,246.01
Patient Refunds	(3,980)	20,556.95	20,556.95	20,556.95	20,556.95	20,556.95	20,556.95
Due:Prior Owners	(3,206,074)	(14,526,230.98)	(14,526,230.98)	(14,526,230.98)	(14,526,230.98)	(14,526,230.98)	(14,526,230.98)
TOTAL TRADE PAYABLES	132,347	(10,768,805)	(10,768,805)	(10,648,299)	(10,603,801)	(10,544,477)	(10,477,953)
ACCRUED WAGES AND RELATED LIABILITIES							
Accrued Payroll	11,060,599	7,493,818.26	7,493,818.26	7,493,818.26	7,493,818.26	7,493,818.26	7,493,818.26
Payroll Clearing	(167,785)	(160,771.58)	(160,771.58)	(160,771.58)	(160,771.58)	(160,771.58)	(160,771.58)
Garnishments Payable	10,118	21,060.73	21,060.73	21,060.73	21,060.73	21,060.73	21,060.73
Federal Payroll Taxes Payable	4,370,213	4,443,877.60	4,443,877.60	4,443,877.60	4,443,877.60	4,443,877.60	4,443,877.60
Deferred Payroll FICA Emergency	2,834,460	2,631,097.82	2,631,097.82	2,631,097.82	2,631,097.82	2,631,097.82	2,631,097.82
CN Payroll Liabilities				**104,563**	**149,755**	**202,369**	**262,405**
401K Employee W/H							
Due:EEF - Payroll Deductions							

Due:Ensign Foundation - Payroll Deductions							
Due:Finding Home Foundation - Payroll deduction	410	590	590	590	590	590	590
Accrued Vacation	2,747,710	3,412,947	3,412,947	3,412,947	3,412,947	3,412,947	3,412,947
TOTAL ACCRUED WAGES AND RELATED LIABILITIES	20,855,725	17,842,620	17,842,620	17,947,184	17,992,376	18,044,989	18,105,025
Accrued Workers Comp							
TOTAL ACCRUED INSURANCE	-	-	-	-	-	-	-
OTHER ACCRUED LIABILITIES							
Accrued Other	158,810	273,196.43	273,196.43	273,196.43	273,196.43	273,196.43	273,196.43
Accrued HSA Plan							
Deferred Revenue	28,067,542	11,027,346	11,027,346	11,027,346	11,027,346	11,027,346	11,027,346
Accrued Insurance Premiums	66,811	27,764	27,764	27,764	27,764	27,764	27,764
Real Property Taxes	7,989	10,339	10,339	10,339	10,339	10,339	10,339
Personal Property Taxes	1,505	3,944	3,944	3,944	3,944	3,944	3,944
Unprocessed Patient Refunds	2,042,371	2,202,572	2,202,572	2,202,572	2,202,572	2,202,572	2,202,572
Sales/Excise/B&O taxes	55,976	107,808	107,808	107,808	107,808	107,808	107,808
Hospice CAP Accrued	1,889,305	469,843	469,843	469,843	469,843	469,843	469,843
Facility Fund	157,595	224,185	224,185	224,185	224,185	224,185	224,185
TOTAL OTHER ACCRUED LIABILITIES	32,447,904	14,346,997	14,346,997	14,346,997	14,346,997	14,346,997	14,346,997
TOTAL CURRENT LIABILITIES	53,435,977	21,420,813	21,420,813	21,645,882	21,735,572	21,847,509	21,974,069
LONG TERM DEBT							
Deferred Rent Liability							
Op Lease Liability ST	3,123,194						
OP Lease Liability LT	11,634,419	17,858,252.22	17,858,252.22	17,858,252.22	17,858,252.22	17,858,252.22	17,858,252.22
Op Lease Liability A/D	(4,300,255)	(7,411,219.35)	(7,411,219.35)	(7,411,219.35)	(7,411,219.35)	(7,411,219.35)	(7,411,219.35)
TOTAL LONG TERM LIABILITIES	10,457,357	10,447,033	10,447,033	10,447,033	10,447,033	10,447,033	10,447,033
TOTAL LIABILITIES	63,893,334	31,867,846	31,867,846	32,092,915	32,182,605	32,294,542	32,421,102

STOCKHOLDERS' EQUITY							
Additional Paid-In-Capital	12,151,918	12,151,917.90	12,151,917.90	12,151,917.90	12,151,917.90	12,151,917.90	12,151,917.90
Spin RE Adjust - Adj	37,049,632	37,049,631.63	37,049,631.63	37,049,631.63	37,049,631.63	37,049,631.63	37,049,631.63
	54,655,908	54,655,908.11	54,655,908.11	54,655,908.11	54,655,908.11	54,655,908.11	54,655,908.11
Retained Earnings, Prior Year **(INCLUDES CN)**	103,857,458	103,857,458	103,857,458	103,857,458	103,857,458	103,857,458	103,857,458
Current Year Income **(INCLUDES CN)**	4,380,987	30,615,789	30,615,789	**30,615,789**	**30,621,370**	**31,162,891**	**32,239,535**
Total Stockholders' Equity	26,231,712	21,141,624	21,141,624	**21,147,205**	**21,683,145**	**22,218,268**	**22,849,174**
TOTAL LIABILITIES AND STOCKHOLDERS' EQUITY	134,470,157	155,614,870	155,614,870	155,620,451	156,161,972	157,238,617	158,946,167
	198,363,491	187,482,716	187,482,716	187,713,366	188,344,577	189,533,159	191,367,269.4
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CORNERSTONE HEALTHCARE INC +
ALL FOUR COUNTIES IS
For the Ten Months Ending
October 31, 2021

	2020	2021	2022	2023	2024	2025	2026
Total Net Home Health Revenue	98,267,134.16	136,834,182.79	136,834,182.79	136,834,182.79	136,834,182.79	136,834,182.79	136,834,182.79
Total Net Hospice Revenue	133,854,590.06	152,937,081.32	152,937,081.32	152,937,081.32	152,937,081.32	152,937,081.32	152,937,081.32
TOTAL NET CN HOSPICE REVENUE				**4,037,516.18**	**6,194,107.13**	**8,705,993.96**	**11,573,176.66**
Total Net Other Revenue	21,921,770.56	21,867,362.25	21,867,362.25	21,867,362.25	21,867,362.25	21,867,362.25	21,867,362.25
TOTAL NET REVENUE	254,043,494.78	311,638,626.36	311,638,626.36	315,676,142.54	317,832,733.49	320,344,620.32	323,211,803.02
DIRECT COSTS							
HH- Therapy Wages	19,220,438.70	27,422,607.70	27,422,607.70	27,422,607.70	27,422,607.70	27,422,607.70	27,422,607.70
HH- Therapy Benefits	4,478,498.13	6,495,684.93	6,495,684.93	6,495,684.93	6,495,684.93	6,495,684.93	6,495,684.93
HH- Therapy Mileage	1,155,452.80	1,528,945.62	1,528,945.62	1,528,945.62	1,528,945.62	1,528,945.62	1,528,945.62
HH - Therapy Other	1,937,682.70	2,916,598.27	2,916,598.27	2,916,598.27	2,916,598.27	2,916,598.27	2,916,598.27
Total Home Health Therapy	26,792,072.33	38,363,836.52	38,363,836.52	38,363,836.52	38,363,836.52	38,363,836.52	38,363,836.52
HH- CNA Wages	1,546,551.53	2,039,445.30	2,039,445.30	2,039,445.30	2,039,445.30	2,039,445.30	2,039,445.30
HH- CNA Benefits	504,052.83	657,154.16	657,154.16	657,154.16	657,154.16	657,154.16	657,154.16
HH- CNA Mileage	395,039.55	404,858.68	404,858.68	404,858.68	404,858.68	404,858.68	404,858.68
HH - CNA Other	22,119.35	21,780.41	21,780.41	21,780.41	21,780.41	21,780.41	21,780.41
Total Home Health CNA	2,467,763.26	3,123,238.55	3,123,238.55	3,123,238.55	3,123,238.55	3,123,238.55	3,123,238.55
HH- Nursing Wages	18,256,116.93	24,592,249.20	24,592,249.20	24,592,249.20	24,592,249.20	24,592,249.20	24,592,249.20
HH- Nursing Benefits	4,608,601.36	6,551,000.18	6,551,000.18	6,551,000.18	6,551,000.18	6,551,000.18	6,551,000.18
HH- Nursing Mileage	1,322,150.05	1,630,556.08	1,630,556.08	1,630,556.08	1,630,556.08	1,630,556.08	1,630,556.08
HH - Nursing Other	168,974.08	638,276.75	638,276.75	638,276.75	638,276.75	638,276.75	638,276.75
Total Home Health Skilled Nursing	24,355,842.42	33,412,082.21	33,412,082.21	33,412,082.21	33,412,082.21	33,412,082.21	33,412,082.21
HH - SS Wages	1,126,096.76	1,516,491.54	1,516,491.54	1,516,491.54	1,516,491.54	1,516,491.54	1,516,491.54
HH - SS Benefits	280,997.42	412,631.79	412,631.79	412,631.79	412,631.79	412,631.79	412,631.79
HH - SS Mileage	56,258.77	85,029.00	85,029.00	85,029.00	85,029.00	85,029.00	85,029.00
HH - SS Other	9,592.05	8,823.14	8,823.14	8,823.14	8,823.14	8,823.14	8,823.14

Total Home Health Social Services	1,472,945.00	2,022,975.47	2,022,975.47	2,022,975.47	2,022,975.47	2,022,975.47	2,022,975.47
HH - Supplies	1,686,752.72	2,641,839.34	2,641,839.34	2,641,839.34	2,641,839.34	2,641,839.34	2,641,839.34
HH - Other Direct Costs	29,135.98	25,453.35	25,453.35	25,453.35	25,453.35	25,453.35	25,453.35
TOTAL DIRECT COSTS - HOME HEALTH	56,804,511.71	79,589,425.44	79,589,425.44	79,589,425.44	79,589,425.44	79,589,425.44	79,589,425.44
Hospice- CNA Wages	4,205,846.34	5,474,276.98	5,474,276.98	5,474,276.98	5,474,276.98	5,474,276.98	5,474,276.98
Hospice- CNA Benefits	1,119,301.42	1,457,306.56	1,457,306.56	1,457,306.56	1,457,306.56	1,457,306.56	1,457,306.56
Hospice- CNA Mileage	695,464.48	892,375.42	892,375.42	892,375.42	892,375.42	892,375.42	892,375.42
Hospice - CNA Other	53,255.16	20,759.73	20,759.73	20,759.73	20,759.73	20,759.73	20,759.73
Total Hospice CNA	6,073,867.40	7,844,718.69	7,844,718.69	7,844,718.69	7,844,718.69	7,844,718.69	7,844,718.69
Hospice- Nursing Wages	19,283,933.72	22,911,050.71	22,911,050.71	22,911,050.71	22,911,050.71	22,911,050.71	22,911,050.71
Hospice- Nursing Benefits	4,094,054.55	5,205,467.13	5,205,467.13	5,205,467.13	5,205,467.13	5,205,467.13	5,205,467.13
Hospice- Nursing Mileage	919,030.13	1,107,907.51	1,107,907.51	1,107,907.51	1,107,907.51	1,107,907.51	1,107,907.51
Hospice - Nursing Other	149,864.59	281,344.18	281,344.18	281,344.18	281,344.18	281,344.18	281,344.18
Total Hospice Skilled Nursing	24,446,882.99	29,505,769.53	29,505,769.53	29,505,769.53	29,505,769.53	29,505,769.53	29,505,769.53
Hospice - SS Wages	3,665,257.39	4,447,027.34	4,447,027.34	4,447,027.34	4,447,027.34	4,447,027.34	4,447,027.34
Hospice - SS Benefits	750,588.97	994,695.11	994,695.11	994,695.11	994,695.11	994,695.11	994,695.11
Hospice - SS Mileage	166,859.40	223,168.08	223,168.08	223,168.08	223,168.08	223,168.08	223,168.08
Hospice - SS Other	7,004.76	2,894.58	2,894.58	2,894.58	2,894.58	2,894.58	2,894.58
Total Hospice Social Services	4,589,710.52	5,667,785.11	5,667,785.11	5,667,785.11	5,667,785.11	5,667,785.11	5,667,785.11
Hospice - Chaplain Wages	2,222,288.47	2,761,314.79	2,761,314.79	2,761,314.79	2,761,314.79	2,761,314.79	2,761,314.79
Hospice - Chaplain Benefits	464,210.10	561,487.87	561,487.87	561,487.87	561,487.87	561,487.87	561,487.87
Hospice - Chaplain Mileage	152,189.39	188,900.40	188,900.40	188,900.40	188,900.40	188,900.40	188,900.40
Hospice - Chaplain Other	2,195.45	1,862.69	1,862.69	1,862.69	1,862.69	1,862.69	1,862.69
Total Hospice Chaplain	2,840,883.41	3,513,565.75	3,513,565.75	3,513,565.75	3,513,565.75	3,513,565.75	3,513,565.75
Hospice - Volunteer Wages	511,478.36	692,949.08	692,949.08	692,949.08	692,949.08	692,949.08	692,949.08
Hospice - Volunteer Benefits	134,607.66	176,635.91	176,635.91	176,635.91	176,635.91	176,635.91	176,635.91
Hospice - Volunteer Mileage	12,571.02	25,939.32	25,939.32	25,939.32	25,939.32	25,939.32	25,939.32
Hospice - Volunteer Other	14,241.08	14,322.93	14,322.93	14,322.93	14,322.93	14,322.93	14,322.93
Total Hospice Volunteer	672,898.12	909,847.24	909,847.24	909,847.24	909,847.24	909,847.24	909,847.24
Hospice - Pharmacy	4,845,509.55	5,404,824.45	5,404,824.45	5,404,824.45	5,404,824.45	5,404,824.45	5,404,824.45
Hospice - Supplies	2,039,624.35	2,576,434.55	2,576,434.55	2,576,434.55	2,576,434.55	2,576,434.55	2,576,434.55

Hospice - DME	4,594,836.62	5,239,062.36	5,239,062.36	5,239,062.36	5,239,062.36	5,239,062.36	5,239,062.36
Hospice- Room and Board	10,425,330.43	9,269,751.82	9,269,751.82	9,269,751.82	9,269,751.82	9,269,751.82	9,269,751.82
Hospice - Respite and GIP	541,917.41	647,001.97	647,001.97	647,001.97	647,001.97	647,001.97	647,001.97
Hospice - Other Direct Costs	264,946.39	340,086.74	340,086.74	340,086.74	340,086.74	340,086.74	340,086.74
TOTAL DIRECT COSTS - HOSPICE	61,336,407.19	70,918,848.21	70,918,848.21	70,918,848.21	70,918,848.21	70,918,848.21	70,918,848.21
Palliative - Nursing Wages	110,088.59	251,189.55	251,189.55	251,189.55	251,189.55	251,189.55	251,189.55
Palliative - Nursing Benefits	26,766.22	54,318.04	54,318.04	54,318.04	54,318.04	54,318.04	54,318.04
Palliative - Supplies	3,202.86	7,563.05	7,563.05	7,563.05	7,563.05	7,563.05	7,563.05
Total Palliative Nursing	140,057.67	313,070.64	313,070.64	313,070.64	313,070.64	313,070.64	313,070.64
TOTAL DIRECT COSTS - PALLIATIVE	140,057.67	313,070.64	313,070.64	313,070.64	313,070.64	313,070.64	313,070.64
PD - Wages	9,236,224.76	9,738,899.99	9,738,899.99	9,738,899.99	9,738,899.99	9,738,899.99	9,738,899.99
PD - Benefits	1,554,567.51	1,736,129.54	1,736,129.54	1,736,129.54	1,736,129.54	1,736,129.54	1,736,129.54
PD - Mileage	264,257.21	306,908.91	306,908.91	306,908.91	306,908.91	306,908.91	306,908.91
PD - Supplies	9,579.54	11,964.90	11,964.90	11,964.90	11,964.90	11,964.90	11,964.90
PD - Other	95,720.18	629,508.55	629,508.55	629,508.55	629,508.55	629,508.55	629,508.55
TOTAL DIRECT COSTS - PRIVATE DUTY	11,160,349.20	12,423,411.89	12,423,411.89	12,423,411.89	12,423,411.89	12,423,411.89	12,423,411.89
Finding Home - Wages	2,020,499.53	1,664,163.48	1,664,163.48	1,664,163.48	1,664,163.48	1,664,163.48	1,664,163.48
Finding Home - Benefits	352,492.08	358,994.97	358,994.97	358,994.97	358,994.97	358,994.97	358,994.97
Finding Home - Mileage	13,706.25	20,276.65	20,276.65	20,276.65	20,276.65	20,276.65	20,276.65
Finding Home - Supplies	4,194.74	8,244.10	8,244.10	8,244.10	8,244.10	8,244.10	8,244.10
Finding Home - Other	145,903.14	358,572.78	358,572.78	358,572.78	358,572.78	358,572.78	358,572.78
TOTAL DIRECT COSTS - FINDING HOME	2,536,795.74	2,410,251.98	2,410,251.98	2,410,251.98	2,410,251.98	2,410,251.98	2,410,251.98
HOSPICE CN							
Registered Nurse				718,501.92	1,101,418.08	1,547,261.92	2,056,033.42
Certified Nursing Assistant				186,810.50	286,368.70	402,288.10	534,568.69
Licensed Clinical Social Worker				141,704.54	217,224.12	305,154.43	405,495.48
Spiritual Care Coordinator				111,766.96	171,331.70	240,685.19	319,827.42
Director of Clinical Services				164,656.69	252,408.31	354,580.86	471,174.33
Payroll Taxes & Benefits				397,032.18	608,625.28	854,991.15	1,136,129.80
Medical Director				98,353.29	150,910.36	212,100.34	281,923.21
Physical Therapist				2,283.76	3,500.86	4,917.97	6,535.10
Occupational Therapist				2,115.63	3,243.13	4,555.91	6,053.99

Speech Therapist				1,915.71	2,936.66	4,125.39	5,481.90
Dietitian				1,793.92	2,749.97	3,863.13	5,133.40
DME				132,000.78	202,348.86	284,257.80	377,727.61
Pharmacy				154,947.93	237,525.40	333,673.48	443,392.17
General Inpatient Costs				79,056.73	121,283.93	170,468.02	226,608.99
Medical Supplies				56,602.98	86,768.80	121,892.00	161,972.60
Inpatient Respite				175,296.38	268,928.85	377,987.15	502,471.30
Room and Board				9,834.50	15,075.66	21,178.15	28,141.96
Mileage				78,675.96	120,605.28	169,425.18	225,135.66
TOTAL DIRECT COSTS-CN HOSPICE				**2,513,350.36**	**3,853,253.94**	**5,413,406.16**	**7,193,807.04**
TOTAL DIRECT COSTS	131,978,121.51	165,655,008.16	165,655,008.16	168,168,358.51	169,508,262.09	171,068,414.32	172,848,815.19
HCHB	1,239,592.36	2,629,033.19	2,629,033.19	2,629,033.19	2,629,033.19	2,629,033.19	2,629,033.19
Administration-Wages	29,854,653.97	39,428,283.42	39,428,283.42	39,428,283.42	39,428,283.42	39,428,283.42	39,428,283.42
Administration-Benefits	6,086,692.64	8,246,761.72	8,246,761.72	8,246,761.72	8,246,761.72	8,246,761.72	8,246,761.72
Administration-Purchased Services	8,523,237.32	10,516,638.62	10,516,638.62	10,516,638.62	10,516,638.62	10,516,638.62	10,516,638.62
Administration-Insurance	905,226.10	1,343,431.91	1,343,431.91	1,343,431.91	1,343,431.91	1,343,431.91	1,343,431.91
Administration-Other	15,049,557.96	12,971,020.47	12,971,020.47	12,971,020.47	12,971,020.47	12,971,020.47	12,971,020.47
Total Administration	60,419,367.99	72,506,136.13	72,506,136.13	72,506,136.13	72,506,136.13	72,506,136.13	72,506,136.13
Marketing - Wages	8,775,534.56	10,706,065.55	10,706,065.55	10,706,065.55	10,706,065.55	10,706,065.55	10,706,065.55
Marketing - Benefits	1,677,793.94	2,065,164.39	2,065,164.39	2,065,164.39	2,065,164.39	2,065,164.39	2,065,164.39
Marketing - Mileage	212,013.89	303,164.21	303,164.21	303,164.21	303,164.21	303,164.21	303,164.21
Marketing - Activity Programs	1,316.75	3,179.19	3,179.19	3,179.19	3,179.19	3,179.19	3,179.19
Marketing - Other	883,718.94	1,178,120.21	1,178,120.21	1,178,120.21	1,178,120.21	1,178,120.21	1,178,120.21
Total Marketing	11,550,378.08	14,255,693.55	14,255,693.55	14,255,693.55	14,255,693.55	14,255,693.55	14,255,693.55
Occupancy - Utilities	257,465.42	308,838.18	308,838.18	308,838.18	308,838.18	308,838.18	308,838.18
Occupancy - Other	10,297.44	16,516.57	16,516.57	16,516.57	16,516.57	16,516.57	16,516.57
Total Occupancy	267,762.86	325,354.75	325,354.75	325,354.75	325,354.75	325,354.75	325,354.75
HOSPICE CN							
Administrator				210,000.00	210,000.00	210,000.00	210,000.00
Business Office Manager, Medical Records, Scheduling				99,791.93	152,974.73	214,897.49	285,560.20
Intake				167,440.00	174,121.17	181,809.10	190,503.78
Community Liaison				129,729.51	198,867.15	279,366.74	371,228.26
Payroll Taxes & Benefits				182,088.43	220,788.92	265,822.00	317,187.67

Advertising				56,375.16	61,941.07	87,059.94	115,731.77
Allocated Costs				219,430.23	336,636.26	473,151.85	628,976.99
B & O Taxes				65,829.07	100,990.88	141,945.55	188,693.10
Dues & Subscriptions				13,950.00	13,950.00	13,950.00	13,950.00
Education and trainings				31,000.00	31,000.00	31,000.00	31,000.00
Information Technology/Computer/Software Maintenance				46,500.00	46,500.00	46,500.00	46,500.00
Insurance				3,720.00	3,720.00	3,720.00	3,720.00
Legal and professional				0.00	0.00	0.00	0.00
Licenses and Fees				41,649.00	0.00	6,622.00	0.00
Postage				18,600.00	18,600.00	18,600.00	18,600.00
Purchased services				37,200.00	37,200.00	37,200.00	37,200.00
Repairs and Maintenance				5,580.00	5,580.00	5,580.00	5,580.00
Cleaning				7,812.00	7,812.00	7,812.00	7,812.00
Office supplies				9,300.00	9,300.00	9,300.00	9,300.00
Equipment lease & maintenance				18,600.00	18,600.00	18,600.00	18,600.00
Building rent or lease				71,010.00	73,086.00	75,228.00	77,696.52
Lease NNN or Common Area Maintenance charges				0.00	0.00	0.00	0.00
Recruitment				20,000.00	12,000.00	12,000.00	12,000.00
Telephones				31,647.56	40,332.01	50,442.50	61,979.02
Travel				26,000.00	20,000.00	20,000.00	20,000.00
TOTAL INDIRECT COST-CN HOSPICE				**1,513,252.89**	**1,794,000.19**	**2,210,607.16**	**2,671,819.30**
TOTAL INDIRECT COSTS	73,477,101.29	89,716,217.62	89,716,217.62	91,229,470.51	91,510,217.81	91,926,824.78	92,388,036.92
TOTAL COSTS	205,455,222.79	255,371,225.78	255,371,225.78	259,397,829.03	261,018,479.91	262,995,239.09	265,236,852.11
Bad Debt	(222.47)	11,753.13	11,753.13	11,753.13	11,753.13	11,753.13	11,753.13
TOTAL OPERATING EXPENSES	205,455,000.32	255,382,978.91	255,382,978.91	259,409,582.16	261,030,233.04	263,006,992.22	265,248,605.24
Service Center Allocation	12,554,525.42	16,494,849.70	16,494,849.70	16,494,849.70	16,494,849.70	16,494,849.70	16,494,849.70
EBITDAR	36,033,969.04	39,760,797.75	39,760,797.75	39,771,710.69	40,307,650.76	40,842,778.40	41,468,348.08
EBITDAR Margin	14.18%	12.76%	12.76%	12.60%	12.68%	12.75%	12.83%
Occupancy- Rent	3,750,368.09	4,970,311.46	4,970,311.46	4,970,311.46	4,970,311.46	4,970,311.46	4,970,311.46
Property Taxes	16,524.46	19,880.01	19,880.01	19,880.01	19,880.01	19,880.01	19,880.01
Total Property Expenses	3,766,892.55	4,990,191.47	4,990,191.47	4,990,191.47	4,990,191.47	4,990,191.47	4,990,191.47
EBITDA	32,267,076.49	34,770,606.28	34,770,606.28	34,781,519.22	35,317,459.29	35,852,586.93	36,478,156.61
EBITDA MARGIN	12.70%	11.16%	11.16%	11.02%	11.11%	11.19%	11.29%
Depreciation and Amortization	1,462,469.74	1,419,460.01	1,419,460.01	1,420,793.01	1,420,793.01	1,420,794.01	1,420,793.01

Gain or loss on disposal	318.71	(770.83)	(770.83)	(770.83)	(770.83)	(770.83)	(770.83)
Other income(expense) net	(225,000.00)	23,608.32	23,608.32	23,608.32	23,608.32	23,608.32	23,608.32
Earnings Before Interest & Tax	31,029,288.04	33,328,308.78	33,328,308.78	33,337,888.72	33,873,828.79	34,408,955.43	35,034,526.11
Interest	4,774,062.39	7,985,061.99	7,985,061.99	7,985,061.99	7,985,061.99	7,985,061.99	7,985,061.99
Earnings Before Income Taxes	26,255,225.65	25,343,246.79	25,343,246.79	25,352,826.73	25,888,766.80	26,423,893.44	27,049,464.12
NET INCOME	1,600.00	1,600.00	1,600.00	1,600.00	1,600.00	1,600.00	1,600.00
	26,253,625.65	25,341,646.79	25,341,646.79	25,351,226.73	25,887,166.80	26,422,293.44	27,047,864.12

EXHIBIT 11

King County Community Health Needs Assessment

2018/2019

King County Hospitals for a Healthier Community

Contents

Acknowledgements

King County Community Health Needs Assessment 2018/2019

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Introduction

King County hospitals play a valuable role in maintaining the health of the population. Our regional hospitals are committed to providing high-quality healthcare as well as supporting community health through specific initiatives designed to meet the needs of their constituents.

HISTORY

The King County Hospitals for a Healthier Community (HHC) collaborative is comprised of 11 hospital/health systems and Public Health - Seattle & King County (see Appendix C for full list of hospitals). The formation of the King County Hospitals for a Healthier Community collaborative in 2013 was notable in both the intent and effort of the hospitals to collectively examine regional health priorities. In addition to conducting a county-wide community health needs assessment, the collaborative allowed partners to dive deeper into health issues that they were addressing in common, e.g. health insurance enrollment and healthy eating. More importantly, the HHC has become a collective table for the sector in addressing population health, with representatives now sitting at King County's Health Enrollment Leadership Circle and the Governing Board of the King County Accountable Community of Health (KCACH).

VISION

The HHC vision is to participate in a collaborative approach that identifies community needs, assets, resources, and strategies towards assuring better health and health equity for all King County residents.

Each member recognized that the collective impact of working together could greatly exceed the work that any one hospital could achieve on its own. The collaborative was created to eliminate duplicative efforts; lead to the creation of an effective, sustainable process and stronger relationships between hospitals and public health; and, identify opportunities for joint efforts to improve the health and well-being of our communities. This shared approach to assessing needs helps hospital community benefit programs focus available resources to address the community's most critical health needs.

COMMITMENT TO HEALTH EQUITY

HHC members remain committed to working in pursuit of the "quadruple aim" of achieving health equity, optimizing health system performance by enhancing the patient experience of care, improving the health of populations, and reducing healthcare costs.

Introduction

Continued

PURPOSE

This report documents the community health needs of King County and provides a foundation to meet the Affordable Care Act (ACA) and Washington state requirement for non-profit hospitals to conduct a Community Health Needs Assessment (CHNA) every three years. This is the second CHNA conducted by the HHC. The collaborative CHNA is designed to highlight strengths and areas of need that cut across geographies, thereby presenting opportunities for collaboration between public health, hospitals, health systems, community organizations, and communities.

The 2018 CHNA also fulfills part of the Accountable Community of Health's Regional Health Needs Inventory (RHNI) requirements - another value to having over-arching cross-sector tables that can avoid redundancy, and that can make connections among related efforts.

REPORT METHODS

In crafting their approach to this report, HHC members defined health broadly and used a population-based community health framework to identify health needs and establish criteria for selecting key indicators within each health topic. Social, cultural, and environmental factors that affect health were considered throughout the process. Because health services account for only around 20 percent of overall health, this report highlights community health needs that will require clinical as well as non-clinical approaches by hospitals and health systems and their partners. This joint CHNA report provides baseline data on community health indicators for all hospitals to use and import for their own CHNA. This work also supports the hospital community benefit programs by providing data to describe community needs and highlight disparities, which can inform focused strategies to target communities experiencing inequities.

While hospitals and health systems reached consensus on a core set of topic areas, each hospital may also gather additional information specific to its service area.

Introduction

Continued

In accordance with the Affordable Care Act, this report includes:

1. **Community description**
2. **Leading causes of death**
3. **Levels of chronic illness**

In addition, this report provides quantitative information about the following identified health needs:

4. **Access to healthcare and use of preventive services**
5. **Mental health**
6. **Alcohol, tobacco, marijuana, and other drugs**
7. **Pregnancy and birth**
8. **Physical activity, nutrition, and weight**
9. **Violence and injury prevention**

Additional indicators for each health need as well as data for other health topics are online at www.kingcounty.gov/health/indicators. Detailed data are reported, when available, for neighborhoods, cities, and regions in King County, and by race/ethnicity, age, income/poverty, gender, and other demographic breakdowns. When possible, comparisons are also made to the Washington state average and Healthy People 2020 objectives for the health of all Americans (www.healthypeople.gov).

Community themes and priorities were gleaned from an inventory of over 40 community assessment/engagement reports conducted over the past 3 years. This year's report will include, as an addendum, a spotlight on the lesbian, gay, bisexual, transgender, and queer (LGBTQ) communities of King County. The addendum will examine the health disparities impacting this population. Three methods were used for the LGBTQ CHNA report addendum:

- Analysis of the Behavioral Risk Factor Surveillance System (BRFSS) survey data for the LGB adult population; and, analysis of the Healthy Youth Survey (HYS) data for the LGB school-age population
- Listening sessions with LGBTQ youth and young adults throughout the county
- Key informant interviews with thought leaders in the LGBTQ community

More details about the CHNA methodology are included in Appendix A.

Introduction

Continued

REPORT LIMITATIONS

There are some notable limitations to this report. First, for some topics of interest, we have incomplete or inadequate quantitative data and a lack of qualitative data to contextualize findings. The exception is the forthcoming LGBTQ spotlight, which will include qualitative findings from youth listening sessions and key informant interviews held throughout the county. Second, racial/ethnic comparisons are made using broad race categories based on a narrow range of options for self-identification in surveys. It is important to report data by race/ethnicity to track progress towards health equity. However, the vast diversity within race/ethnicity categories does not allow us to distinguish among ethnic groups or nationalities within categories. Our ability to report data by the many ethnic groups and nationalities living in King County is limited by sufficient sample sizes and how various surveys collect self-reported racial/ethnic data. Additionally, for some data sources, the most recently available data comes from 2015, not 2016 or 2017.

Finally, space and resource limitations prevent us from mentioning all of the valuable organizations and assets in our communities. A continuously updated statewide database of health and human service information and referrals for Washington state can be found at https://resourcehouse.info/win211/Index.

COMMUNITY STRENGTHS AND CHALLENGES

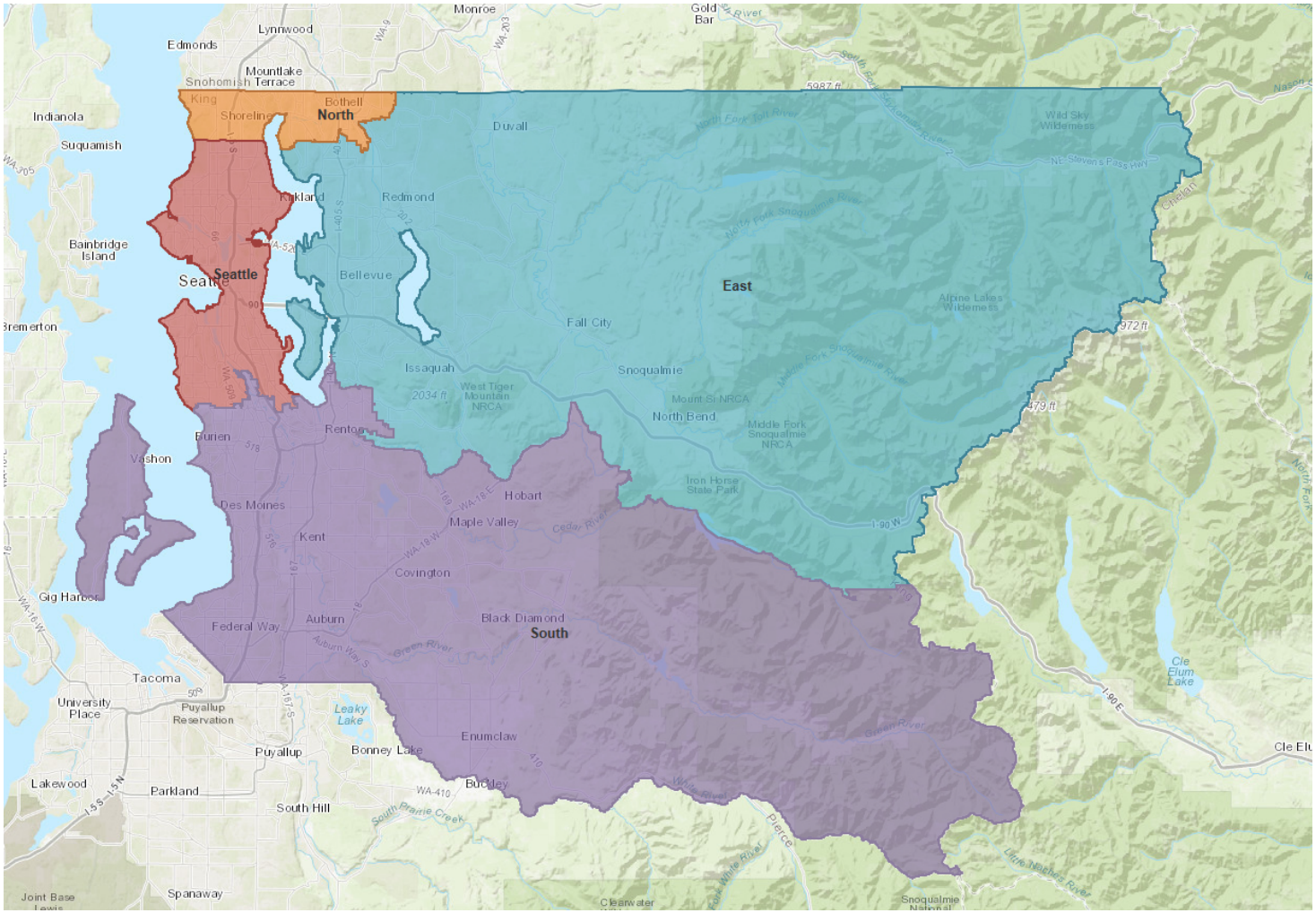
King County is often noted for its unique geographic location, providing close proximity to attractive outdoor features like the Puget Sound, many freshwater lakes, and the Cascade Range. In addition, the county includes both high-density cities like Seattle, as well as many rural areas where residents live and work. Overall, King County ranks among the top counties in the nation on measures of socioeconomic status, health, and well-being. Increasing racial/ethnic diversity, driven in part by immigration, contribute to the unique cultural strengths and assets that benefit the entire region.

Nevertheless, county residents continue to experience stark differences by place, race, and income. The places where we live, work, and play are major predictors of our life experiences. Together, these experiences greatly influence our ability to reach our full potential and thrive as productive members of society. In many ways, "place" is a proxy for opportunity, influencing our access to work, education, healthcare, food, and recreation.[1] Evaluating regional differences in health indicators helps identify neighborhoods with the greatest opportunities for improving health.

Introduction

Continued

King County regions



People of color and low-income residents are at disproportionate risk of being uninsured and having poor health and social outcomes. Many health and social indicators—such as housing quality, alcohol-related deaths, obesity, lack of health insurance, and smoking—show regional patterns of inequity. South King County is home to some of the most racially and ethnically diverse communities in our county, and experiences disparities in multiple health and social indicators. As development moves south, many low-income families will need to relocate to find affordable housing, likely increasing their distance from jobs, educational opportunities, and other resources.

Introduction

Continued

Despite these challenges, our county has an opportunity to learn how to better serve all residents in an era of rapidly expanding prosperity. Washington state and King County leadership continue to stand behind strategies to improve the health and well-being of local residents. This includes embracing the diversity of our communities and partnering with state and local government, community-based organizations, and others to be vocal about healthcare as a key value and priority in King County. Sustaining the gains in health coverage over the past 3 years is a key aspect of this work. Working together, hospitals, health systems, public health, community organizations and communities can improve living conditions and residents' ability to lead healthy lives and achieve their full potential. The success of any effort to fundamentally address health inequities will require meaningful consideration of the impacts of racial, social and economic factors on the health of King County residents. As an overarching assessment of health in King County, the county-wide CHNA provides a foundation for future community partnerships and well-aligned strategies that will succeed in responding to the inequities that it identifies.

WORKING TOGETHER TOWARDS HEALTHIER COMMUNITIES

Over the past three years, a number of King County initiatives have been implemented to address some of the key health challenges and disparities that face our community. The last CHNA report identified the need for increased collaboration among community-based organizations, governmental agencies, advocacy organizations, hospitals and health systems, and the private sector. The initiatives described below are notable as they are explicit in their engagement to assure cross-sector representation, where different stakeholders work collectively for a common purpose, commit to authentic community engagement, and strive to understand and support community-driven solutions.

King County Accountable Community of Health

The King County Accountable Community of Health (KCACH), partnering with the Healthier Washington initiative, seeks to transform health and healthcare by addressing social drivers of health via practice transformation, value-based purchasing, and use of performance measures. The emphasis is on prevention and recovery, coupled with a firm commitment

Introduction

Continued

to racial equity. As one of the state's nine ACHs, King County's regional partnership has identified four Medicaid transformation projects for which the KCACH will be accountable:

- Integrate health system and community approaches to better manage and control chronic disease;
- Reduce opioid-related death and illness through prevention, treatment and recovery support;
- Implement diversion strategies to promote more appropriate use of emergency care services and person-centered care through increased access to primary care and social services; and,
- Improve coordination of care for Medicaid enrollees through better integration of financing and delivery of physical and behavioral health services through Managed Care Organizations.

A major focus of the KCACH is bringing together diverse stakeholders and partners to implement the Medicaid transformation project demonstration in our county. This is a strategic opportunity to attract significant federal investment to our region to improve health outcomes and address the social and economic factors that impact health.

Physical and Behavioral Health Integration

An integrated healthcare system is one that is able to meet the physical and behavioral healthcare needs of an individual in a holistic, culturally responsive fashion where the individual is engaged in their care. The KCACH is moving forward with expanding bi-directional integration of physical and behavioral healthcare and including integration of oral health to offer more coordinated, whole-person care. This project reflects the KCACH's vision of "having a system that provides whole-person, patient-centered care" with a primary strategy of "building a bridge between medical, behavioral health, and community providers."

Bi-directional integration of healthcare will:

- Improve access to behavioral health through enhanced screening and treatment of behavioral health disorders in primary care settings;
- Expand access to physical health services for individuals with chronic behavioral health conditions through increased screening, identification, and treatment of physical health disorders in behavioral healthcare settings
- Improve active coordination of care among medical and behavioral health providers as well as addressing barriers to care; and

Introduction

Continued

- Align new bi-directional integration with existing, successful community efforts including addressing the social determinants of health.

Bi-directional integration of healthcare is the cornerstone of health systems transformation. Lack of care coordination is a significant driver of avoidable healthcare costs and poor outcomes for Medicaid beneficiaries as well as other consumers. Strengthening providers' ability and capacity to provide client-centered whole-person care, including stronger alignment with social determinant needs, will improve outcomes for the target population and strengthen the foundation for transforming the delivery system.

BEST STARTS FOR KIDS

The transformation called for by the 2013 King County Health and Human Services Transformation Plan to shift from a crisis and sick-care oriented system, to one focused on prevention, wellness, and the elimination of disparities, is now in action. King County voters approved the Best Starts for Kids (BSK) Levy (Ordinance 18088) in late 2015, creating a vital source of funding to build healthier communities. BSK is the most comprehensive approach to early childhood development in the nation. BSK invests in programs to promote healthier, more resilient families and communities, starting with prenatal support and continuing through teenage years. The levy generates $65 million annually for investments in prevention and early intervention for children, youth, families, and communities. After a year of community-informed planning in 2016, the Best Starts for Kids initiative established a Children and Youth Advisory Board.

While many BSK strategies are addressing access to services, some investments will focus on making systemic changes that drive health outcomes. These include investments in addressing the inequitable over-representation of youth of color in our juvenile justice system. This means changing practices and policies to do a better job of providing alternative pathways to success for our youth by re-building connections for youth within the education system and the economy.

Executive Summary

King County
Community Health
Needs Assessment
2018/2019

For the first time, more than half of King County children are children of color.

This Community Health Needs Assessment (CHNA) is a King County Hospitals for a Healthier Community (HHC) collaborative product that fulfills Section 9007 of the Affordable Care Act. In accordance with those requirements, the report presents a detailed **description of the community,** analyses of data on **life expectancy and leading causes of death**, and a review of levels of **chronic illness** throughout King County. In addition, this report provides quantitative information about additional community health needs that were identified by the HHC.

COMMUNITY INPUT

Local community needs assessments, strategic plans, and reports from the past three years were reviewed to identify community health needs and to provide context to the quantitative data presented. Key themes that emerged from these assessments of community health are presented in the Community Identified Priorities section of the report.

In addition, this year's spotlight on the lesbian, gay, bisexual, transgender, and queer (LGBTQ) communities of King County will examine the health disparities impacting these populations. The spotlight which will be released as an addendum to this report will include analyses of Behavioral Risk Factor Surveillance System (BRFSS) survey data for the LGB adult population; Healthy Youth Survey (HYS) data for the LGB school-age population; and qualitative findings from a series of listening sessions with LGBTQ youth and young adults throughout the county, and key informant interviews with thought leaders in LGBTQ communities.

Executive Summary

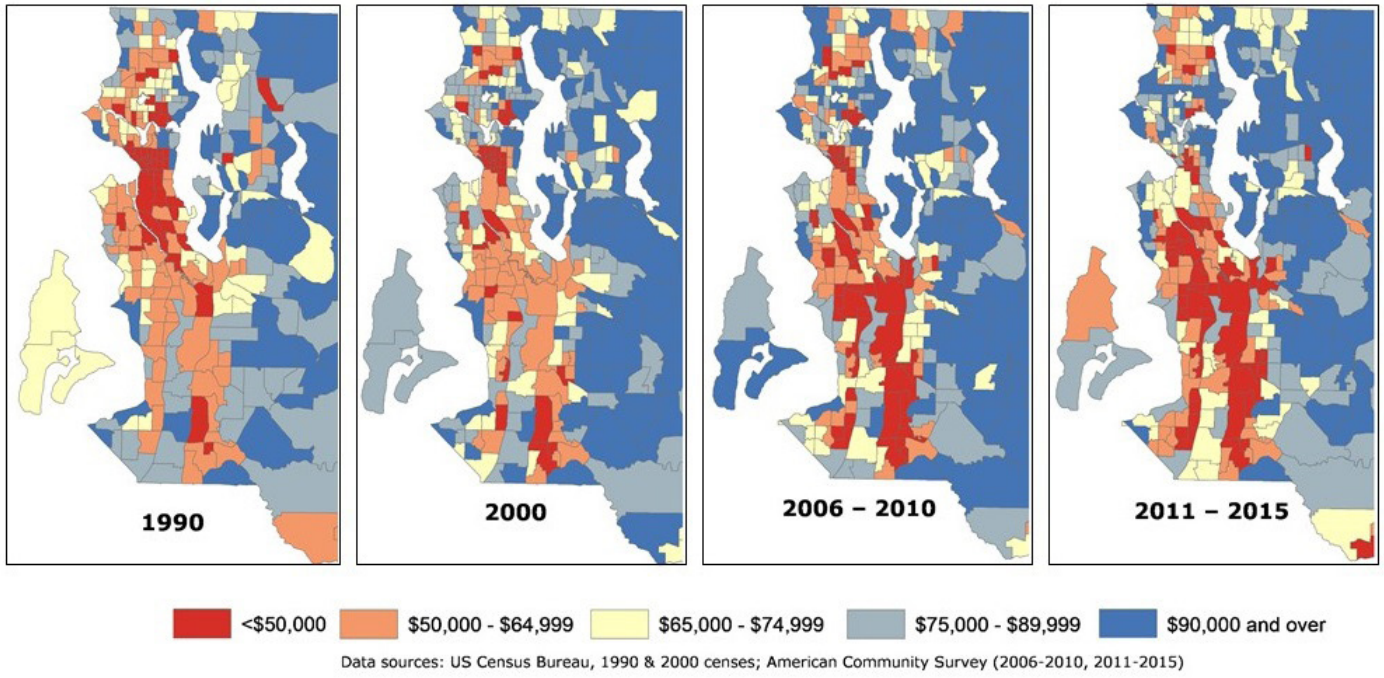
Continued

KING COUNTY'S CHANGING POPULATION

In the past three years, King County has experienced a substantial growth spurt – in population and diversity. For the first time, more than half of King County children are children of color. The population boom has occurred in tandem with rapid rises in the cost of housing – and in homelessness.

As housing costs skyrocketed, poverty has become more concentrated in South Region where, at least until recently, housing has been more affordable, especially for families with children. Life expectancy and a host of other health outcomes are linked to income – a link that may help explain why South Region residents often experience poorer health than residents of other regions. In addition, although babies born in King County in 2015 are expected to live longer than those born in 1990, national data suggest that improvements in life expectancy for those in the top income quartile are 2.5 times greater than for those in the bottom income quartile,[2] a difference that, over time, tends to magnify existing disparities.

Median household income by King County neighborhood, 1990-2015



Executive Summary

Continued

The population is aging: by 2040 almost 1 in 4 King County residents is projected to be age 60 or older – up from 1 in 7 in 2000.[3] The fastest-growing segment will be those 85 and older. Disability rates are highest for older adults (40% in King County), and per-person healthcare expenditures for adults age 65 and older have historically been 5 times greater than expenditures for children and 3 times greater than those for working-age adults.[4] Healthcare systems need to prepare for this important demographic shift with adequate workforce capacity and accessible services.

ACROSS KING COUNTY OVERALL, WHAT'S GETTING BETTER?

Although disparities remain, three county-wide successes stand out. These improvements occurred in the context of supportive policy changes – at the federal, state, county, city, and/or school levels.

- Since implementation of the Affordable Care Act, **health insurance coverage** has improved dramatically – for all ages, racial/ethnic groups, and cities.

- **Cigarette smoking** – still the leading preventable cause of death in the United States – has declined across regions, age groups, and racial/ethnic groups. The decline in youth smoking was accompanied by a county-wide decline in **youth substance use**.

- Fewer students in 8th, 10th, and 12th grades are **drinking sugar-sweetened beverages daily**, mirroring a national trend among high school students.[5]

ACROSS KING COUNTY OVERALL, WHAT'S FAILING TO IMPROVE OR GETTING WORSE?

Although many indicators showed little or no improvement, the following have special relevance for healthcare providers:

- In the context of escalating housing prices, **student homelessness in King County** has more than doubled since 2008, reaching 8,411 (nearly 3% of enrolled students) in the 2015-16 school year. More than half of the students were in elementary school or pre-kindergarten. In addition, the 2017 Point-In-Time Count identified 11,643 individuals experiencing homelessness, 50% of whom had one or more disabling conditions.

- **Insufficient physical activity** is associated with obesity, which in turn is linked to diabetes and other chronic diseases (including 4 in 10 cancers diagnosed in the United States).[6] Fewer than 1 in 4 adults and youth get the recommended amount of exercise. This represents no change for adults, and modest but inadequate improvement for 8th, 10th, and 12th graders, given the importance of physical activity to health.

Executive Summary

Continued

- The overall **obesity** rate for King County adults has been flat since 2009 (at more than 1 in 5 adults). Nationally, adult obesity levels rose for decades, stabilized between 2003 and 2012, then rose again slightly for women.[7] At 22%, the 2015 adult obesity rate in King County was significantly lower than the Washington state rate of 26%, and the national rate of 29% (although the 2011-2015 rate in South Region matches the national rate, at 29%).[8] For King County youth, obesity has held steady around 9% since 2004 except in South Region, where it has increased. In comparison, high school students nationally experienced a steady increase in obesity from 1999 to 2013, which appeared to level off at a higher rate -14% in 2015.

- **Although new data about food insecurity have not been collected since 2013**, we know that use of food assistance services is often associated with food insecurity. By 2016, participation in the Basic Food program (formerly food stamps) had not returned to pre-recession levels and was increasing for older adults, especially in South Region. A similar pattern was found for visits to King County food banks.

- Regarding **mental health**, 30% of youth reported feeling sad or hopeless for 2 or more consecutive weeks, to the extent that they stopped doing some of their usual activities; this has gotten worse since 2004 in King County overall, driven by increases in this indicator among youth in South Region. Among adults, the percentage experiencing psychological distress has not changed since the last report.

- **Drug-related deaths**, especially those related to heroin and methamphetamine, increased dramatically between 2010 and 2016.

HOW IS INCOME LINKED TO HEALTH?

Despite overall improvements in some areas, we find consistent income/poverty gradients in health outcomes (also often reflected in racial/ethnic differences). Many of these patterns tell a story in which inequitable access to care and prevention – especially early in life – sets the stage for later health concerns. The following sets of indicators showed robust links to measures of economic prosperity; usually median income or neighborhood poverty (family economic data were not available for measures of health-related behaviors and outcomes for youth).

Income Gradients for Determinants of Health

- **Access to care and use of preventive services:** Notable differences by income included ***health insurance coverage*** (a 7-fold difference between adults in high- and low-poverty neighborhoods, even after implementation of the Affordable Care Act); having ***unmet medical needs*** due to cost (8-fold difference between adults in the highest and lowest income tiers), ***incomplete childhood vaccines***, meeting ***screening guidelines for colorectal cancer*** (adults), having had a ***dental visit in the past year*** (adults), and ***having dental caries*** before 3rd grade (young children).

Executive Summary

Continued

- **Pregnancy, childbirth, and the first years of life:** Income differences favoring higher incomes were found for ***early and adequate prenatal care, low birth weight***, and ***infant mortality***.

- **Adult physical activity and weight:** Adults in the lowest income tier were 1.5 times as likely to be ***obese*** as those with the highest incomes, and high-income adults were 1.6 times as likely as those with the lowest incomes to ***meet physical activity guidelines***.

- **Tobacco:** Adults with the lowest incomes were 4 times as likely as those with the highest incomes to ***smoke cigarettes***.

Income Gradients for Health Outcomes

- **Chronic diseases:** Adults with the lowest incomes were at least twice as likely as those with the highest incomes to have a ***disability,*** or diagnoses of ***diabetes*** or ***asthma.***

- **Mental health:** Adults in the lowest income tier were almost 15 times as likely as high-income adults to have experienced ***serious psychological distress*** in the past month.

- **Hospitalizations:** Residents in high-poverty neighborhoods were most likely to be hospitalized for ***unintentional injuries*** and for ***suicide attempts***.

- **Life expectancy and types of cancer:** Consistent with national findings, King County residents of low-poverty neighborhoods live longer than those in high-poverty neighborhoods. And residents of high-poverty neighborhoods are most likely to be diagnosed with lung and kidney cancers (both strongly associated with smoking, one of the income-linked behavioral determinants of health).

HOW IS PLACE RELEVANT TO HEALTH?

Recent analyses also found persistent (and increasing) disparities by geographic location, or place. We focus primarily on King County's South Region, which also has the highest concentration of poverty, plus disproportionate representations of people of color and immigrants (half of whom settle in South Region), and significant linguistic diversity. One in four South Region adults has a bachelor's degree, compared to more than half of adults in each of the county's other regions. Not surprisingly, a close look at South Region reveals some of the same disparities that emerged when we focused on poverty.

Executive Summary

Continued

Determinants of Health by Location

Access to care and use of preventive services: South Region residents had the lowest rates of ***health insurance*** and ***annual dental visits by adults***, and the highest rate of ***unmet medical needs*** due to cost.

Pregnancy, childbirth, and the first years of life: South Region mothers were least likely to get ***early and adequate prenatal care***; South Region also had the highest rates of ***infant mortality*** and ***incomplete vaccines***. Also, the proportion of East Region mothers getting ***early and adequate prenatal care*** has declined sharply.

Physical activity, weight, and nutrition: Daily consumption of sugar-sweetened beverages by youth was highest among South Region youth, and South Region was the only region where youth obesity was getting worse.

Tobacco: South Region had the highest rate of adult smoking, and was the only region where the county-wide decline in adult smoking did not continue after 2006.

Health Outcomes by Location

Chronic diseases: South Region adults had the county's highest rates of ***disability*** and ***diabetes***, and the ***diabetes*** rate is rising in South and East regions. There were no regional differences for child or adult asthma.

Mental health: South Region youth are increasingly likely to experience ***depressive feelings.***

Hospitalizations and suicide deaths: The rate of ***unintentional injury hospitalizations*** is decreasing county-wide. The rate in South Region remains higher than other regions. The rate of ***suicide death*** is increasing in South Region.

Analyses often spotlight South Region as an area of concern, in part because of concentrated poverty. Drilling a bit deeper into the most recent data, we find meaningful differences among South Region neighborhoods. For example, while the rate for ***early and adequate prenatal care*** was below the county average in most South King County neighborhoods near the I-5 corridor (all neighborhoods in Auburn, Federal Way, and Kent, 2 of Renton's 3 neighborhoods, and SeaTac/Tukwila), South Region neighborhoods that did not differ from the county average included those with Puget Sound waterfront (Burien, Des Moines/Normandy Park, Vashon Island) and more rural areas considerably inland from I-5 (Black Diamond/Enumclaw/SE County, Covington/Maple Valley, Fairwood).

Executive Summary

Continued

Health concerns are not confined to South Region. For example, the proportion of mothers receiving ***early and adequate prenatal care*** in East Region has declined significantly since 2000. According to the most recent data, mothers in Seattle and North Region were more likely than East Region mothers to get ***early and adequate prenatal care***. Closer examination revealed that 3 of the 14 King County neighborhoods with rates below the 2011-2015 county average were in Bellevue. In another departure from the focus on South Region, ***suicide hospitalization*** was most likely for residents of Seattle and North Region, and the East Region rate increased significantly from 2000 to 2015.

HOW ARE RACE AND ETHNICITY RELEVANT TO HEALTH?

Racial and ethnic disparities in health and social outcomes persist throughout the county. People of color in King County are more likely to be uninsured and to have poor health outcomes. Across a number of health and social indicators, both whites and Asians fare better than others. However, national data suggest that the aggregate category of "Asians" masks disparities within the Asian category. There is a large body of evidence that demonstrates disparities in health outcomes, particularly for Southeast Asians compared to other Asian ethnicities. This is true of other races as well. For example, existing data do not permit us to disaggregate Somali, Ethiopian, and other emerging African communities from multi-generational African-American communities. Nevertheless, the presence of disparities by race/ethnicity underscore the need to further explore the causes of inequities that result in disparate outcomes and identify solutions.

Determinants of Health by Race/Ethnicity

- **Access to care and use of preventive services:** Although ***health insurance coverage*** has improved overall, most communities of color remain disproportionately uninsured. In 2016, Hispanic adults were least likely of all racial/ethnic groups to have healthcare coverage, with an uninsured rate nearly 3 times the county average. Black and Hispanic residents were most likely to report having ***unmet medical needs*** due to cost.

- **Pregnancy, childbirth, and the first years of life:** American Indian/Alaska Native, Black, Hispanic, and Native Hawaiian/Pacific Islander mothers were less likely than Asians and whites to get ***early and adequate prenatal care***. Black and American Indian/Alaska Native infants experienced the highest rates of ***low birth weight*** and ***infant mortality***. Rates of ***low birth weight*** among Asian infants were also higher than the county average; however, they had the lowest rates of ***infant mortality***.

Executive Summary

Continued

- **Physical activity, weight, and nutrition:** Adult *obesity* rates were lowest for Asians and highest for American Indians/Alaska Natives; among youth, *obesity* rates were lowest for Asians and whites and significantly higher for all other groups. Asian and Hispanic youth were least likely to meet ***physical activity*** standards.

- **Tobacco:** Among 8th, 10th, and 12th graders, American Indian/Alaska Native youth were significantly more likely than white, Black, Hispanic, and Asian youth to use ***tobacco*** – nearly 4 times as likely as Asian youth to smoke cigarettes.

Health Outcomes by Race/Ethnicity

- **Chronic diseases:** *Diabetes* rates among Black adults were significantly higher than the county average and nearly twice the rate among Asian adults. The rate of ***asthma*** among American Indians/Alaska Natives is 4 times that of Asian adults.

- **Mental health:** Hispanic, Native Hawaiian/Pacific Islander, American Indian/Alaska Native, and multiple-race youth were more likely than Asian, Black, and white youth to experience ***depressive feelings.***

- **Suicide and homicide deaths:** *Suicide deaths* were higher than the county average for whites and American Indians/Alaska Natives in King County. Homicide deaths, however, were much higher for Black residents than for any other group, at more than 5 times the county average.

- **Life expectancy, causes of death, and types of cancer:** At 86.3 years, life expectancy is highest among Hispanic and Asian residents; Native Hawaiian/Pacific Islanders (75.0 years) have the lowest life expectancy of all racial/ethnic groups in King County. All racial/ethnic groups share heart disease and cancer as the top 2 causes of death. Among types of cancer, liver cancer is most common among American Indians/Alaska Natives; prostate cancer most prevalent among Black males; cervical cancer highest for Hispanic and Black women. Breast cancer is highest among white women – although Black women are most likely to die from breast cancer. Although the numbers are low due to low population size, Native Hawaiians/Pacific Islanders have strikingly high rates of breast, lung, colorectal, and uterine cancers.

Executive Summary

Continued

SUMMARY OF HEALTH TOPICS

Determinants of Health

Access to Care and Use of Preventive Services: Access to ***health insurance*** improved substantially after implementation of the Affordable Care Act (ACA), and in the year after ACA implementation fewer adults reported ***not being able to see a doctor because of cost***. Children who live in high-poverty neighborhoods were least likely to have completed the ***vaccinations recommended for young children*** by 35 months. More than 1 in 3 adults age 50-75 failed to meet ***colorectal cancer screening guidelines***. Low-income adults were least likely to use preventive services such as colorectal cancer screening and ***regular dental visits***. Adults in South Region were least likely to report seeing a dentist in the past year – a trend that is getting worse, but only in South Region. About 4 in 10 King County preschoolers, kindergarteners, and 2nd and 3rd graders had experienced ***dental caries***. White children were less likely than children of all other races/ethnicities to have had dental caries.

Pregnancy, childbirth, and the first years of life: Seven in 10 of King County's expectant mothers received ***early and adequate prenatal care***, but substantial disparities by poverty and race/ethnicity persist. Pregnant women in South Region were significantly less likely than those in other regions to get early and adequate prenatal care (67.3%), and the rate of ***early and adequate prenatal care*** in East Region has decreased since the last report. Disparities in birth outcomes reported in 2015/2016 have not diminished.

Physical Activity, Weight, & Nutrition: While the proportion of 8th, 10th, and 12th grade students meeting federal standards for ***physical activity*** has increased, fewer than 1 in 4 students met the criteria – the same rate as adults (who showed no improvement). Among even the highest-income adults, only 26% met federal standards. Although there were no racial/ethnic differences among adults, Asian and Hispanic students were least likely to meet physical activity standards. For youth, physical activity did not differ by region, but South Region adults were significantly less likely to meet standards.

Almost 1 in 10 King County students in 8th, 10th, and 12th grades were ***obese***, with males and students who identify as lesbian, gay, or bisexual having rates above the county average. Student obesity rates have been flat since 2004 or falling in all regions of the county except South Region where it is rising. Adults were more than twice as likely as youth to be obese, with highest rates for those with the lowest incomes, American Indians/Alaska Natives and Blacks, and those age 45-64. Unlike youth, obesity in adults did not differ by gender or sexual orientation.

Executive Summary

Continued

Fifteen percent of youth reported ***drinking sugar-sweetened beverages (SSB) daily.*** Females, Asians, and whites reported the lowest rates of daily SSB consumption, while students in South Region were most likely to drink sugary beverages.

Tobacco & Other Drugs: *Cigarette smoking* has dropped for youth and adults across all age groups and regions, although the South Region decline for adults has stalled since 2006. Among both youth and adults, American Indians/Alaska Natives reported the highest rates. While there were no gender differences among youth, male adults were more likely than females to smoke. For youth and adults, those who identified as lesbian, gay, or bisexual (LGB) were more likely than heterosexuals to smoke cigarettes. Combining 8th, 10th, and 12th graders, only 5% smoked cigarettes; for 12th graders alone, 10% reported smoking. Adults in the lowest income tier were 4 times more likely to smoke than adults with the highest incomes.

The proportion of 8th, 10th, and 12th graders who reported ***using alcohol, marijuana, painkillers (to get high) or any illicit drugs*** – 1 in 4 – has declined since 2004. As with other risky behaviors, youth substance use increased with age, with a 4-fold difference between the rates for 12th graders and 8th graders. Although there were no gender differences, substance use among LGB youth was 1.5 times the rate for heterosexual youth.

King County ***deaths related to prescription opioids*** dropped from 2010 to 2016. During the same period, deaths related to heroin more than doubled, and those related to methamphetamine increased more than 6-fold. According to a recent survey, heroin and other opiates were injection drug users' drugs of choice; 20% of respondents had experienced a non-fatal overdose in the past year. Although almost 8 out of 10 respondents expressed interest in reducing or stopping opioid use, fewer than 3 in 10 were currently in treatment.

Health Outcomes

Life expectancy and leading causes of death: An infant born in King County in 2015 can expect to live to age 81.9 – longer than in most parts of the United States, but no different from King County life expectancy in 2009. Within the county, differences in ***life expectancy*** are linked to poverty and location and can be as great as 10 years. Similarly, age-adjusted ***death rates***, which declined for decades, plateaued after 2010, possibly because the decrease in deaths from cardiovascular disease was offset by increases in deaths from Alzheimer's disease. Cancer and heart disease are still the ***leading causes of death*** in King County. In childhood and early adulthood (younger than 45), males are much more likely than females to die. There are also notable disparities by neighborhood poverty.

Executive Summary

Continued

Chronic Illnesses: In King County 7% of adults have been told by a doctor that they have ***diabetes***. Disparities by income, geography, and race/ethnicity were substantial: at least 10% of Blacks, American Indians/Alaska Natives, and Native Hawaiians/Pacific Islanders reported a diabetes diagnosis. Diabetes rates are rising in South and East Regions and for Hispanics and whites.

Seven percent of King County children and 9% of adults had ***asthma***, although no age or regional differences were identified in either group. Although income was not linked to childhood asthma, adult asthma was most common in low-income households. Asians had the lowest rate of adult asthma -- the only significant racial/ethnic difference in either children or adults. Between 2000 and 2015, however, asthma rates increased only for white adults. In adults only, females were more likely than males to have asthma. Adults who identified as lesbian, gay, or bisexual were more likely than heterosexual adults to suffer from asthma.

The ***leading causes of adult hospitalization*** are pregnancy/childbirth, heart disease, injuries, and mental illness. Males are still more likely than females to be hospitalized for heart disease. ***Leading causes of hospitalization for children*** are respiratory infections, injuries, and mental illness.

The top three types of cancer in King County are lung, prostate, and breast cancer. Native Hawaiians/Pacific Islanders, Blacks, and whites had the highest rates of breast, prostate, colon, and lung cancers.

Mental Health: The proportion of ***youth with depressive feelings*** has increased across the county. Rates were higher than the county average for female and LGB students, as well as those who live in South Region and those who were Hispanic, Native Hawaiian/Pacific Islander, American Indian/Alaska Native and multiple-race. Although the proportion of King County adults with ***serious psychological distress*** was considerably lower (4%), there was a 15-fold difference between the lowest and highest income groups and a 2-fold difference between LGB and heterosexual adults. Of all racial/ethnic groups, Asian adults had the lowest rates of serious psychological distress.

Violence and Injury Prevention: *Hospitalization for unintended injuries* was most likely for males, for adults age 65 and older, for residents of high-poverty neighborhoods, and for residents of South Region. The overall decline in King County ***suicide hospitalizations*** since 2000 masks opposing regional trends – a significant increase in East Region and a decrease in South Region. Suicide hospitalization rates were highest in Seattle and North Region, lowest in East Region. Adults age 18-24 had higher rates

King County Community Health Needs Assessment

2018/2019

King County Hospitals for a Healthier Community

Contents

Acknowledgements

King County Community Health Needs Assessment 2018/2019

Public Health-Seattle & King County
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Executive Summary

King County
Community Health
Needs Assessment
2018/2019

For the first time, more than half of King County children are children of color.

This Community Health Needs Assessment (CHNA) is a King County Hospitals for a Healthier Community (HHC) collaborative product that fulfills Section 9007 of the Affordable Care Act. In accordance with those requirements, the report presents a detailed **description of the community,** analyses of data on **life expectancy and leading causes of death**, and a review of levels of **chronic illness** throughout King County. In addition, this report provides quantitative information about additional community health needs that were identified by the HHC.

COMMUNITY INPUT

Local community needs assessments, strategic plans, and reports from the past three years were reviewed to identify community health needs and to provide context to the quantitative data presented. Key themes that emerged from these assessments of community health are presented in the Community Identified Priorities section of the report.

In addition, this year's spotlight on the lesbian, gay, bisexual, transgender, and queer (LGBTQ) communities of King County will examine the health disparities impacting these populations. The spotlight which will be released as an addendum to this report will include analyses of Behavioral Risk Factor Surveillance System (BRFSS) survey data for the LGB adult population; Healthy Youth Survey (HYS) data for the LGB school-age population; and qualitative findings from a series of listening sessions with LGBTQ youth and young adults throughout the county, and key informant interviews with thought leaders in LGBTQ communities.

Executive Summary

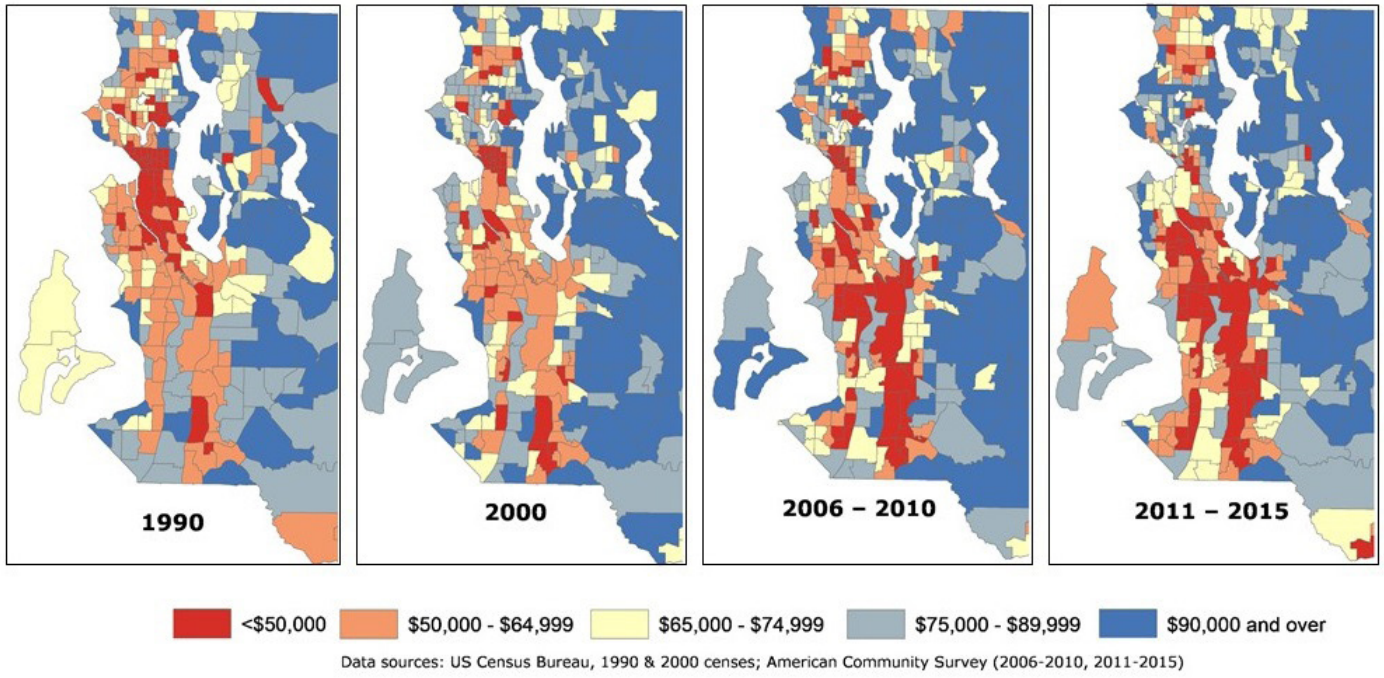
Continued

KING COUNTY'S CHANGING POPULATION

In the past three years, King County has experienced a substantial growth spurt – in population and diversity. For the first time, more than half of King County children are children of color. The population boom has occurred in tandem with rapid rises in the cost of housing – and in homelessness.

As housing costs skyrocketed, poverty has become more concentrated in South Region where, at least until recently, housing has been more affordable, especially for families with children. Life expectancy and a host of other health outcomes are linked to income – a link that may help explain why South Region residents often experience poorer health than residents of other regions. In addition, although babies born in King County in 2015 are expected to live longer than those born in 1990, national data suggest that improvements in life expectancy for those in the top income quartile are 2.5 times greater than for those in the bottom income quartile,[2] a difference that, over time, tends to magnify existing disparities.

Median household income by King County neighborhood, 1990-2015



Executive Summary

Continued

The population is aging: by 2040 almost 1 in 4 King County residents is projected to be age 60 or older – up from 1 in 7 in 2000.[3] The fastest-growing segment will be those 85 and older. Disability rates are highest for older adults (40% in King County), and per-person healthcare expenditures for adults age 65 and older have historically been 5 times greater than expenditures for children and 3 times greater than those for working-age adults.[4] Healthcare systems need to prepare for this important demographic shift with adequate workforce capacity and accessible services.

ACROSS KING COUNTY OVERALL, WHAT'S GETTING BETTER?

Although disparities remain, three county-wide successes stand out. These improvements occurred in the context of supportive policy changes – at the federal, state, county, city, and/or school levels.

- Since implementation of the Affordable Care Act, **health insurance coverage** has improved dramatically – for all ages, racial/ethnic groups, and cities.

- **Cigarette smoking** – still the leading preventable cause of death in the United States – has declined across regions, age groups, and racial/ethnic groups. The decline in youth smoking was accompanied by a county-wide decline in **youth substance use**.

- Fewer students in 8th, 10th, and 12th grades are **drinking sugar-sweetened beverages daily**, mirroring a national trend among high school students.[5]

ACROSS KING COUNTY OVERALL, WHAT'S FAILING TO IMPROVE OR GETTING WORSE?

Although many indicators showed little or no improvement, the following have special relevance for healthcare providers:

- In the context of escalating housing prices, **student homelessness in King County** has more than doubled since 2008, reaching 8,411 (nearly 3% of enrolled students) in the 2015-16 school year. More than half of the students were in elementary school or pre-kindergarten. In addition, the 2017 Point-In-Time Count identified 11,643 individuals experiencing homelessness, 50% of whom had one or more disabling conditions.

- **Insufficient physical activity** is associated with obesity, which in turn is linked to diabetes and other chronic diseases (including 4 in 10 cancers diagnosed in the United States).[6] Fewer than 1 in 4 adults and youth get the recommended amount of exercise. This represents no change for adults, and modest but inadequate improvement for 8th, 10th, and 12th graders, given the importance of physical activity to health.

Executive Summary

Continued

- The overall **obesity** rate for King County adults has been flat since 2009 (at more than 1 in 5 adults). Nationally, adult obesity levels rose for decades, stabilized between 2003 and 2012, then rose again slightly for women.[7] At 22%, the 2015 adult obesity rate in King County was significantly lower than the Washington state rate of 26%, and the national rate of 29% (although the 2011-2015 rate in South Region matches the national rate, at 29%).[8] For King County youth, obesity has held steady around 9% since 2004 except in South Region, where it has increased. In comparison, high school students nationally experienced a steady increase in obesity from 1999 to 2013, which appeared to level off at a higher rate -14% in 2015.

- **Although new data about food insecurity have not been collected since 2013**, we know that use of food assistance services is often associated with food insecurity. By 2016, participation in the Basic Food program (formerly food stamps) had not returned to pre-recession levels and was increasing for older adults, especially in South Region. A similar pattern was found for visits to King County food banks.

- Regarding **mental health**, 30% of youth reported feeling sad or hopeless for 2 or more consecutive weeks, to the extent that they stopped doing some of their usual activities; this has gotten worse since 2004 in King County overall, driven by increases in this indicator among youth in South Region. Among adults, the percentage experiencing psychological distress has not changed since the last report.

- **Drug-related deaths**, especially those related to heroin and methamphetamine, increased dramatically between 2010 and 2016.

HOW IS INCOME LINKED TO HEALTH?

Despite overall improvements in some areas, we find consistent income/poverty gradients in health outcomes (also often reflected in racial/ethnic differences). Many of these patterns tell a story in which inequitable access to care and prevention – especially early in life – sets the stage for later health concerns. The following sets of indicators showed robust links to measures of economic prosperity; usually median income or neighborhood poverty (family economic data were not available for measures of health-related behaviors and outcomes for youth).

Income Gradients for Determinants of Health

- **Access to care and use of preventive services:** Notable differences by income included ***health insurance coverage*** (a 7-fold difference between adults in high- and low-poverty neighborhoods, even after implementation of the Affordable Care Act); having ***unmet medical needs*** due to cost (8-fold difference between adults in the highest and lowest income tiers), ***incomplete childhood vaccines***, meeting ***screening guidelines for colorectal cancer*** (adults), having had a ***dental visit in the past year*** (adults), and ***having dental caries*** before 3rd grade (young children).

Executive Summary

Continued

- **Pregnancy, childbirth, and the first years of life:** Income differences favoring higher incomes were found for ***early and adequate prenatal care, low birth weight***, and ***infant mortality***.

- **Adult physical activity and weight:** Adults in the lowest income tier were 1.5 times as likely to be ***obese*** as those with the highest incomes, and high-income adults were 1.6 times as likely as those with the lowest incomes to ***meet physical activity guidelines***.

- **Tobacco:** Adults with the lowest incomes were 4 times as likely as those with the highest incomes to ***smoke cigarettes***.

Income Gradients for Health Outcomes

- **Chronic diseases:** Adults with the lowest incomes were at least twice as likely as those with the highest incomes to have a ***disability,*** or diagnoses of ***diabetes*** or ***asthma.***

- **Mental health:** Adults in the lowest income tier were almost 15 times as likely as high-income adults to have experienced ***serious psychological distress*** in the past month.

- **Hospitalizations:** Residents in high-poverty neighborhoods were most likely to be hospitalized for ***unintentional injuries*** and for ***suicide attempts***.

- **Life expectancy and types of cancer:** Consistent with national findings, King County residents of low-poverty neighborhoods live longer than those in high-poverty neighborhoods. And residents of high-poverty neighborhoods are most likely to be diagnosed with lung and kidney cancers (both strongly associated with smoking, one of the income-linked behavioral determinants of health).

HOW IS PLACE RELEVANT TO HEALTH?

Recent analyses also found persistent (and increasing) disparities by geographic location, or place. We focus primarily on King County's South Region, which also has the highest concentration of poverty, plus disproportionate representations of people of color and immigrants (half of whom settle in South Region), and significant linguistic diversity. One in four South Region adults has a bachelor's degree, compared to more than half of adults in each of the county's other regions. Not surprisingly, a close look at South Region reveals some of the same disparities that emerged when we focused on poverty.

Executive Summary

Continued

Determinants of Health by Location

Access to care and use of preventive services: South Region residents had the lowest rates of ***health insurance*** and ***annual dental visits by adults***, and the highest rate of ***unmet medical needs*** due to cost.

Pregnancy, childbirth, and the first years of life: South Region mothers were least likely to get ***early and adequate prenatal care***; South Region also had the highest rates of ***infant mortality*** and ***incomplete vaccines***. Also, the proportion of East Region mothers getting ***early and adequate prenatal care*** has declined sharply.

Physical activity, weight, and nutrition: Daily consumption of sugar-sweetened beverages by youth was highest among South Region youth, and South Region was the only region where youth obesity was getting worse.

Tobacco: South Region had the highest rate of adult smoking, and was the only region where the county-wide decline in adult smoking did not continue after 2006.

Health Outcomes by Location

Chronic diseases: South Region adults had the county's highest rates of ***disability*** and ***diabetes***, and the ***diabetes*** rate is rising in South and East regions. There were no regional differences for child or adult asthma.

Mental health: South Region youth are increasingly likely to experience ***depressive feelings.***

Hospitalizations and suicide deaths: The rate of ***unintentional injury hospitalizations*** is decreasing county-wide. The rate in South Region remains higher than other regions. The rate of ***suicide death*** is increasing in South Region.

Analyses often spotlight South Region as an area of concern, in part because of concentrated poverty. Drilling a bit deeper into the most recent data, we find meaningful differences among South Region neighborhoods. For example, while the rate for ***early and adequate prenatal care*** was below the county average in most South King County neighborhoods near the I-5 corridor (all neighborhoods in Auburn, Federal Way, and Kent, 2 of Renton's 3 neighborhoods, and SeaTac/Tukwila), South Region neighborhoods that did not differ from the county average included those with Puget Sound waterfront (Burien, Des Moines/Normandy Park, Vashon Island) and more rural areas considerably inland from I-5 (Black Diamond/Enumclaw/SE County, Covington/Maple Valley, Fairwood).

Executive Summary

Continued

Health concerns are not confined to South Region. For example, the proportion of mothers receiving ***early and adequate prenatal care*** in East Region has declined significantly since 2000. According to the most recent data, mothers in Seattle and North Region were more likely than East Region mothers to get ***early and adequate prenatal care***. Closer examination revealed that 3 of the 14 King County neighborhoods with rates below the 2011-2015 county average were in Bellevue. In another departure from the focus on South Region, ***suicide hospitalization*** was most likely for residents of Seattle and North Region, and the East Region rate increased significantly from 2000 to 2015.

HOW ARE RACE AND ETHNICITY RELEVANT TO HEALTH?

Racial and ethnic disparities in health and social outcomes persist throughout the county. People of color in King County are more likely to be uninsured and to have poor health outcomes. Across a number of health and social indicators, both whites and Asians fare better than others. However, national data suggest that the aggregate category of "Asians" masks disparities within the Asian category. There is a large body of evidence that demonstrates disparities in health outcomes, particularly for Southeast Asians compared to other Asian ethnicities. This is true of other races as well. For example, existing data do not permit us to disaggregate Somali, Ethiopian, and other emerging African communities from multi-generational African-American communities. Nevertheless, the presence of disparities by race/ethnicity underscore the need to further explore the causes of inequities that result in disparate outcomes and identify solutions.

Determinants of Health by Race/Ethnicity

- **Access to care and use of preventive services:** Although ***health insurance coverage*** has improved overall, most communities of color remain disproportionately uninsured. In 2016, Hispanic adults were least likely of all racial/ethnic groups to have healthcare coverage, with an uninsured rate nearly 3 times the county average. Black and Hispanic residents were most likely to report having ***unmet medical needs*** due to cost.

- **Pregnancy, childbirth, and the first years of life:** American Indian/Alaska Native, Black, Hispanic, and Native Hawaiian/Pacific Islander mothers were less likely than Asians and whites to get ***early and adequate prenatal care***. Black and American Indian/Alaska Native infants experienced the highest rates of ***low birth weight*** and ***infant mortality***. Rates of ***low birth weight*** among Asian infants were also higher than the county average; however, they had the lowest rates of ***infant mortality***.

Executive Summary

Continued

- **Physical activity, weight, and nutrition:** Adult *obesity* rates were lowest for Asians and highest for American Indians/Alaska Natives; among youth, *obesity* rates were lowest for Asians and whites and significantly higher for all other groups. Asian and Hispanic youth were least likely to meet ***physical activity*** standards.

- **Tobacco:** Among 8th, 10th, and 12th graders, American Indian/Alaska Native youth were significantly more likely than white, Black, Hispanic, and Asian youth to use ***tobacco*** – nearly 4 times as likely as Asian youth to smoke cigarettes.

Health Outcomes by Race/Ethnicity

- **Chronic diseases:** *Diabetes* rates among Black adults were significantly higher than the county average and nearly twice the rate among Asian adults. The rate of ***asthma*** among American Indians/Alaska Natives is 4 times that of Asian adults.

- **Mental health:** Hispanic, Native Hawaiian/Pacific Islander, American Indian/Alaska Native, and multiple-race youth were more likely than Asian, Black, and white youth to experience ***depressive feelings.***

- **Suicide and homicide deaths:** *Suicide deaths* were higher than the county average for whites and American Indians/Alaska Natives in King County. Homicide deaths, however, were much higher for Black residents than for any other group, at more than 5 times the county average.

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Executive Summary

Continued

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Chronic Illnesses: In King County 7% of adults have been told by a doctor that they have ***diabetes***. Disparities by income, geography, and race/ethnicity were substantial: at least 10% of Blacks, American Indians/Alaska Natives, and Native Hawaiians/Pacific Islanders reported a diabetes diagnosis. Diabetes rates are rising in South and East Regions and for Hispanics and whites.

Seven percent of King County children and 9% of adults had ***asthma***, although no age or regional differences were identified in either group. Although income was not linked to childhood asthma, adult asthma was most common in low-income households. Asians had the lowest rate of adult asthma -- the only significant racial/ethnic difference in either children or adults. Between 2000 and 2015, however, asthma rates increased only for white adults. In adults only, females were more likely than males to have asthma. Adults who identified as lesbian, gay, or bisexual were more likely than heterosexual adults to suffer from asthma.

The ***leading causes of adult hospitalization*** are pregnancy/childbirth, heart disease, injuries, and mental illness. Males are still more likely than females to be hospitalized for heart disease. ***Leading causes of hospitalization for children*** are respiratory infections, injuries, and mental illness.

The top three types of cancer in King County are lung, prostate, and breast cancer. Native Hawaiians/Pacific Islanders, Blacks, and whites had the highest rates of breast, prostate, colon, and lung cancers.

Mental Health: The proportion of ***youth with depressive feelings*** has increased across the county. Rates were higher than the county average for female and LGB students, as well as those who live in South Region and those who were Hispanic, Native Hawaiian/Pacific Islander, American Indian/Alaska Native and multiple-race. Although the proportion of King County adults with ***serious psychological distress*** was considerably lower (4%), there was a 15-fold difference between the lowest and highest income groups and a 2-fold difference between LGB and heterosexual adults. Of all racial/ethnic groups, Asian adults had the lowest rates of serious psychological distress.

Violence and Injury Prevention: *Hospitalization for unintended injuries* was most likely for males, for adults age 65 and older, for residents of high-poverty neighborhoods, and for residents of South Region. The overall decline in King County ***suicide hospitalizations*** since 2000 masks opposing regional trends – a significant increase in East Region and a decrease in South Region. Suicide hospitalization rates were highest in Seattle and North Region, lowest in East Region. Adults age 18-24 had higher rates

Executive Summary

Continued

than all other age groups, and adults in high-poverty neighborhoods were almost twice as likely as those in low-poverty neighborhoods to be hospitalized after a suicide attempt.

Although there were no regional differences in ***suicide deaths***, this rate has been rising in South Region since 2000. In King County, males were 3 times more likely than females to commit suicide. Older adults (ages 45-64 and 65+) were most likely to commit suicide. Unlike suicide hospitalizations, suicide deaths did not differ by poverty level. King County's most recent suicide rate (12.2 per 100,000 population) was 4.5 times the rate of homicides (2.7 deaths per 100,000). Among racial/ethnic groups, whites were most likely (13.8 per 100,000), while Asians (6.6 per 100,000) and Blacks (7.4 per 100,000) were least likely to commit suicide. The opposite pattern was found for homicide deaths, where the rate for Black residents was 14.1 per 100,000 – more than 5 times the county average.

HOSPITALS FOR A HEALTHIER COMMUNITY (HHC) PRIORITIES

By aligning hospital/health system priorities with the community identified priorities that were gathered through various focus groups, interviews, and community conversations – the Hospitals for a Healthier Community collaborative works jointly as well as individually to address the following areas:

1. Mental health & substance use disorders

2. Access to care & transportation

3. Physical health with a focus on obesity, cancer, & diabetes

4. Housing & homelessness

HHC members continue to create opportunities to collaborate between public health, health systems, community organizations, as well as communities. In addition, efforts to leverage and align goals across many other initiatives, such as HealthierHere (King County's Accountable Community of Health) encourages agencies to collectively invest in data, programs, and policies that create equitable and targeted interventions for these identified health areas.

Executive Summary

Continued

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Community Identified Priorities

To enhance our understanding of King County residents' priorities, we reviewed over 40 community needs assessments, strategic plans, or reports – many with community engagement components and all conducted over the past three years. Themes shared across the documents included:

- Support for youth and families
- Support for older adults
- Equity and social determinants of health
- Housing and homelessness
- Access to healthcare

A variety of community engagement activities conducted by community and governmental organizations confirmed the themes as priorities and enabled King County residents to elaborate on them. These exchanges also identified strategies, community assets, and resources. Though not a comprehensive list of all assets and resources, examples of work being done around the shared themes are highlighted in the sections below. Beyond specific programs and policies, most King County communities share a broad set of assets that help shift the balance toward health and well-being.

Nearly every community report highlighted the need for safe and affordable housing as an important issue.

Community Identified Priorities

Continued

SUPPORT FOR YOUTH AND FAMILIES

Community conversations revealed strong interest in services that support King County infants, youth, and families, especially early learning opportunities that were both more affordable and culturally relevant. Communities called for:

- **More Early Head Start programs.** Limited access to child care subsidies for those who don't qualify for current Head Start or ECEAP subsidies was mentioned as a significant barrier.
- **More free and low-cost options for child care.**
- **Access to child care services for children with special needs**, as well as options for crisis and respite care.
- **Keeping kids engaged through after-school programs and summer activities.** Middle-school-aged children especially need safe spaces after school and strong mentorship opportunities, since this is a crucial transition stage.
- **Supporting youth to develop into confident and productive adults.** This includes:
  - » A focus on socio-emotional development with training in communication, decision-making, self-advocacy, skill building, and healthy relationships
  - » Substance abuse and violence prevention
  - » Dropout re-engagement programs
  - » Academic support to increase graduation rates
  - » College preparation and career planning

Assets

King County voters approved the Best Starts for Kids (BSK) Levy (Ordinance 18088) in late 2015, creating a vital source of funding to build healthier communities. While many BSK strategies address access to services, BSK is also investing in systemic changes that provide alternative paths to success for our youth. This means changing practices and policies to do a better job of re-building connections for youth with the education system and the economy. It is considered the most comprehensive approach to childhood development in the United States.

Community Identified Priorities

Continued

SUPPORT FOR OLDER ADULTS

A common set of concerns for older adults emerged in the priorities highlighted by cities, the county, local aging support services, and in community conversations. These included:

- Increase in older adults experiencing poverty and food insecurity
- Need for affordable housing
- Need for assistance with navigation of the healthcare system
- Need for appropriate transportation
- Need for sustainable systems of caregiving
- Addressing the needs of aging women

Housing was a major concern for older adults, especially those with low, and often fixed, incomes. King County seniors who participated in community conversations described additional barriers to affordable housing based on personal histories – such as past evictions, debts, or poor credit. Economic security can help buffer the challenges of growing older. Without economic security, older adults may experience hunger and a variety of negative health and social outcomes that are exacerbated by poverty.

Many older adults also need support in navigating the healthcare system – from understanding their health insurance coverage to scheduling appointments. Participants in community conversations stressed the importance of culturally competent health and human services. Case management and navigation assistance were also priorities, especially for those in vulnerable groups like veterans and people with disabilities.

Many older adults are challenged by limited transportation options and physical isolation from their communities – either because they live in rural areas or because of physical circumstances that limit their mobility. Residents of rural, suburban, and urban settings emphasized the importance of creating more sustainable systems of caregiving by (a) ensuring that caregivers are paid well and given adequate support, and (b) decreasing reliance on volunteer service, which can be inconsistent.

The needs of aging women were highlighted, as women have longer life expectancies than men and often face greater financial hardship since they generally earn less than men. These pay gaps particularly affect women of color and LGBTQ women. Older women in the workforce are especially vulnerable to economic hardship, as they routinely take on caregiving responsibilities for other family members (typically unpaid), and can lose their income due to changes in their mobility, personal health, or access to transportation and other support systems.

Community Identified Priorities

Continued

Assets

Several assets for supporting older adults were identified:

- In late 2017, King County voters renewed the existing Veterans and Human Services Levy and broadened it to support older adults and their caregivers. The new Veterans, Seniors and Human Services Levy increases investments in housing stability, healthy living, social engagement, financial stability, and support systems for older adults.

- With an extensive network of community partners, Community Living Connections – Seattle & King County helps adults dealing with aging and disability issues (including older adults, adults with disabilities, caregivers, families, and professionals) get the information and support they need by streamlining access to programs and services through a "no wrong door" model.

- Washington's new Medicaid Transformation Demonstration Waiver includes two innovative programs, Medicaid Alternative Care (MAC) and Tailored Support for Older Adults (TSOA), to support unpaid family caregivers.

- In The Washington State Plan to Address Alzheimer's Disease and other Dementias, consumer and public-private stakeholders are working to prepare the state to meet the challenges of dementia and Alzheimer's disease, which in King County is expected to increase more than 2-fold, from 27,887 residents in 2015 to 67,797 residents in 2040.

Community Identified Priorities

Continued

EQUITY & SOCIAL DETERMINANTS OF HEALTH

To strengthen communities and improve the health of King County residents, we need to address **deeply rooted inequities by race and place,** repeatedly documented in this report. The seeds of many disparities were sown by a history of selective disinvestment in certain communities. Multiple community reports stressed the importance of:

- **Providing resources equitably**
- **Incorporating equity into all community efforts**
- **Targeting support to groups with the highest needs**

Input from across the county revealed concerns over racial and socioeconomic disparities in education, health and human services, environment, transportation, justice and public safety, and economic development. Community members noted:

- **Racial inequities in school dropout rates, disciplinary actions, and matriculation to higher education.**
- **Difficulties in accessing health and human services** for people of color, undocumented immigrants, and members of tribal communities.
- **Worse environmental conditions** for people of color and residents of lower-income neighborhoods, which were described as requiring longer commutes and having less access to healthy food, fewer trees, more traffic, and more harmful environmental exposures than more prosperous neighborhoods.
- **Lack of transportation services in rural areas, especially for people with disabilities.**
- **Diversion of city services** towards gentrified neighborhoods.
- **Overrepresentation in the prison population of people of color,** who were also more likely to be profiled by law enforcement.

Community Identified Priorities

Continued

Unequal access to economic opportunity was expressed as a concern, particularly in a county experiencing a rapid expansion of population and jobs. Community members called out the higher poverty rates experienced by immigrants, refugees, African Americans, Hispanics, and Native populations, and noted that unequal access to jobs was an ongoing challenge for residents of color in King County. Enduring power inequities, as reflected in the history of redlining and current gentrification trends in parts of Seattle, have limited opportunities for African Americans to purchase homes, develop wealth, and sustain stable communities.

Access to affordable and healthy food is a shared priority across King County communities. In many communities, problems with access to food are compounded by low wages, unaffordable housing, and the increasing costs of other basic needs such as childcare, transportation, and healthcare. Community members reporting on this issue made it clear that food insecurity cannot be separated from systemic problems of poverty, transportation, and housing.

Assets

Across the county, concerned government bodies, non-profit organizations, faith organizations, and community members are investing in efforts to better understand and respond to these inequities, addressing issues such as food justice, housing access, and economic opportunity.

- The Communities of Opportunity (COO) initiative, launched in 2014 by the Seattle Foundation and King County, focuses on places, policies, and systems changes to strengthen community connections and lead to more equitable health, housing, and economic outcomes. Through investments in community-led partnerships, COO supports organizations working to increase health, housing, and economic opportunities through policy and systems reform. Importantly, communities are driving the initiative, which is governed by a coalition of leaders from communities, philanthropy, and county government.

Community Identified Priorities

Continued

HOUSING & HOMELESSNESS

Nearly every community report highlighted housing affordability as a key issue. Summaries of community members' input described the crucial role that stable and safe housing plays in maintaining a sense of community connection and overall quality of life. Residents in parts of South King County, where housing costs are relatively lower than other regions, expressed concerns over impending displacement as housing costs continue to rise.

Local organizations assessing the needs of LGBTQ residents called out housing and personal safety as major concerns. Many prioritized reducing the overrepresentation of youth who identify as LGBTQ and youth of color among those experiencing homelessness.

More broadly, community members expressed grave concern about homelessness and the disproportionate distribution of its burden across King County communities. While acknowledging that the county struggles to develop sufficient resources to meet the needs of our homeless populations, many residents were dismayed that, in the midst of our region's robust "economic recovery," homelessness continues to increase.

Assets

In late 2017, Best Starts for Kids announced that, after only one year in operation, partners in its Youth and Family Homelessness Prevention Initiative had prevented more than 3,000 people from becoming homeless. BSK's flexible approach enabled case managers to meet the specific needs of people on the verge of homelessness, such as assistance with landlord negotiations, employment, and utility bills.

Community Identified Priorities

Continued

ACCESS TO HEALTHCARE

King County has an abundance of healthcare resources – specifically a high ratio of primary care physicians per capita and the existence of several large hospital systems. However, community residents who participated in a local hospital needs assessments ranked **"access to healthcare" as their number one health need,** and described problems including:

- Lack of mental health services
- Language barriers
- System navigation
- Transportation and location of facilities
- Wait times and hours of operation
- Access to specialty care services
- Inability to pay

Mental, behavioral, and addiction services were repeatedly cited as insufficient and difficult to access. In Seattle, residents described steep cultural barriers, as mental health remains a taboo topic in many populations. Rural and suburban residents complained that sufficient mental health resources simply do not exist, especially for school-aged children in Maple Valley, Enumclaw, and Covington.

Despite the expansion of Medicaid and health insurance marketplaces, specific barriers to accessing care persist for residents in rural areas, low-income residents, and some communities of color. These issues were especially noted among American Indian/Alaska Native children and residents of low-income households and the South King County area. Many residents said they could get coverage, but were not eligible for subsidies or Medicaid and could not afford the premiums. Even among those with coverage, many face ongoing challenges with finding specialty care, adult dental care, and behavioral health services. High deductibles and co-pays still impede access to care when residents are forced to choose between healthcare and other basic needs.

Community Identified Priorities

Continued

Assets

The King County Accountable Community of Health (KCACH) will be a major driver of healthcare delivery system reform in the coming years. This new, cross-sector entity is charged with regional implementation of the Medicaid Transformation Demonstration Project, an 1115 Medicaid waiver. The KCACH brings together leaders from the hospital industry, managed care organizations, community clinics, community-based organizations, local government and more to work collaboratively on innovative approaches to providing whole-person care. The KCACH is launching a portfolio of four key projects focused on health promotion and prevention and healthcare delivery system redesign. The focus for these projects includes, 1) bi-directional integration of physical and behavioral health; 2) transitional care for Medicaid beneficiaries leaving hospitals, jail, or psychiatric inpatient care; 3) addressing the opioid crisis; and 4) coordination of care for chronic disease prevention and control. The KCACH will also address cross-cutting needs related to workforce development, health information technology, and support for the move to value-based purchasing.

COMMUNITY VOICES: A CONTEXT FOR UNDERSTANDING

This review of community reports and perspectives has enhanced our appreciation for the diverse experiences of the many populations living in our county. We can paint a truer and more comprehensive portrait of health in King County when we're able to pair our quantitative estimates for community health indicators with the voices of the people who live, work, and play here. These subjective insights provide the context needed to interpret the patterns we see in the data and are especially important in a county that is growing and changing so rapidly. Incorporating the insights of community residents and workers into our understanding of health needs will help us design interventions that are appropriately targeted and sustainable on a community level.

Description of Community

Since the last CHNA, the economic boom has been acutely felt by longtime residents and new arrivals alike. While we see greater diversity in our county, the diverse communities in the North and South are not the same as those in Seattle and East Regions. Driving this boom is the strong tech sector that is dramatically reshaping our population demographics. The increase in tech jobs has sparked record setting growth, with an influx of young, highly educated, high income earners in the Seattle and East Regions, creating one of the most competitive housing markets in the nation.[9] This influx has resulted in displacement of many residents further North and South in search of affordable housing options. The impacts of displacement include: increased time spent commuting rather than being home with family, shopping for, preparing and eating meals together, or having time and access to opportunities for physical activity – all of which contribute to disproportionate rates of chronic disease and early death. The effects of these complex challenges to wellness can be seen in regional and economic disparities in health outcomes outlined throughout the report. Although disparities remain in many health indicators, some county-wide successes stand out as well, as described in the Executive Summary and corresponding report sections.

Economic development favors those who can take advantage of it, while marginalizing those at lower economic strata and increasing their health risks.

Description of Community

Continued

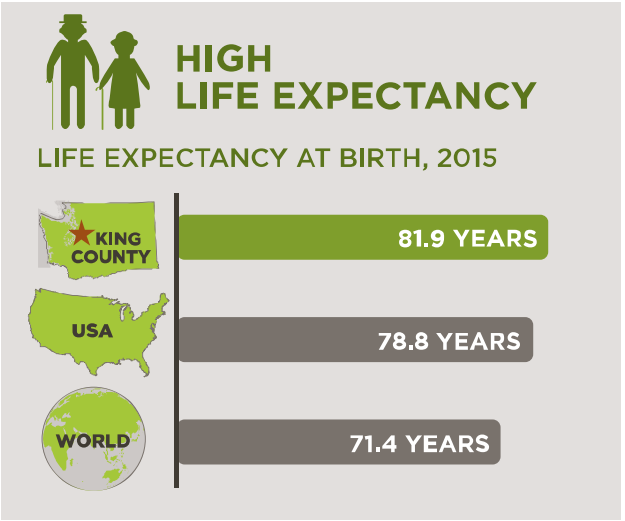
INTRODUCTION

King County is the 13th most populous county in the United States, with an estimated 2016 population of over 2 million and growing. In addition to Seattle, King County includes 38 cities and several unincorporated areas, making it the largest metropolitan county in the State of Washington in population, number of cities, and employment.[10] The county is divided into four geographic regions.[11] With an estimated 741,000 residents, South Region is home to over a third of the county's population – more than Seattle (687,000), East Region (549,000), and North Region (128,000).[i] Across the four regions, 20 school districts and 11 hospital and health systems serve King County families.

King County ranks among the top counties in the U.S. on measures of health and wealth. Life expectancy is in the 95th percentile among US counties, at 82 years.[12] The population is highly educated, with 48% of residents having at least a bachelor's degree, compared to 31% nationally. King County has been at the center of Washington's economic recovery since 2010, following the most recent national recession.[13] With multiple booming industries and unemployment at its lowest rate since 2008,[14] many families are thriving. Median household income has steadily increased, reaching more than $25,000 higher than the national average in 2015.

[i] *Washington State Office of Financial Management, Forecasting & Research Division. State of Washington 2016 Population Trends [report] and Small Area Estimates Program (SAEP) estimates. 2016. https://www.ofm.wa.gov/washington-data-research/population-demographics/population-estimates/small-area-estimates-program. Accessed December 1, 2017.*

However, the success of all residents is challenged by geographic, racial/ethnic, and socioeconomic disparities that negatively impact many communities. Despite high rankings on measures of socioeconomic status and health, county residents continue to experience stark differences in social and health outcomes by place, race, and income. Life expectancy varies widely by neighborhood, with gaps of more than 10 years between neighborhoods with the highest and lowest life expectancies. People in affluent areas have greater access to environments and other resources that encourage healthy behaviors. The convergence of these factors, plus disparities in educational attainment, household income, and health insurance coverage can profoundly influence the health of our communities.

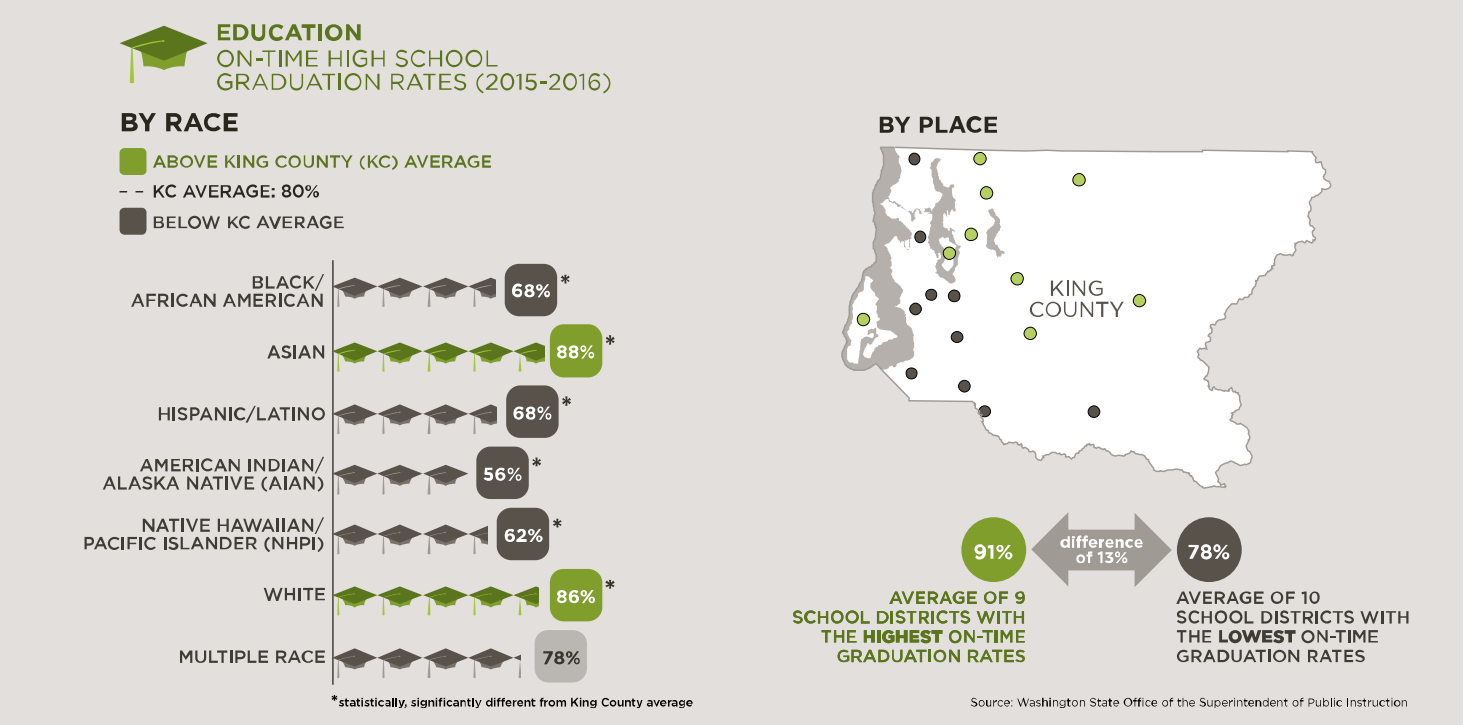


Source: WA State Department of Health, Center for Health Statistics, death certificates

Educational Attainment

While nearly half of King County residents had at least a bachelor's degree in 2011-2015, this level of educational attainment was significantly lower in South Region at 27%. The proportion of adults with a bachelor's degree dropped to less than 1 in 4 among individuals living in poverty.

High school students in 6 South Region districts, and in Seattle, are the least likely to graduate on time compared to those in other districts. Apart from Asian and multiple-race students, fewer than 7 in 10 high school students of color graduate from high school on time. Racial and regional disparities in high school graduation rates reflect ongoing challenges with equity in education.

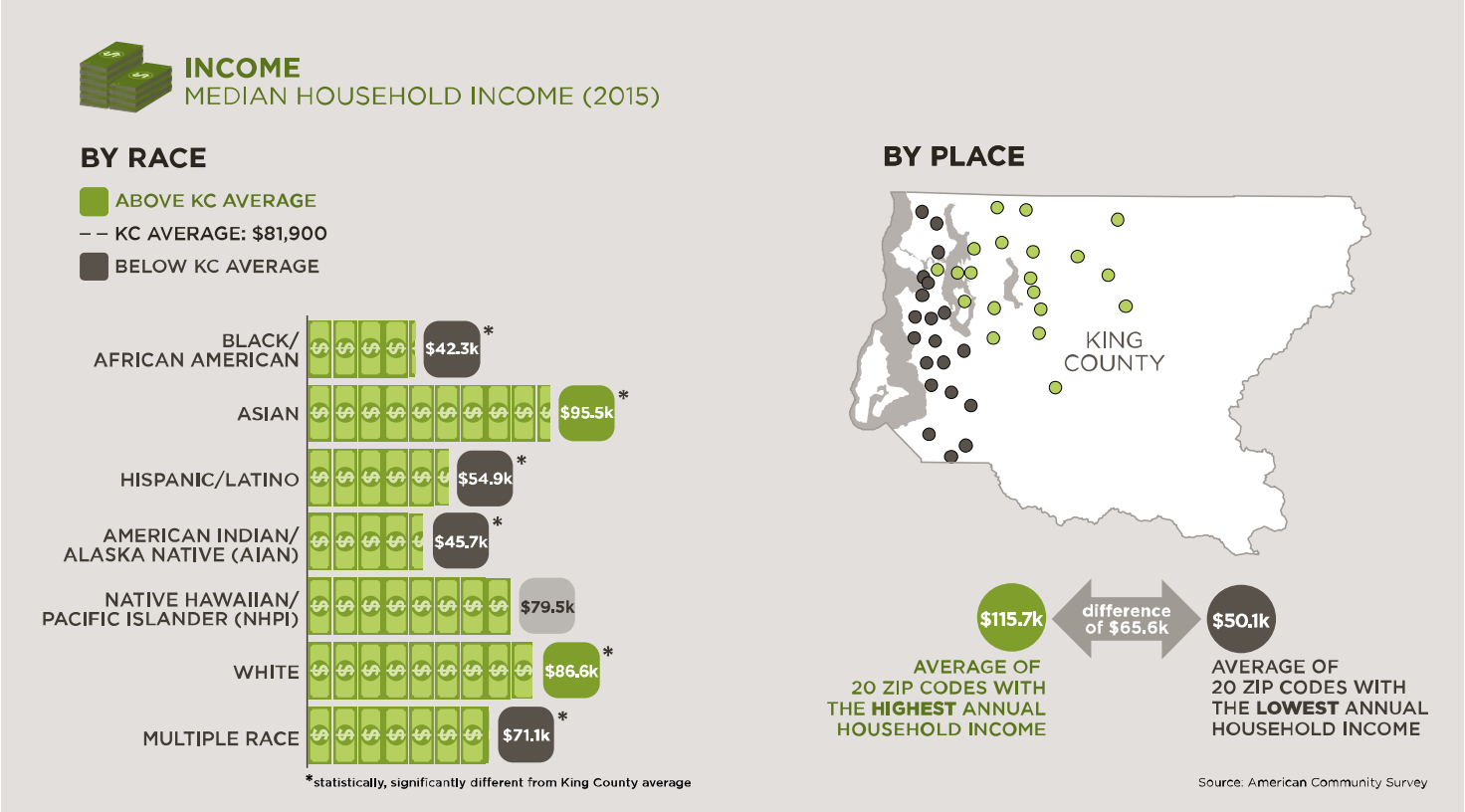


Description of Community

Continued

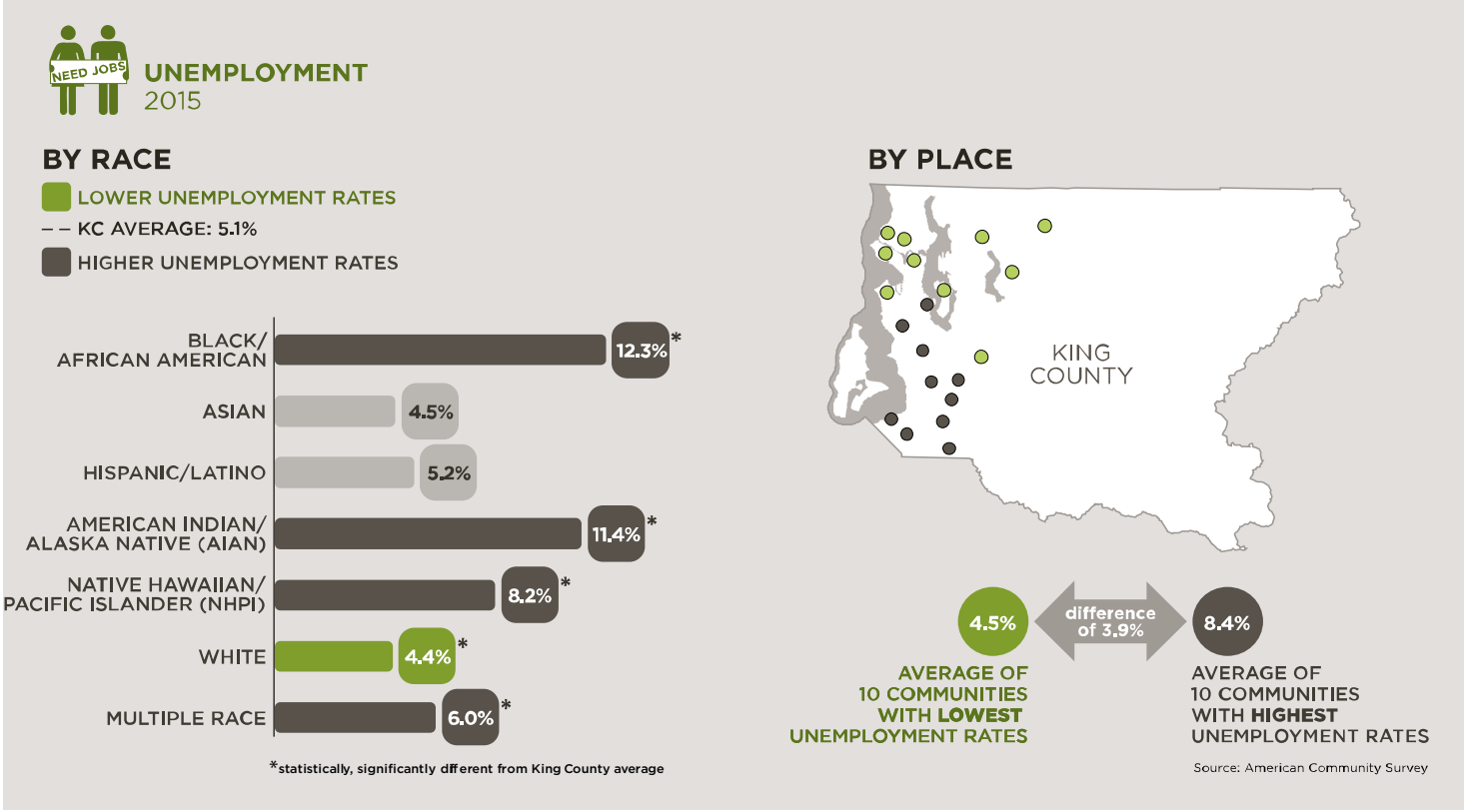
Household Income

In 2015, Black households in King County reported annual household income less than half that of whites and Asians, and significantly lower than Hispanic and multiple-race households. At just under $35,000 per year, household income among young adults ages 18 to 24 was less than half that of adults 25 to 64. Income among adults over 65 is also significantly lower than the county average, leaving residents in these two age groups vulnerable to rapidly increasing costs of living.



Unemployment

Data from 2015 show stark racial and geographic disparities in King County unemployment rates. The rate of unemployment among Black and American Indian/Alaska Native residents was more than 2.5 times the unemployment rates of white and Asian residents. South Region communities had some of the highest unemployment rates in the county. Two years later, the county unemployment rate had fallen to 3.9% (September, 2017),[15] reflecting steady recovery from the economic recession.



Health Insurance Coverage

Health insurance coverage rates have improved across the board. In 2013, 16.4% of King County adults did not have health insurance; in 2016 – after implementation of the Affordable Care Act – 6.7% lacked coverage. Since the first open-enrollment period for the Affordable Care Act in 2014, King County hospitals and health systems have played a key role in helping families access free and low-cost health insurance options. Initiatives such as the ***Coverage is Here King County*** campaign, and targeted activities of hospitals, health centers, and community-based organizations were key in getting residents enrolled. South Region cities such as Tukwila, SeaTac, Kent, Des Moines, and Auburn have experienced the largest increases in coverage. Reaching this historic low rate of uninsurance, King County's success has been recognized as one of the best in the nation.[16]

Despite improvements in insurance coverage since implementation of the Affordable Care Act, disparities persist. Those least likely to have health insurance include low-income adults, the unemployed, and most communities of color. Work remains to be done to increase access to insurance among the groups who are least likely to be insured. As healthcare reform remains at the forefront of national conversations, any future healthcare act will need to maintain and expand access to health insurance for all.

The Access to Care & Use of Preventive Services section of this report presents a more detailed description of disparities in insurance coverage.

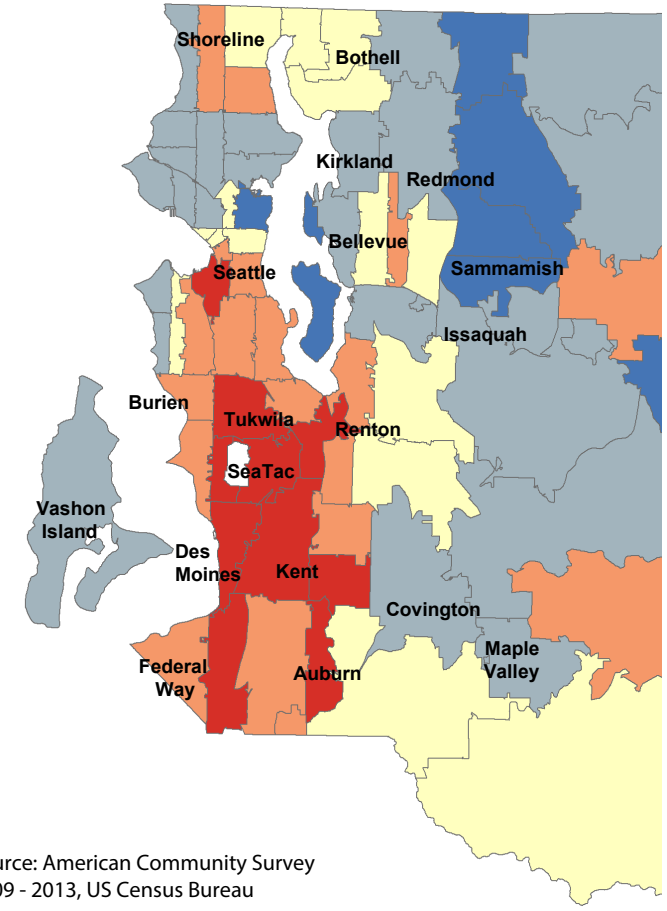
Description of Community

Continued

Before and after the Affordable Care Act:

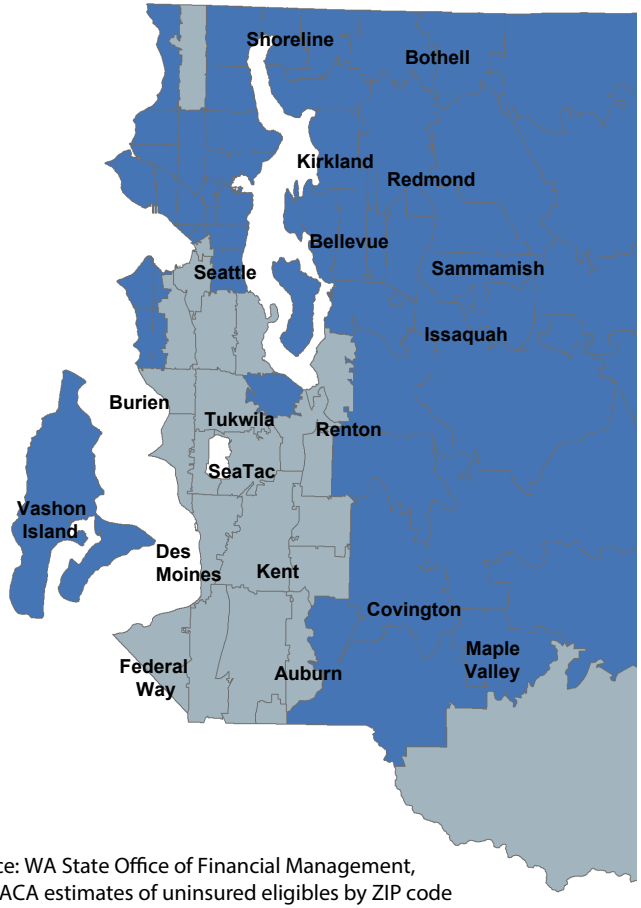
Uninsured adults age 18-64 by ZIP code in King County, Washington

2009 - 2013



Source: American Community Survey 2009 - 2013, US Census Bureau

2016



Source: WA State Office of Financial Management, post-ACA estimates of uninsured eligibles by ZIP code

Percent uninsured

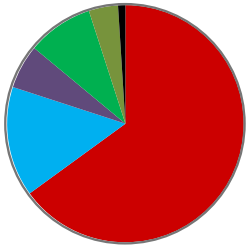
0% - 6% | 7% - 12% | 13% - 18% | 19% - 25% | 26% - 45%

CHANGING DEMOGRAPHICS

The population of King County continues to experience dramatic growth and increasing diversity. Since 2010, the county has grown by more than 173,000 residents, with most of the increase attributable to people of color. The population is now 38% people of color, nearly tripling in the past 35 years. Increases in the Asian population accounted for 34% of the population growth in King County from 2010 to 2016. Hispanic/Latino communities have also grown rapidly in King County, accounting for 23% of the increase since 2010.

King County, 2010

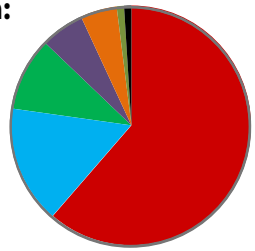
Population: 1,931,249



White/non-Hispanic	65%
Asian/non-Hispanic	15%
Hispanic/Latino	9%
Black/African American non-Hispanic	6%
Multiple race	4%
American Indian/Alaska Native/non-Hispanic	1%
Native Hawaiian/Pacific Islander/non-Hispanic	1%

King County, 2016

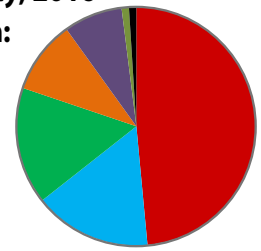
Population: 2,105,100



White/non-Hispanic	62%
Asian/non-Hispanic	16%
Hispanic/Latino	10%
Black/African American non-Hispanic	6%
Multiple race	5%
American Indian/Alaska Native/non-Hispanic	1%
Native Hawaiian/Pacific Islander/non-Hispanic	1%

Population under age 18, King County, 2016

Population: 441,454



White/non-Hispanic	49%
Asian/non-Hispanic	16%
Hispanic/Latino	16%
Multiple race	10%
Black/African American non-Hispanic	8%
American Indian/Alaska Native/non-Hispanic	1%
Native Hawaiian/Pacific Islander/non-Hispanic	1%

Data source: US Census Bureau, Census 2010, WA State Office of Financial Management 2016 Percentages may not add up to 100% due to rounding

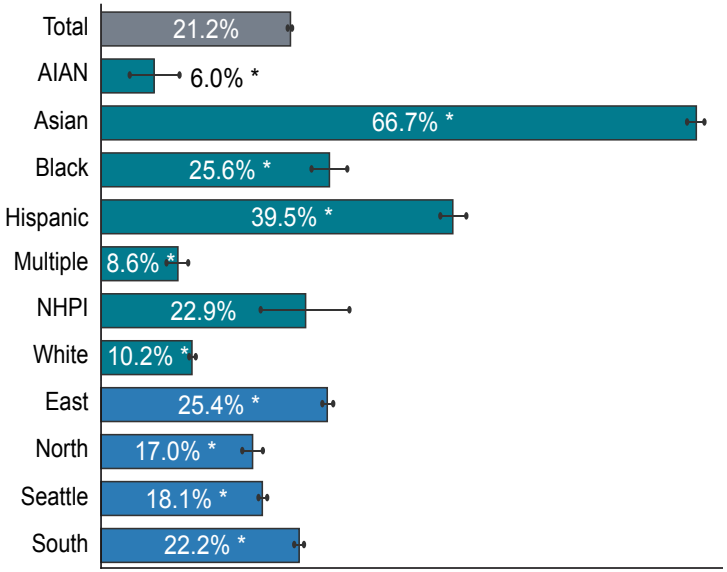
Description of Community

Continued

Immigration from multiple countries contributes to growing cultural and linguistic diversity in the county. Foreign-born residents, including immigrants and refugees, account for almost half of the population growth in King County in the past 25 years. As of 2015, the population of King County was 21.7% foreign born, compared to 13.5% nationally. Of all race or ethnic groups in the county, the Asian community had the highest proportion of foreign-born residents. In 2015, the largest local population of foreign-born residents was in Bellevue, at 39.1%, more than double the 17.5% in Seattle.

Foreign-born residents

King County (average: 2011-2015)



Source: American Community Survey Public Use Micro Sample (PUMS)

* = statistically, significantly different from King County average

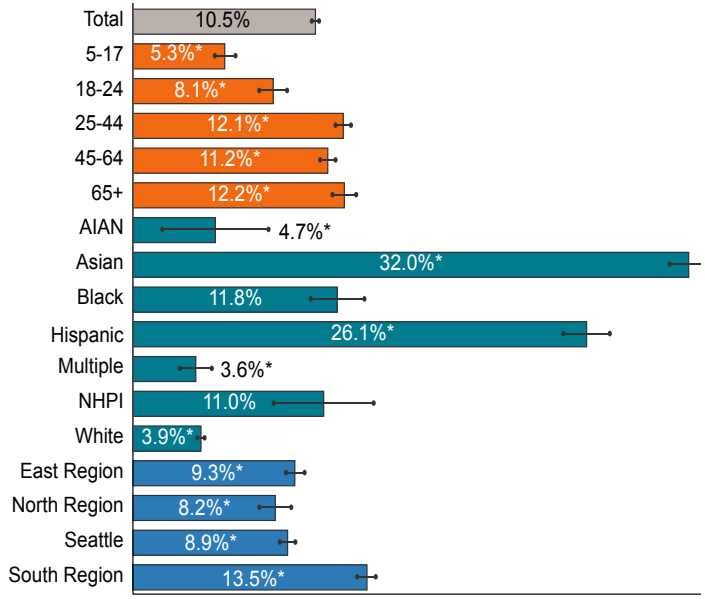
Description of Community

Continued

Approximately 170 languages are spoken in King County, and more than 1 of every 4 King County residents speaks a language other than English at home (versus speaking ***only*** English at home). Among these are Spanish (the most frequently spoken language), Chinese, Vietnamese, Tagalog, Korean, French, and African languages (most commonly Somali, Tigrinya and Amharic).[17] While this linguistic diversity greatly enriches the broader community, 4 in 10 of our foreign-born residents report that they speak English less than "very well." Language barriers can severely limit access to education, employment, and healthcare, making it difficult for immigrant families to maintain health and flourish in the community.

Percent age 5 and older who speak English less than "very well"

King County (average: 2011-2015)



Source: American Community Survey Public Use Micro Sample (PUMS)

* = statistically, significantly different from King County average

Description of Community

Continued

Immigrants have been and continue to be a vital part of our county's health and prosperity, contributing to our workforce, economy, and rich cultural heritage. Promoting and maintaining health in this growing population are necessary features of a robust community. The national political climate, influenced in part by changes in federal immigration policy, has led some immigrants to avoid seeking medical care.[18] Fear of deportation and disruption of families among both lawful and undocumented immigrants contributes to stress, anxiety, and depression. Irrespective of social class, these challenges can contribute to negative health outcomes for large numbers of King County residents.

Our burgeoning racial and ethnic diversity is most visible among King County children, of whom 51.1% were non-white in 2016. Children (from birth through 17 years) represent 21.0% of the King County population. Students in King County schools speak dozens of different languages;[19] and the Tukwila School District has been dubbed "the most diverse school district in the nation."[20] The county's fast-growing southern suburbs include several school districts that are "majority minority"–where children of color make up more than half of the student population.

King County's population of older adults will continue to grow as baby boomers age. The population of adults 65 and older comprised 12% of the county's population in 2016, and is projected to reach 15% by the year 2020.[21] From a longer-term perspective, the number of 65-and-older adults in the King County population is expected to more than double, from the 2010 Census count of 210,679 (11% of total population) to a projected 477,754 in 2040 (20% of total). In addition to these substantial increases in the number and proportion of older adults, the age distribution of King County's older adults is expected to flip, with the majority shifting from the 65-74 age group to those 75 and older[ii]. Since disability and many serious health conditions are associated with increasing age, and per-person healthcare costs for this age group are dramatically higher than for any other age group, this demographic trend will significantly impact demands on King County healthcare systems.

[ii] *A group that comprised 46% of older adults in 2010 but will swell to 53% of the 65+ population – more than a quarter of a million individuals – in 2040.*[21]

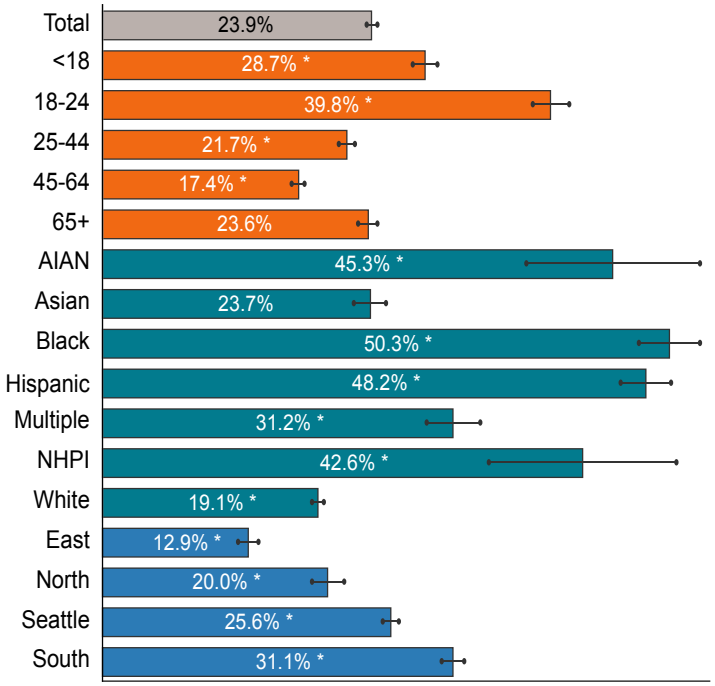
PERSISTENT DISPARITIES RELATED TO POVERTY

Poverty continues to impact at least 1 of every 5 residents. After a period of increase between 2008 and 2013, the percentage of King County residents living in poverty has slowly declined. From 2011 to 2015, an average of more than 500,000 adults and children lived in or near poverty in King County (below 200% of the Federal Poverty Level); childhood poverty rates have remained fairly stable in recent years.

Urban economic development in the county's largest cities has shaped demographics across the county. The South Region is home to the majority of the county's low-income households, especially families with children. Not surprisingly, staggering racial and regional differences in poverty mirror disparities observed in most chronic disease indicators, disproportionately burdening communities of color and South Region families.

Poverty and near poverty

King County (average: 2011-2015)



Source: American Community Survey Public Use Micro Sample (PUMS)

* = statistically, significantly different from King County average

Description of Community

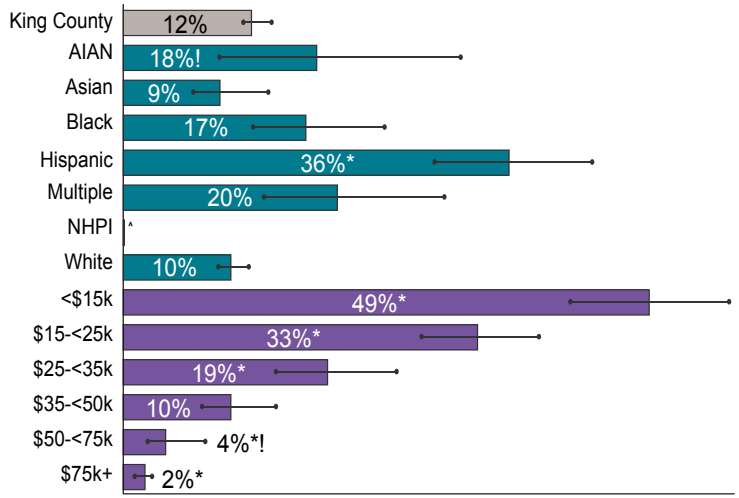
Continued

Uncertainty about Food

Residents living in poverty cannot always afford to feed their families. Food insecurity (the uncertainty of having enough money to adequately feed all family members)[iii] is associated with obesity and stress, all of which are more prevalent among low-income populations and are risk factors for several chronic health conditions.[22] Access to affordable healthy foods is essential for adult and child health. Averaging data from three survey years, more than 1 in 10 King County adults reported that within the past 12 months they ran out of food and didn't have money to buy more. South Region residents were more likely than those in other regions to report this kind of food hardship, which also affected 1 in 3 Hispanic households. By 2016, participation in the Basic Food program by King County residents still had not returned to pre-recession levels, and was increasing for older adults, especially in South Region cities.[23] A similar pattern was found for visits to King County food banks.[24]

Food insecurity

King County (average: 2010, 2011, & 2013)



Source: Behavioral Risk Factor Surveillance System

* = Significantly different from King County average

! = Interpret with caution; sample size is small, so estimate is imprecise

^ = Data suppressed if too few cases to protect confidentiality and/or report reliable rates

[iii] *United States Department of Agriculture, Economic Research Service. Definitions of Food Security. https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/definitions-of-food-security/. Updated October 4, 2017. Accessed November 1, 2017.*

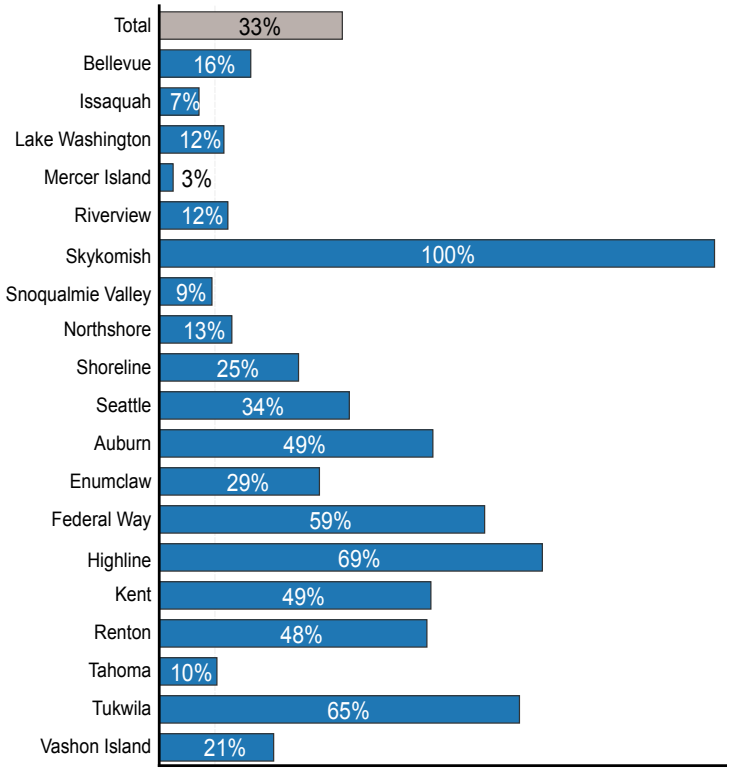
Description of Community

Continued

Eligibility for the Free or Reduced-Price Meal program – another marker for poverty and food insecurity – varied widely in the 2016-2017 school year – from 10% of students in the Tahoma School District to nearly 70% in Highline and Tukwila. With the exception of the small, rural district of Skykomish, all districts with 50% or more students in the Free or Reduced-Price Meal programs were located in South Region.

Students eligible for free/ reduced price meal

King County (2016-2017 school year)



Source: Washington State Office of the Superintendent of Public Instruction

Description of Community

Continued

Unaffordable Housing

Escalating housing prices disproportionately burden older adults, communities of color, and people living in poverty. Lack of affordable housing contributes to a multidimensional cycle of poverty and displacement that drastically changes communities. With explosive growth of local businesses and the influx of new residents, rental and home prices continue to rise throughout the county. During 2011-2015, almost half of renters and over one third of owners with a mortgage in King County were paying at least 30% of their household income on housing, a level deemed unaffordable by the U.S. Department of Housing and Urban Development. The majority of those living at or near poverty are bearing this level of "housing cost burden" -- more than 8 in 10 renters and 9 out of 10 mortgage-paying home owners.

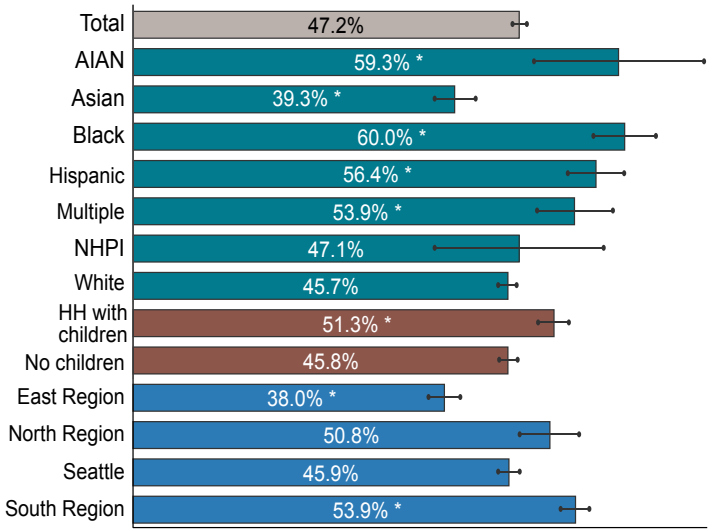
Over 64% of renters and 50.1% of mortgage-paying owners over the age of 65 experience cost burden associated with housing.

Female homeowners are significantly more likely than males to experience mortgage-related cost burden. The gender disparity is even wider among renters, where more than half of female renters (54.4%) experience housing cost burden compared to 40.5% of males.

Cost burden affects more than half of renters with children.

Cost-burdened renters

King County (average: 2011-2015)



Source: American Community Survey Public Use Micro Sample (PUMS)

* = statistically, significantly different from King County average

Renters and homeowners alike have turned to South Region to find affordable housing, but that comes at a price as well – the cost, in time and money, of traveling longer distances to work, usually in a car. Light rail offers a convenient, affordable alternative to driving, but until recently served one South Region community -- Tukwila. Five years after light rail came to King County, use of public transit by Tukwila commuters more than doubled (from 7% to 16%); at the same time, the share of Tukwila residents who drove to work alone dropped from 73% to 65%. Commute modes did not change in South Region cities without light rail service. In Kent and Auburn, for example, 3 out of 4 commuters were still driving to work, and only 6% used public transit.[25]

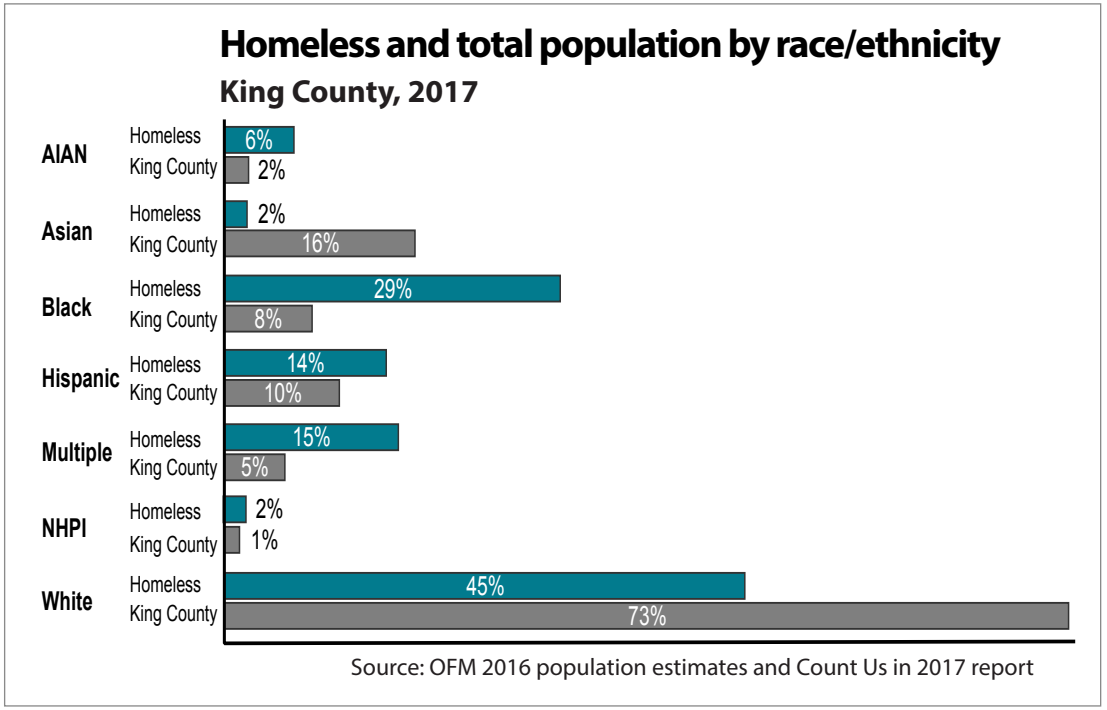
Description of Community

Continued

Increasing Homelessness

Homelessness in King County is a growing concern, affecting families, communities, and agencies in multiple regions. The 2017 Point-In-Time Count identified 11,643 individuals, youth, and members of families experiencing homelessness in King County, with the majority in Seattle.[26] Nearly half of that count was unsheltered -- living on the streets, in abandoned buildings, in vehicles, or in tents. Unaccompanied youth and young adults under the age of 25 made up 13% of the individuals counted. Almost a quarter of the individuals identified were experiencing chronic homelessness,[iv] compared to fewer than 10% in 2015 and 2016. Key findings from the report include:

- Issues with housing affordability were identified as primary contributors to homelessness for nearly 1 out of 4 respondents, and more than 70% called out affordable housing and rental assistance as crucial to ending their homelessness.
- 50% of homeless individuals had one or more disabling conditions.
- 17% of homeless individuals reported serious mental illness.
- 40% of homeless individuals reported a history of domestic violence or partner abuse; this was true of 58% of survey respondents who identified as lesbian, gay, bisexual, transgender, or queer (LGBTQ).
- Homelessness disproportionately impacts people of color (55% of respondents identified as a person of color). Black individuals are overrepresented in the homeless population by more than 3-fold.



[iv] Chronic homelessness is defined as sleeping in places not meant for human habitation or staying in emergency shelters for a year or longer, or experiencing at least four such episodes of homelessness in the last three years, and also living with a disabling condition such as a chronic health problem, psychiatric or emotional condition, or physical disability.[26]

Description of Community

Continued

For families and children, residential instability can rupture social ties, hinder academic performance, and damage physical and emotional health. Student homelessness may be our most sensitive indicator of family homelessness, as it captures a range of social challenges related to being without stable housing. In King County, student homelessness has more than doubled since 2008, reaching 8,411 (nearly 3% of enrolled students) in the 2015-16 school year.[27] In most school districts at least half of the homeless students were in elementary school or pre-kindergarten. Although student homelessness has increased county-wide, it varies considerably across school districts. The Tukwila District had the highest rate, at 1 in 9 students, compared to fewer than 1 in 100 in Mercer Island, Issaquah, Northshore, Tahoma, and Vashon Island school districts.[27] While the majority of homeless students were "doubled up" with friends or extended family, 3% were unsheltered.

Disparities in Out-of-Home Placements

At about 5 per 1,000, the rate of King County children in out-of-home placements has remained fairly stable over the past ten years. As of January 2017, just over 1,400 King County children had been placed in care outside their immediate family (in residential centers, foster and adoptive homes, group homes and detention centers, and relative placements).[28] Although racial/ethnic disparities have narrowed over the past decade, rates of out-of-home care are still higher in many communities of color, hovering around 9 out of every 1,000 Black and Native Hawaiian/Pacific Islander children and 19 per 1,000 American Indian/Alaska Native children.

Youth and young adults with a history of child welfare involvement face a high risk of homelessness. Nearly 1 in 5 respondents in the 2017 Point In Time survey reported a history of foster care.[26] Rates of foster-care involvement were highest among LGBTQ respondents (33%) and unaccompanied young people under 25 years of age (29%). Less than 1% reported that they were living in foster care immediately prior to becoming homeless.

Description of Community

Continued

Disparities in Disability

Nearly 1 in 4 King County adults reported having a physical, mental, or emotional impairment or condition that limits their function or ability to perform major activities of life. Disability rates in King County have remained relatively unchanged over the past 10 years, consistently impacting some communities more than others. Disability prevalence increases with age – from 13% for the youngest adults to 40% for those 65 and older. As previously mentioned, both the size and the expected life span of King County's older adult population are increasing. At one quarter of the population, the health and social needs of residents affected by disabilities must be considered in all healthcare planning.

- At 26%, disability rates are highest in South Region, exceeding the overall rate of the county.

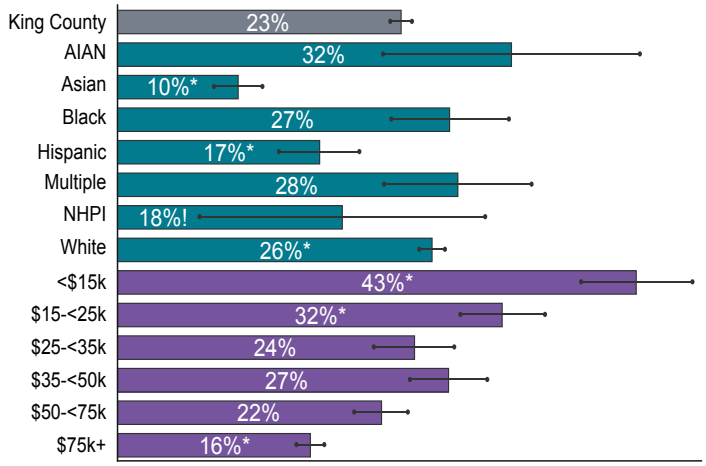
- Adults who identify as bisexual are significantly more likely to report disability than those who identify as heterosexual.

- Disability is lowest among Asian and Hispanic residents, compared to most other racial/ethnic groups.

- Lower income is associated with higher disability rates. Just as disability may limit employment opportunities and thus income, the limited and sometimes dangerous circumstances of poverty may increase risk for disability.

Disability (adult)

King County (average: 2011-2015)



Source: Behavioral Risk Factor Surveillance System

* = Significantly different from King County average

! = Interpret with caution; sample size is small, so estimate is imprecise

Description of Community

Continued

RECURRING THEMES: INCOME, PLACE, AND RACE

Throughout King County, people of color and low-income residents are more likely to have poor health and social outcomes. While these outcomes cannot be attributed to any one factor, we know that economic development favors those who can take advantage of it, while marginalizing those at lower economic strata, increasing their health risks. Systemic racism – like exposure to toxins, social support, and a living wage – is a determinant of health. The impacts of racism can be deep and long-lasting, affecting health through structural and social processes that are not moderated by age, sex, birthplace, or education level,[29–31] and should not be confused with the idea of race. More than half of all Black and Hispanic King County residents live in South Region, where health outcomes are below the county average on almost every indicator. The effects of these inequities spread far beyond South Region, challenging the health and prosperity of all King County residents. The social and economic determinants of health – shaped by local distributions of money, power, and resources – cannot be ignored if we hope to improve healthcare and health outcomes.

Life Expectancy & Leading Causes of Death

Life expectancy and leading causes of death are broad foundational health measures often used to assess the health of the population and monitor progress in preventing disease and disability, as well as reducing health disparities. Although life expectancy in King County is higher than it was in 1990, there have been no significant improvements since 2009. Similarly, age-adjusted death rates stopped their decades-long decline in 2010. This stalemate may result from two competing factors – a sharp decline in cardiovascular disease in many age groups countered by an increase in deaths from Alzheimer's disease among those age 85 and older.

Hispanic and Asian residents in King County live an average of 11 years longer than Native Hawaiians/Pacific Islanders.

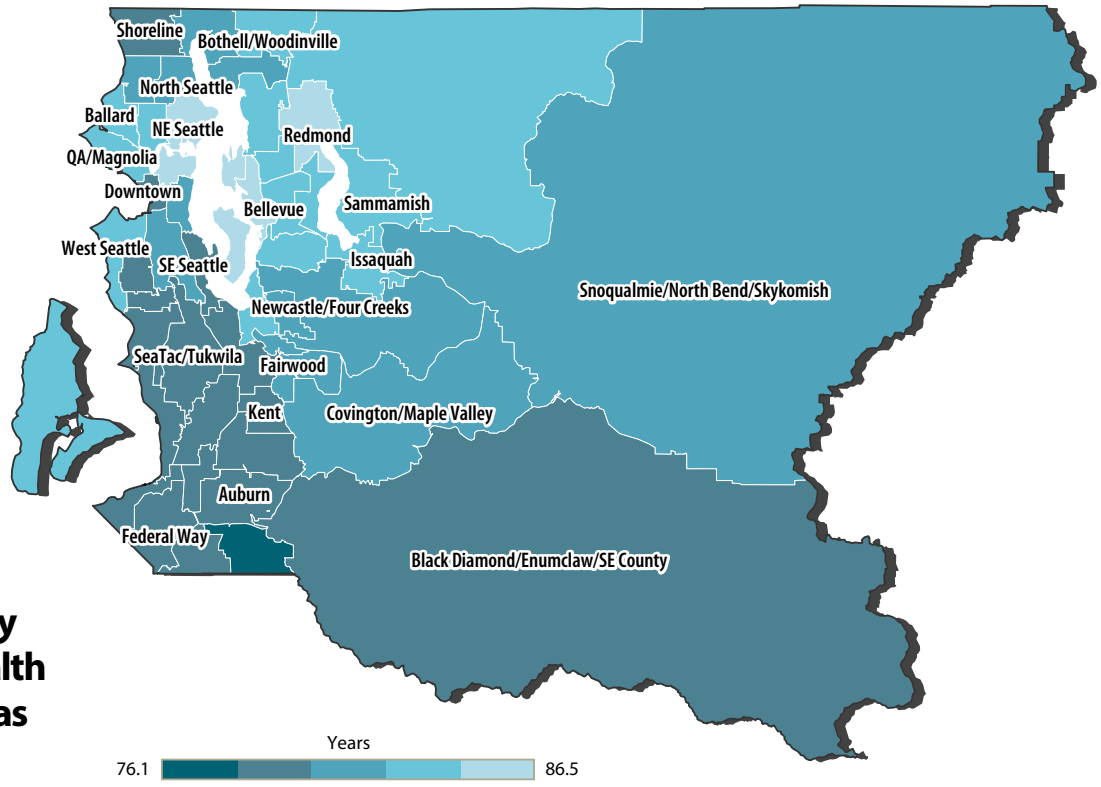
Life Expectancy & Leading Causes of Death

Continued

LIFE EXPECTANCY

This indicator shows life expectancy at birth – the number of years a newborn can expect to live. Life expectancy increased in King County from 79.5 in 2000, to 81.9 in 2010, but has plateaued since then (the 2015 life expectancy was 81.9 years). While King County's life expectancy exceeds the national average, variations within the county reflect noteworthy differences in life expectancy by place and race/ethnicity. For 2011-2015, average life expectancy at birth was 81.8 years in King County.

- Residents of NE Seattle are expected to live an average of 10.4 years longer than those in South Auburn.
- Life expectancy is highest among Hispanic (86.3 years) and Asian (86.1 years) residents. Native Hawaiian/Pacific Islander (75 years) residents have the lowest life expectancy of all racial/ethnic groups in King County.
- Residents living in low-poverty neighborhoods live an average of 5 years longer than those in high-poverty areas.



Life expectancy at birth by Health Reporting Areas

King County, (average: 2011-2015)

Data source: Washington State Department of Health, Center for Health Statistics, Death Certificates.

Life Expectancy & Leading Causes of Death

Continued

LEADING CAUSES OF DEATH

- Despite reductions in the rate of death from cardiovascular disease (CVD), heart disease was still – with cancer – 1 of the top 2 leading causes of death in King County from 2011 to 2015. Leading causes of death varied by age. While cancer and heart disease were leading causes of deaths for adults over age 45, unintentional injuries and suicides were leading causes of death among children, teens, and young adults.

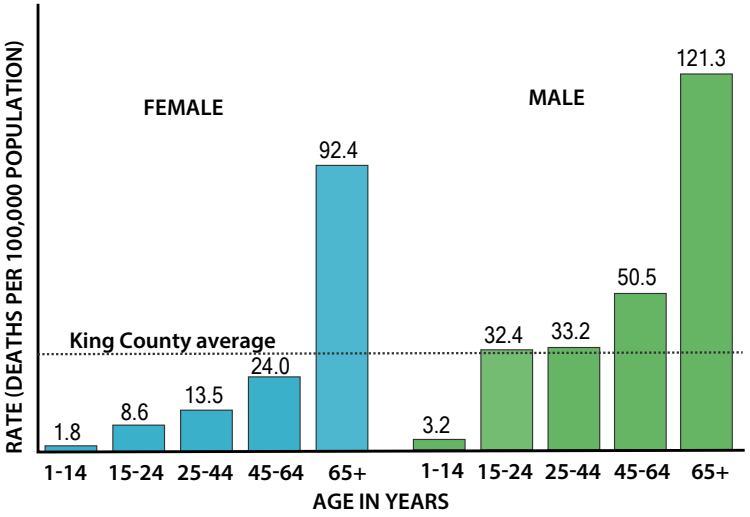
- With the exception of Alzheimer's disease, the rank order of causes of death has been fairly stable over time. Alzheimer's moved from #10 in the 1991-1995 period, to #4 in 2001-2005, and finally to #3 in 2011-2015. It is unclear whether the change in rank is due to additional attribution of deaths to Alzheimer's versus other conditions or an actual increase in the condition.

- Averaged across the life span, men in King County die at 1.4 times the rate for women. Life expectancy for men (79.5 years) is significantly lower than for women (83.9 years).

- In the 15-24 age group (notoriously high for risk-taking among males), males die at a rate 2.7 times that of females. In the same age group, the average death rate from unintentional injury among males is nearly 4 times the rate among females.

- The male suicide rate is 2 to 3 times the female rate in each age group, starting as early as 15-24 years old and up to age 64.

Unintentional injury death rate by age
King County (average: 2011-2015)



Data source: WA State Department of Health, Death Certificate Data

Life Expectancy & Leading Causes of Death

Continued

- Males are also more likely than females to be killed by someone else, with a homicide rate 2.3 times the female rate in 15-24 year-olds, and 3.6 among those age 25-44.

- Among leading causes of death, Alzheimer's disease is the only exception where women are more likely to die of the disease than men. Among adults older than 65, the female rate of death from Alzheimer's was 1.8 times the rate among males. Even among adults of all ages, females are 1.3 times more likely than males to die of Alzheimer's disease.

- Cancer was the leading cause of death among women between the ages of 25-44. It is the third leading cause of death among men of that age group, following unintentional injury and suicide.

- Heart disease death rates among men are 1.6 times those among women.

- The rate of heart disease among Native Hawaiians/Pacific Islanders (NHPI) is 3.3 times the rate among Asians, although the overall number of these deaths in NHPI (an average of 17 deaths per year) is small.

- The top three causes of death among Native Hawaiians/Pacific Islanders are related to obesity (heart disease, cancer, and diabetes) – this group has the 3rd highest obesity rates (28%) behind American Indians/Alaska Natives (AIAN) (44%) and Blacks (33%) – although the precision of estimates among the NHPI and AIAN groups is limited by small sample sizes.

- The rate of unintentional injury death for American Indians/Alaska Natives (n=14) is 1.9 times the rate for Blacks (n=46), 2.2 times the rate for whites (n=533), and 4 times the rate for Asians (n=44).

Life Expectancy & Leading Causes of Death

Continued

Leading causes of death, King County (average: 2011-2015)

(ranked by the number of deaths)

		BY RACE/ETHNICITY						
Rank	Total	AIAN	Asian	Black	Hispanic	Multiple race	NHPI	White
All	All 619.5 (12,409)	All 857.7 (113)	All 436.1 (1,006)	All 796.6 (738)	All 432.0 (277)	All 341.3 (113)	All 963.4 (67)	All 634.1 (10,337)
1	Cancer 147.7 (2,941)	Cancer 140.1 (19)	Cancer 117.2 (288)	Cancer 191.3 (178)	Cancer 96.0 (61)	Cancer 84.1 (26)	Heart disease 270.0 (17)	Cancer 150.4 (2,410)
2	Heart disease 125.7 (2,534)	Heart disease 156.9 (18)	Heart disease 80.9 (180)	Heart disease 154.9 (134)	Heart disease 89.5 (43)	Heart disease 65.0 (16)	Cancer 217.6 (16)	Heart disease 129.6 (2,163)
3	Alzheimer's disease 41.5 (832)	Unintentional 72.8 (14)	Stroke 33.9 (75)	Unintentional injury 38.4 (46)	Unintentional injury 20.8 (27)	Unintentional injury 16.6 (12)	Diabetes 62.2 (4)	Alzheimer's disease 44.7 (762)
4	Unintentional injury 31.7 (654)	Chronic liver disease 44.8 (9)	Unintentional injury 17.7 (44)	Diabetes 50.3 (44)	Stroke 27.2 (14)	Suicide 7.1 (6)	Unintentional injury 21.7 (4)	Unintentional injury 33.8 (533)
5	Stroke 30.6 (605)	Chronic lower resp. disease 67.0 (7)	Alzheimer's disease 19.1 (38)	Stroke 41.6 (35)	Chronic liver disease 10.4 (11)	Chronic lower resp. disease 28.3 (6)	Stroke 73.1 (3)	Chronic lower resp. disease 31.9 (503)
6	Chronic lower resp. disease 29.8 (571)	Diabetes 31.7 (4)	Diabetes 16.6 (38)	Chronic lower resp. disease 27.0 (24)	Diabetes 18.2 (11)	Diabetes 12.2 (4)	Chronic lower resp. disease 62.7 (2)	Stroke 29.3 (484)
7	Diabetes 18.5 (370)	Stroke 42.8 (4)	Chronic lower resp. disease 12.8 (28)	Alzheimer's disease 35.5 (24)	Suicide 5.5 (10)	Alzheimer's disease 19.7 (3)	Septicemia 19.5 (2)	Diabetes 17.0 (275)
8	Suicide 12.2 (255)	Suicide 14.7 (3)	Suicide 6.6 (21)	Homicide 14.1 (19)	Alzheimer's disease 26.3 (8)	Stroke 12.0 (3)	Nephritis 28.7 (1)	Suicide 13.8 (213)
9	Chronic liver disease 9.5 (210)	Alzheimer's disease 31.2 (2)	Influenza/ pneumonia 9.0 (19)	Essential hypertension 19.4 (16)	Homicide 3.2 (6)	Influenza/ pneumonia 8.2 (2)	Suicide 6.6 (1)	Chronic liver disease 10.4 (179)
10	Influenza/ pneumonia 9.0 (183)	Influenza/ pneumonia 14.0 (2)	Parkinson's disease 8.1 (17)	Nephritis 15.9 (14)	Pneumonitis 12.4 (5)	Homicide 1.5 (2)	Influenza/ pneumonia 11.9 (1)	Influenza/ pneumonia 8.9 (150)

CAUSE CATEGORY:

All causes | Chronic disease | Infectious disease | Other | Injury/violence

Data source: WA State Department of Health, Death Certificate Data.

Note: For each cause, the first number shown is the 5-year average rate per 100,000 and the number in parentheses is the average annual count for that cause over the 5-year period. For leading causes by age, the rates are age-specific. All other rates are age-adjusted.

Chronic Illnesses

Chronic illnesses are among the leading causes of death, disability, and hospitalization in King County. They are common and costly, underscoring the need for targeted prevention and health-promotion strategies. This section focuses on two chronic illnesses – asthma and diabetes – for which the healthcare system plays a key role in prevention, screening, and treatment. We also review leading causes of hospitalization and leading causes of cancer incidence.

South Region adults were more likely to have diabetes than adults in all other regions, a disparity that has not changed since 2013.

ASTHMA

Adult Asthma

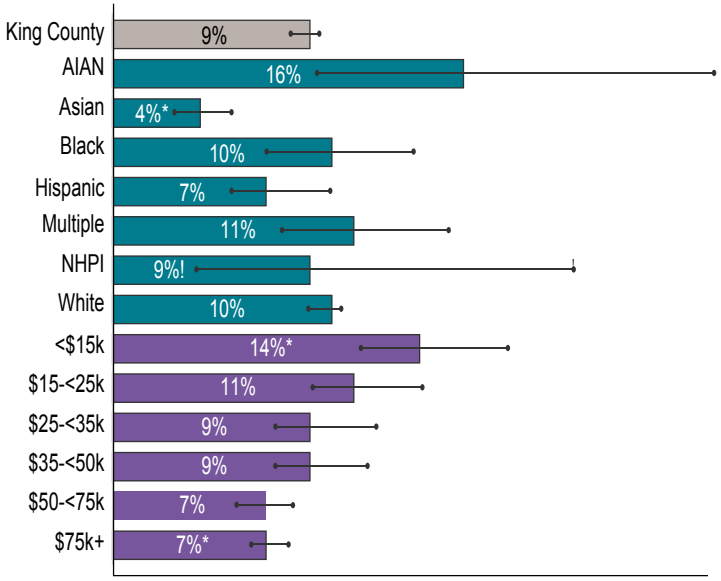
From 2011 to 2015, 9% of King County adults reported i) they had been told by a health professional at some point in their life that they had asthma and ii) they still had asthma. Adult asthma rates reported in 2015 have not significantly changed throughout the county since 2000.

- Women were 1.6 times as likely as men to have asthma.

- Adults with annual household income below $15,000 were 1.6 to 2.0 times as likely to have asthma as those with income above $50,000, demonstrating a growing income disparity in asthma prevalence.

Asthma (adults)

King County (average: 2011-2015)



Source: Behavioral Risk Factor Surveillance System

* Significantly different from King County average

! Interpret with caution; sample size is small, so estimate is imprecise

Childhood Asthma

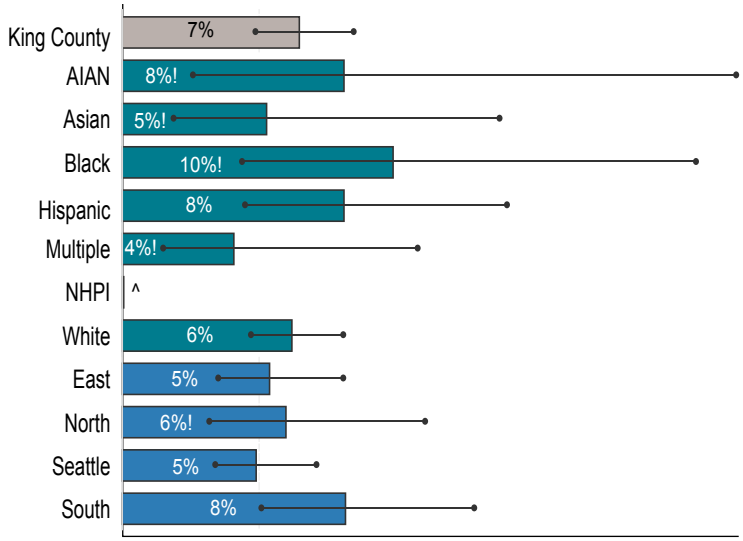
From 2011 to 2014, 7% of King County children age 0-17 had asthma.

- Since the last report (reporting asthma rates from 2009-2013), the distributions of childhood asthma by race and place have not changed significantly.

- Children age 10-14 had 2.8 times the asthma rate of children age 5-9.

Current asthma among children age 0-17

King County (average: 2011-2014)



Source: Behavioral Risk Factor Surveillance System

! Interpret with caution; sample size is small, so estimate is imprecise

^ Data suppressed if too few cases to protect confidentiality and/or report reliable rates

Chronic Illnesses

Continued

DIABETES

From 2011 to 2015, 7% of King County adults reported having been told by a doctor that they had diabetes (excluding "pre-diabetes" and diagnoses during pregnancy), the same rate as from 2009 to 2013.

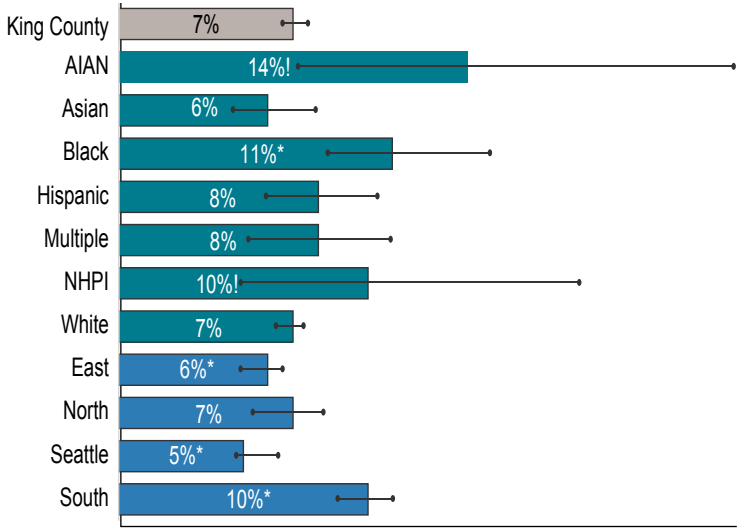
- Diabetes prevalence increases with age. Diabetes rates among adults over age 65 are 2.6 times the county average.

- Black adults were 1.8 times as likely as Asian adults to have diabetes.

- Adults with annual income greater than $75,000 were less likely than those with lower incomes to have diabetes. South Region adults were more likely to have diabetes than adults in all other regions.

Diabetes (adults)

King County (average: 2011-2015)



Source: Behavioral Risk Factor Surveillance System

* Significantly different from King County average

! Interpret with caution; sample size is small, so estimate is imprecise

LEADING CAUSES OF HOSPITALIZATION

Hospitalization data from 2011 to 2015 provide a valuable perspective on the public health impact of chronic diseases and injuries in King County.

- The leading causes of hospitalization among adults were pregnancy/childbirth-related, heart disease, injuries, and mental illness.
- The hospitalization rate for heart disease was 54% higher among men than women – unchanged since the 2008-2012 report period.
- For children ages 1 to 14, the leading causes of hospitalization were respiratory infections, injuries, and mental illness.
- Infants were most frequently hospitalized during birth and for respiratory infections and jaundice.

King County, (2011-2015)

(ranked by the number of hospitalizations)

Rank	Total	Female	Male
All	All 8,324.7 (167,527)	All 9,334.9 (97,568)	All 7,421.5 (69,958)
1	Pregnancy/ childbirth-related 1,177.7 (25,117)	Pregnancy/ childbirth-related 2,403.4 (25,116)	Heart disease 754.7 (6,933)
2	Heart disease 611.2 (12,400)	Heart disease 489.0 (5,466)	Mental illness 524.2 (5,392)
3	Unintentional injuries 530.8 (10,711)	Unintentional injuries 489.9 (5,443)	Unintentional injuries 562.2 (5,268)
4	Mental illness 517.8 (10,699)	Mental illness 512.6 (5,307)	Septicemia 397.7 (3,631)
5	Cancer and benign tumors 372.4 (7,750)	Cancer and benign tumors 390.7 (4,202)	Cancer and benign tumors 361.4 (3,547)
6	Septicemia 356.5 (7,265)	Septicemia 325.8 (3,633)	Osteoarthritis 253.7 (2,538)
7	Osteoarthritis 290.8 (6,144)	Osteoarthritis 322.9 (3,605)	Lower GI disorders 246.3 (2,371)
8	Lower GI disorders 239.6 (4,881)	Urinary system disease 242.8 (2,683)	Urinary system disease 235.3 (2,074)
9	Urinary system disease 238.9 (4,757)	Lower GI disorders 233.0 (2,509)	Stroke 217.3 (1,925)
10	Stroke 196.6 (3,941)	Stroke 178.9 (2,016)	Respiratory infections 212.9 (1,862)

Cause category

Total | Birth/ pregnancy | Injury/ violence
Chronic Disease | Infectious Disease | Other

See next page for notes and data source

Notes: Leading causes of hospitalization

King County, 2011-2015 (ranked by the number of hospitalizations)

Note: Rate = Hospitalizations per 100,000 population, age-adjusted to the 2000 U.S. population.

The leading causes of hospitalization are ranked by the number of hospitalizations over the 5-year period (second number in parentheses).

Data Source: Washington State Department of Health, Center for Health Statistics, Hospital Discharge Data (CHARS) 1987-2015.

Pregnancy and childbirth-related includes normal childbirth as well as complications such as prolonged pregnancy and high blood pressure (e.g. preeclampsia, eclampsia).

Heart disease: Major sub-causes include congestive heart failure, cardiac dysrhythmias, acute myocardial infarction (i.e. heart attack), and coronary artery disease.

Unintentional injuries: Major sub-causes include falls, motor vehicle accidents, and poisoning.

Mental illness: Major sub-causes include bipolar disorder, depression, schizophrenia, and alcohol and substance-related disorders.

Cancer and benign tumors: Major sub-causes include uterine cancer, colorectal cancer, prostate cancer, lung cancer, and lymphatic cancer.

Septicemia, also known as sepsis, occurs when a bacterial infection enters the bloodstream and the body's response to the infection triggers widespread inflammation.

Osteoarthritis is a common and painful disease caused by degeneration of the protective cartilage in joints.

Lower gastrointestinal disorders: Major sub-causes include intestinal obstruction without hernia, appendicitis, and diverticulitis.

Urinary system diseases include bladder and urinary tract infections, kidney stones, kidney failure, incontinence, and interstitial cystitis.

Stroke occurs when blood flow to the brain stops, due either to blockage by a blood clot or the rupture and bleeding of a blood vessel.

Respiratory infections: Major sub-causes include pneumonia and acute bronchitis.

Cancer Incidence

Except in the first year of life, cancer and benign growths are among the top 5 causes of hospitalization. The incidence and types of cancer vary substantially by age, gender, race/ethnicity, and neighborhood poverty.

- Cancer rates are highest for those age 65 and older. Rank ordered by the number of new cases per year in this age group, the top three are cancers of the breast (females), prostate (males), and lung.

- Although the numbers are low due to low population size, Native Hawaiians/Pacific Islanders have strikingly high rates of breast, lung, colorectal, and uterine cancers. Black males have the highest rate of prostate cancer; American Indians/Alaska Natives have the highest rate of liver cancer; and whites have the highest rate of melanoma (skin) cancer.

- The incidence of lung and kidney cancers – both linked to cigarette smoking – increase with neighborhood poverty (and liver cancer makes the list of top-10 cancer sites only in high-poverty neighborhoods). Breast and prostate cancers show the opposite pattern, with higher rates in more prosperous neighborhoods, possibly reflecting the longer life expectancies associated with wealth.

Most common cancer types (new cases)
King County (average: 2010-2014)
(ranked by the number of cases)

Rank	Total	Male	Female
1	**Breast (Female) 144.0 (1,553)**	Prostate (Male) 121.7 (1,178)	Breast (Female) 144.0 (1,553)
2	**Prostate (Male) 121.7 (1,178)**	Lung 57.8 (488)	Lung 47.0 (489)
3	**Lung 51.6 (977)**	Colorectal 39.7 (370)	Colorectal 31.7 (339)
4	**Colorectal 35.3 (709)**	Skin Melanoma 34.3 (321)	Uterine (Female) 25.8 (289)
5	**Skin Melanoma 28.2 (580)**	Non-Hodgkin Lymphoma 27.2 (248)	Skin Melanoma 24.0 (259)
6	**Non-Hodgkin Lymphoma 21.9 (438)**	Oral/Pharynx 16.9 (170)	Thyroid 19.8 (209)
7	**Uterine (Female) 25.8 (289)**	Leukemia 19.0 (168)	Non-Hodgkin Lymphoma 17.4 (190)
8	**Leukemia 14.9 (289)**	Liver 15.1 (155)	Ovary (Female) 12.4 (136)
9	**Kidney 13.9 (282)**	Brain 8.3 (80)	Leukemia 11.6 (121)
10	**Thyroid 13.3 (279)**	Stomach 8.9 (78)	Oral/Pharynx 7.3 (80)

Note: Under each cancer site, the first number shown is the 5-year average age-adjusted rate per 100,000 and the number in the parentheses is the average annual count from that cause over the 5-year period. The table presents cancers at the invasive stages only. Cancers at the in situ stage are excluded.

Data Source: Washington State Cancer Registry

Access to Healthcare & Use of Preventive Services

Access to health services is defined as "the timely use of personal health services to achieve the best health outcomes."[32] Access to comprehensive, high-quality healthcare facilitates prevention and early detection of disease. Health insurance coverage is a key component of entry to the healthcare system. In general, people without health insurance receive less medical care and have worse health outcomes. As such, disparities in insurance coverage perpetuate disparities in health and quality of life.

Following implementation of the Affordable Care Act (ACA), healthcare coverage increased dramatically – statewide and in King County. Beginning in October 2010, more young adults were allowed to remain on their parents' health insurance plans. From 2010 to 2016, lack of health insurance dropped by more than 2/3 among young adults ages 18-24. With the initiation of the individual mandate in 2014, access to private insurance was expanded and more adults became eligible for Medicaid.

King County hospitals played an important role in helping families access health insurance, partnering with other organizations on the Coverage Is Here King County campaign to enroll community members in qualified health plans. As a member of the partnership, Public Health-Seattle & King County developed

After implementation of the Affordable Care Act, the percentage of King County residents without health insurance decreased by half.

a network of enrollment navigators who offered enrollment assistance at libraries, food banks, and other public places in communities with the highest rates of uninsured residents. These cooperative efforts paid off. After ACA implementation for additional age groups in 2014, lack of insurance among the unemployed dropped from 42.8% in 2013 to 18.8% in 2016 ; foreign-born naturalized citizens saw a 10.3% absolute decline in lack of coverage.[33]

Access to Healthcare & Use of Preventive Services

Continued

UNINSURED ADULTS

Expansion of coverage through the ACA has reduced the rate of uninsured adults from 16.4% in 2013 (prior to the ACA individual mandate) to 6.7% in 2016. Despite widespread and collective outreach efforts, significant disparities persist.

- Most communities of color remain disproportionately uninsured (American Indians/Alaska Natives, Blacks, and Hispanics/Latinos are all significantly less likely than whites to have coverage). For example, in 2016, Hispanic adults were 6.5 times as likely as non-Hispanic whites to be without coverage.

- Although coverage improved considerably in South Region cities from 2013 to 2016, residents of these cities were still more likely than residents of other areas to be uninsured in 2016.

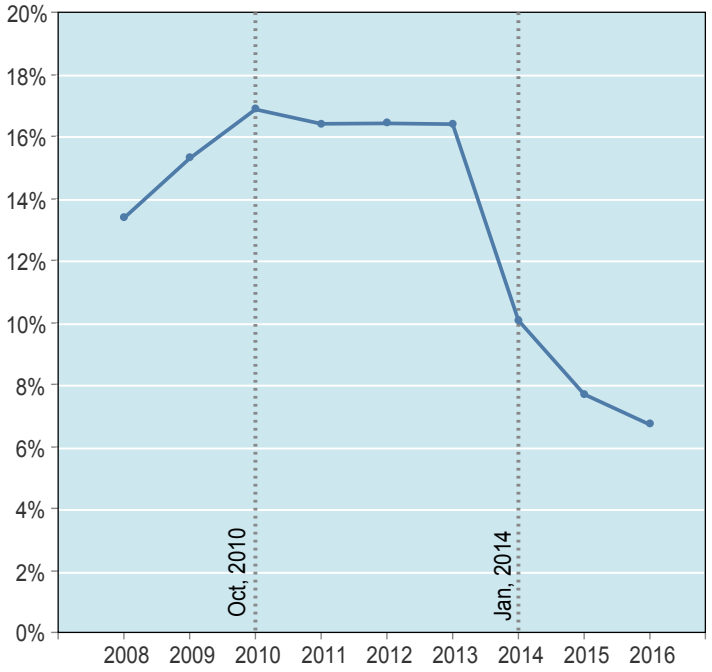
- In 2016, low-income adults (household income below 200% of the Federal Poverty Level) were more than 7 times as likely as those in the highest income households to be uninsured.

- Lack of insurance coverage decreased with age, from a high of 8.1% for 18- to 24-year olds to 4.9% for adults age 55-64.

It will be a few years before we can combine multiple years of "before-ACA" and "after-ACA" data to make stronger comparisons of geographic and racial disparities.

Adults age 18-67 with no health insurance

King County (2008-2016)



Source: American Community Survey

Access to Healthcare & Use of Preventive Services

Continued

UNMET MEDICAL NEEDS

Uninsured adults are more likely to have unmet needs due to cost. Costs are a barrier to seeking needed medical care for 1 in 7 King County adults. Many adults and children in the county do not receive recommended clinical preventive services or regular oral healthcare services.

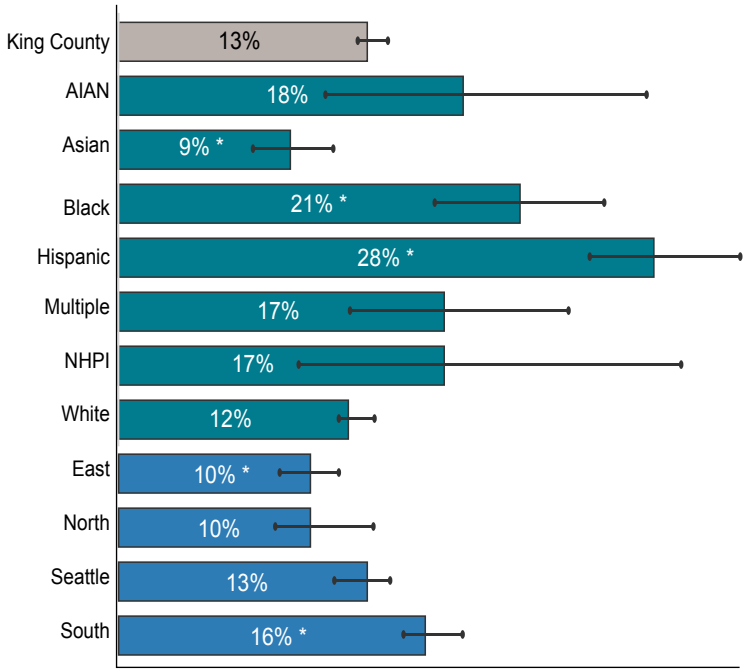
From 2011 to 2015, an average of 13% of King County adults reported they needed to see a doctor in the past 12 months but could not, due to cost. Unmet medical needs were significantly lower in 2015 (the year after implementation of the ACA, and the latest year for which data are available) than in 2013 (the year before ACA implementation). Disparities across the implementation period are shown in 5-year averages for 2011-2015.

- Adults age 25-44 were more likely (16%) than any other age group to report unmet healthcare needs. Only 4% of adults 65 and older reported unmet needs due to cost.

- Asian residents were the least likely of any racial/ethnic group to report having unmet medical needs. Black residents were twice as likely and Hispanics were 3 times more likely than Asians to report unmet medical needs.

- Adults with household income below $15,000 were 8 times as likely as those earning more than $75,000 to report unmet medical needs.

Unmet medical needs (adults)
King County (average: 2011-2015)



Source: Behavioral Risk Factor Surveillance System

* Statistically, sigificantly different from King County average

Access to Healthcare & Use of Preventive Services

Continued

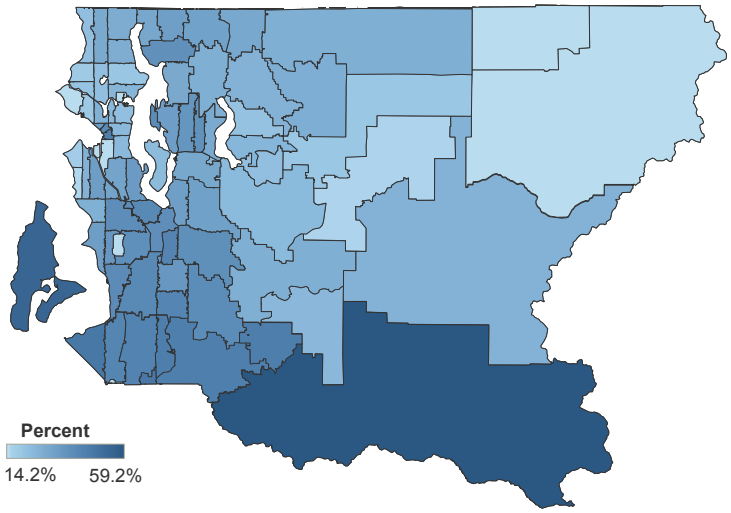
INCOMPLETE VACCINES

Despite improvements, King County still does not meet the Healthy People 2020 objective of reducing incomplete vaccination coverage to 20% of children age 19-35 months. Vaccination rate estimates are based on vaccination records submitted by healthcare providers to the Washington State Immunization Information System (WSIIS). According to the most recent WSIIS report, infant vaccination rates have improved in King County. Analysis of WSIIS data reported as of February 1, 2017 revealed the following:

- In 2014, 38% of King County children age 19-35 months had not completed the recommended set of immunizations for young children; by 2017, the percentage had dropped to 33%.
- Seattle leads King County regions in completion of vaccinations for young children with the county's lowest rate (27%) of incomplete vaccinations by 35 months. Vaccination rates in the North Region of the county have improved since 2014 (41% incomplete in 2014 compared to 31% in 2017).
- Incomplete vaccination rates are highest in low-income neighborhoods.
- In the 98022 zip code – covering parts of Enumclaw and neighboring areas to the East – 59% of children 19-35 months old have not received the complete series of childhood vaccines. This is the highest rate in King County. At 55%, Vashon Island also has one of the county's highest incomplete vaccination rates.

Incomplete vaccination coverage, age 19-35 months,

King County (2017)
King County overall (2017): 33.4%



Data suppressed if too few cases to protect confidentiality and/or report reliable rates, suppressed areas will appear gray in map.

Source: WA State Immunization Information System (Child Profile Health Promotion & Immunization Registry System) PHSKC, APDE; 08/2017

4:3:1:3:3:1:4 series is defined as 4 or more doses of diphtheria, tetanus, acellular pertussis (DTaP) vaccine; 3 or more doses of polio vaccine; 1 measles vaccine; 3 or more doses of Haemophilus influenzae type b (Hib) vaccine; 3 or more doses of hepatitis B (Hep B) vaccine; 1 or more doses of varicella vaccine; and 4 or more doses of pneumococcal conjugate vaccine (PCV).

WSIIS estimates of vaccination coverage may underestimate true coverage due to i) incomplete submission of vaccine records, and ii) retention of vaccine records of children after they have moved to another area. Children may not receive vaccines for a variety of reasons, including i) barriers to accessing clinical preventive services, and ii) family choices to not have children vaccinated.

Access to Healthcare & Use of Preventive Services

Continued

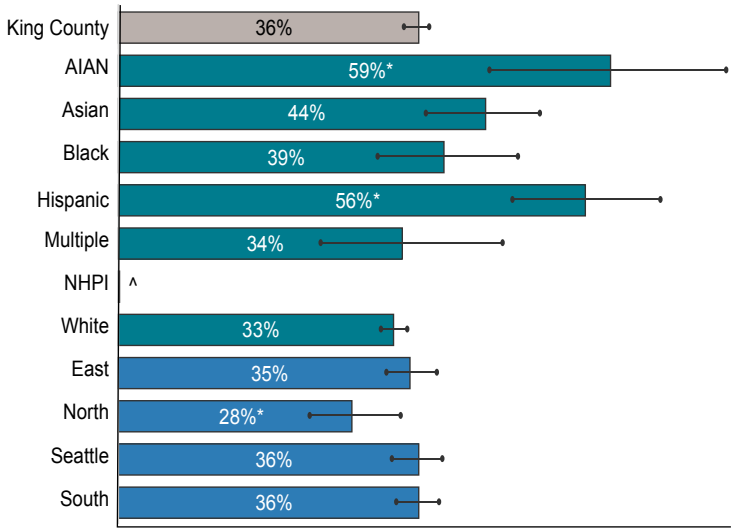
COLORECTAL CANCER SCREENING

From 2011 to 2015, more than 1 in 3 King County adults age 50-75 failed to meet colorectal cancer screening guidelines.

- More than half of adults with a household income below $15,000 failed to meet screening guidelines
- Adults with household income of $75,000 or more were significantly more likely to meet screening guidelines than those with household incomes below $50,000.
- Of all cities and neighborhoods, SeaTac/Tukwila and North East Bellevue shared the highest rate – 47% -- of adults who had not met screening guidelines. At 18%, Bothell/Woodinville had the lowest rate.

Did not meet colorectal cancer screening guidelines (age 50-75)

King County (average: 2011-2015)



Source: Behavioral Risk Factor Surveillance System

* Sigificantly different from King County average

^ Data suppressed if too few cases to protect confidentiality and/or report reliable rates

Access to Healthcare & Use of Preventive Services

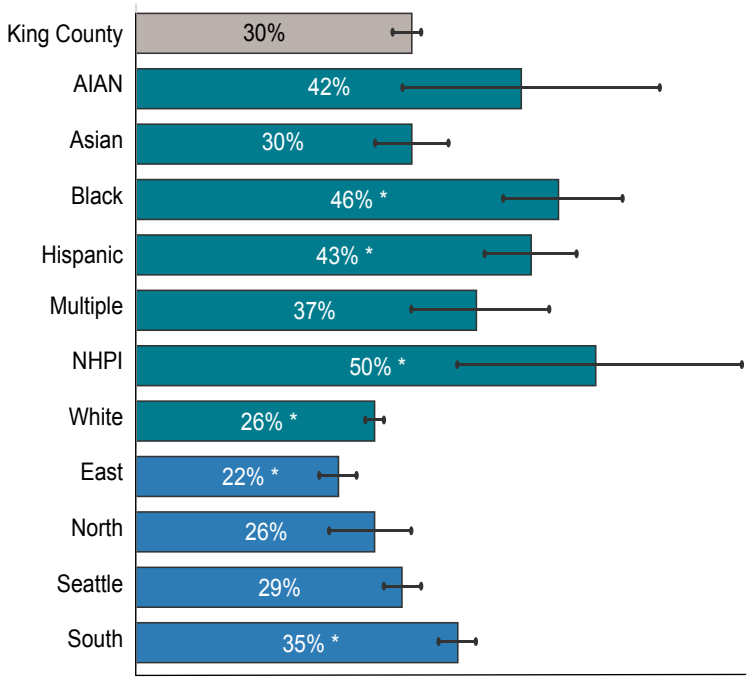
Continued

ADULT DENTAL VISITS

From 2011 to 2015, an average 30% of King County adults reported they did not visit a dentist or dental clinic in the past year. This rate has not changed significantly since 2009.

- More than half of adults with household income below $25,000 had not visited a dentist in the past year, reflecting no change in income disparities for dental care since the 2008-2012 reporting period.
- Whites were significantly more likely than all other racial/ethnic groups, with the exception of Asians, to have had a dental visit in the previous year.
- Regional comparisons show that adults in South Region were most likely (35%) to report that they had not seen a dentist in the previous year. The percentage of adults without consistent dental care has risen over the past 10 years in South Region, while remaining relatively flat in other King County regions.

No dental checkup in past year (adults)
King County (average: 2011-2015)



Source: Behavioral Risk Factor Surveillance System

* Statistically, sigificantly different from King County average

Access to Healthcare & Use of Preventive Services

Continued

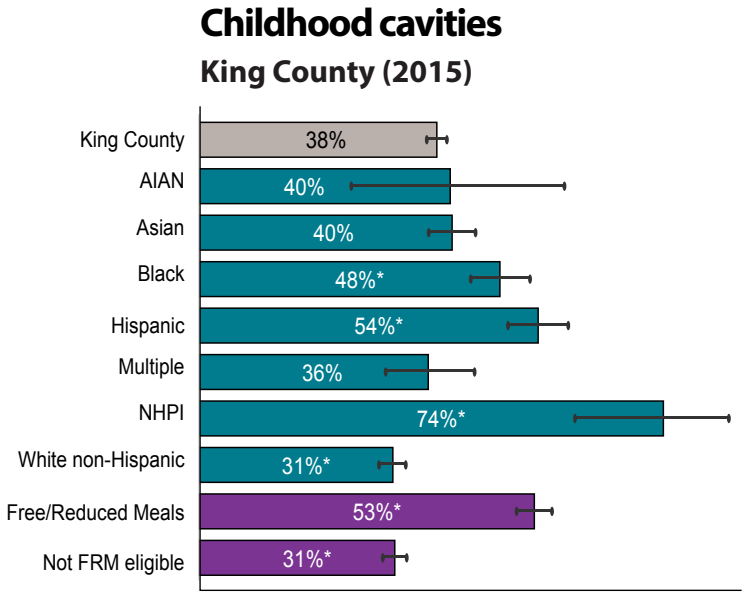
CHILDHOOD DENTAL CARIES

The presence of dental caries (cavities) is a marker of dental health and access to care among children. Childhood experiences with caries – treated or untreated – have not changed much in recent years. In 2015, 38% of children in King County had caries – about the same as the 40% reported in 2010. Among a sample of preschoolers, kindergarteners, and 2nd and 3rd graders, rates were highest for children in grades 2 and 3. Noteworthy disparities in childhood caries warrant targeted outreach related to dental health.

- At a rate 2.4 times that of white children, Native Hawaiian/Pacific Islander children were significantly more likely to have had caries than children in other racial/ethnic groups. Asian, Black, Hispanic, and multiple-race children were also more likely than white children to have had caries.

- More than half of children who are eligible for free/reduced lunch have had caries.

- At 33%, students from English-speaking households were significantly less likely to have had caries than those from households where the primary language was Spanish (54%) or another non-English language (47%).



Source: Smile Survey 2015

* Differs significantly from King County average

Mental Health

Mental illness is a broad term that covers a range of conditions affecting emotion, thinking, and behavior. Common mental health conditions are depression, anxiety, and substance use disorders. Like other health conditions, mental illness is treatable. In general, a mentally healthy person functions well at home, work, and school, and is able to cope with the challenges of daily living. People experiencing "adult serious psychological distress" or "youth with depressive feelings" (the two mental health indicators below) may benefit from consultation with a mental health professional.

Since 2004, youth rates of depressive feelings have increased in King County overall and in South Region.

Mental Health

Continued

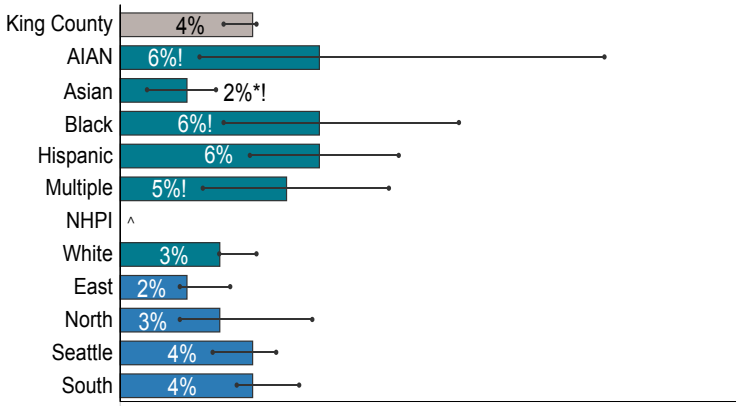
ADULT SERIOUS PSYCHOLOGICAL DISTRESS

From 2011 to 2015, 4% of adults in King County experienced "serious psychological distress" (determined by responses to survey questions about the frequency, over the past 30 days, of feeling nervous, hopeless, restless, worthless, that everything was an effort, and so depressed that nothing could cheer them up). Rates of this indicator have not significantly changed throughout the county since 2009.

- At 15%, the rate for adults with household income below $15,000 was almost 4 times the county average and 15 times the rate for adults with household income at or above $75,000. Income did not just differentiate those at the extremes of the distribution. Adults with income below $25,000 were 3.5 to 7 times more likely than those making $35,000 or more to experience serious psychological distress.

- Adults who identified as lesbian, gay, or bisexual (LGB) were more than twice as likely as heterosexual adults to report serious psychological distress. This was true for both males and females. While stable throughout the county overall, the rate of this indicator among LGB adults has increased significantly since 2009.

Serious psychological distress (adults)
King County (average: 2011-2015)



Source: Behavioral Risk Factor Surveillance System

* Sigificantly different from King County average
! Interpret with caution; sample size is small, so estimate is imprecise
^ Data are suppressed if too few cases to protect confidentiality and/or report reliable rates

Mental Health

Continued

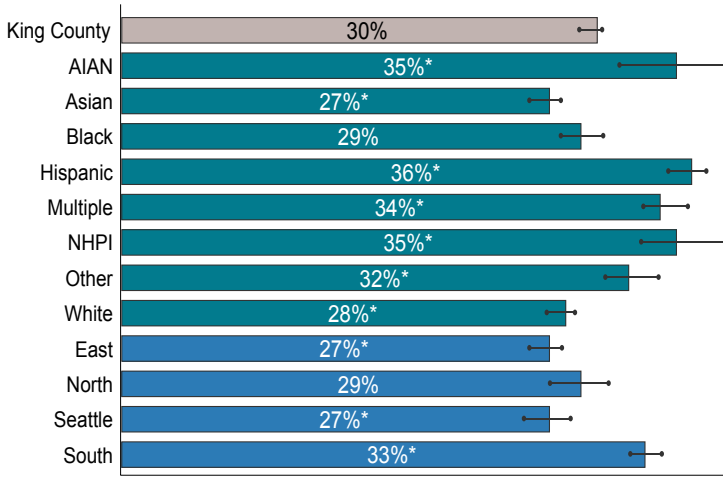
YOUTH WITH DEPRESSIVE FEELINGS

Averaging data from 2014 and 2016, close to 1 in 3 (30%) of King County 8th, 10th, and 12th grade students experienced depressive feelings. Students were considered to have had depressive feelings if they reported that, almost every day for 2 or more consecutive weeks during the past year, they had felt so sad or hopeless that they stopped doing some of their usual activities.

- Female students were 1.7 times as likely as males to report depressive feelings.
- Hispanic, Native Hawaiian/Pacific Islander, American Indian/Alaska Native, and multiple-race youth were more likely than Asian, Black, and white youth to report depressive feelings.
- Youth in South Region were more likely than those in Seattle, East, and North regions to experience depressive feelings.
- From 2004 to 2016, youth rates of depressive feelings increased in King County overall and in South Region. Rates also increased for white and multiple-race students, but declined for Asian students.

Youth with depressive feelings (school - age)

King County (average: 2014 & 2016)



Source: Healthy Youth Survey

* Sigificantly different from King County average

Alcohol, Tobacco, Marijuana, & Other Drugs

While cigarette smoking is the leading preventable cause of death in the United States, excessive use of alcohol is also linked to health risks and premature death. Because tobacco use and alcohol abuse pose significant risks to public health, monitoring these indicators is an ongoing priority in King County.

Youth substance use is a particularly pressing public health concern. The brain is still developing through the early to mid-20s, and regular use of marijuana by youth has been associated with risks for addiction and negative effects on school performance.[v] Driving while under the influence of marijuana and alcohol is especially concerning, given the impact of these substances on the skill necessary for safe driving. Washington state law prohibits giving or selling tobacco to minors under the age of 18, and prohibits selling or giving alcohol or marijuana to minors younger than 21. Given recent changes in state policy decriminalizing recreational marijuana use among adults, monitoring its use and impact on youth is a public health priority.

The opioid epidemic has garnered national headlines as a public health emergency. Preventing opioid addiction, improving access to treatment, and reducing fatal overdoses are areas of targeted action in King County.

[v] *Centers for Disease Control and Prevention (CDC). What Parents Need to Know About Marijuana Use and Teens. 2017.* https://www.cdc.gov/marijuana/pdf/Marijuana-Teens-508.pdf. Accessed Oct. 20, 2017.

Across all King County regions, youth cigarette smoking has decreased by half since 2004.

Alcohol, Tobacco, Marijuana, & Other Drugs

Continued

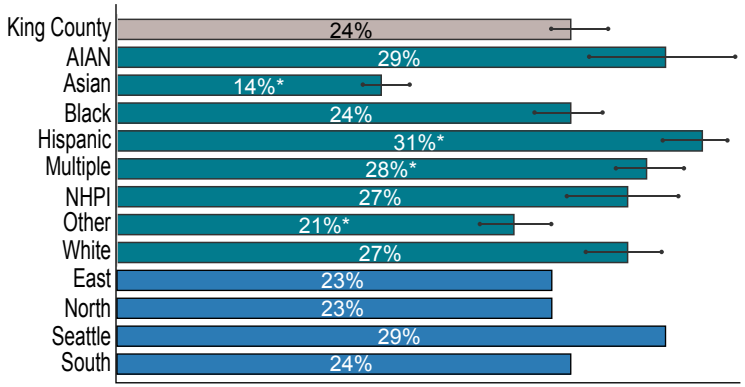
YOUTH SUBSTANCE USE

Tobacco, alcohol, and marijuana are all potentially addictive, as are many prescription drugs. Laws are in place to help protect youth during the years when their brains are most susceptible to addiction. This substance use indicator reports on 8th, 10th, and 12th graders' use of alcohol, marijuana, painkillers (to get high), or any illicit drug (other than alcohol, tobacco, and marijuana) in the past 30 days.

- Averaging data from 2014 and 2016, 24% of King County youth attending public schools in the 8th, 10th and 12th grades reported using alcohol, marijuana, painkillers, or any illicit drug in the past 30 days.
- Nearly 4 out of 10 students in 12th grade engaged in alcohol, marijuana, painkillers, or any illicit drug use in the past 30 days.
- There was no gender difference in substance use.
- Lesbian, gay, and bisexual students were 1.5 times more likely than heterosexual students to report substance use.
- The substance use rate for 12th-grade youth was 4.3 times that of the 8th graders and 1.6 times the county average for students of all grades.
- From 2004 to 2016, youth substance use rates declined for the county overall.

Alcohol, marijuana, painkiller, or any illicit drug use (school-age)

King County (average: 2014 & 2016)



Source: Healthy Youth Survey

* Significantly different from King County average

Alcohol, Tobacco, Marijuana, & Other Drugs

Continued

TOBACCO USE

According to the Centers for Disease Control and Prevention, "cigarette smoking harms nearly every organ of the body, causes many diseases, and reduces the health of smokers in general." One of the most encouraging findings in this report is that smoking rates continue to go down for both adults and youth.

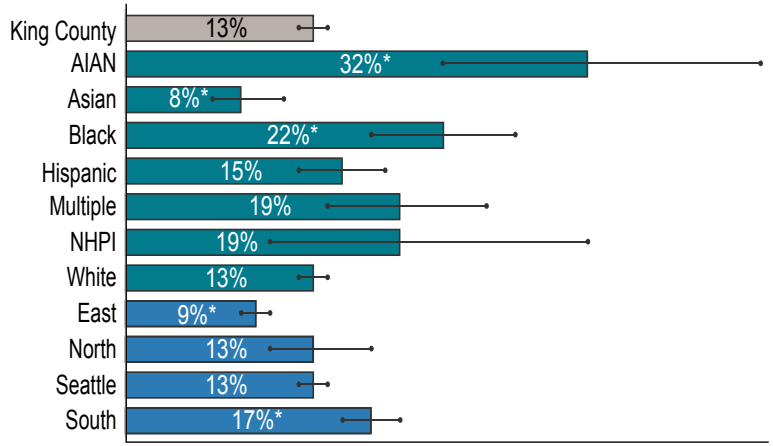
Adult Smoking

Due in part to policy changes and associated cultural shifts, adult cigarette smoking has declined dramatically since the year 2000. From 2011 to 2015, 13% of King County adults reported that they currently smoked cigarettes every day or on some days.

- Adults with household income less than $15,000 were 4 times more likely than those with income at or above $75,000 to be current smokers.
- Males were 1.3 times more likely than females to smoke cigarettes.
- Lesbian, gay, and bisexual adults were almost twice as likely as heterosexual adults to be current smokers.
- Approximately 3 out of 10 American Indian/Alaska Native residents were cigarette smokers.
- Adults in South Region were almost twice as likely as those in East Region to be current smokers.
- From 2000 to 2015, adult smoking rates declined by 43% for the county overall and for all regions except South Region, where the rate declined between 2000 and 2006 and leveled out between 2006 and 2015. Still, the adult smoking rate in South Region declined by 38% over the 15-year period.

Cigarette smoking (adults)

King County (average: 2011-2015)



Source: Behavioral Risk Factor Surveillance System

* Significantly different from King County average

Alcohol, Tobacco, Marijuana, & Other Drugs

Continued

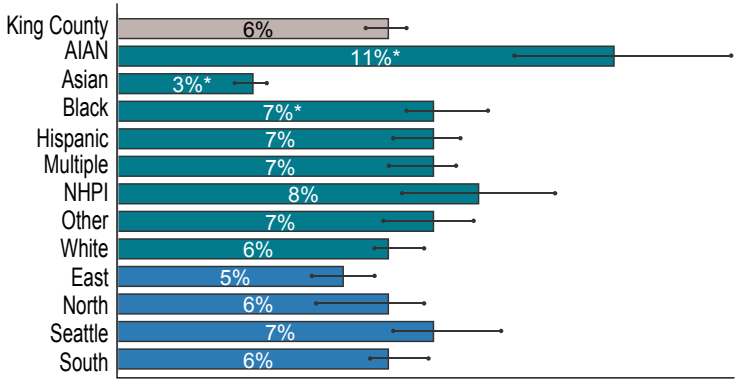
Youth Smoking

School-age students were considered cigarette smokers if they had smoked in the last month. This indicator did not include use of other tobacco products. Averaging data from 2014 and 2016, 6% of King County youth attending public schools in the 8th, 10th and 12th grades were current cigarette smokers.

- Among 12th graders, 1 in 10 were smokers, more than 3 times the rate for 8th graders.
- Although smoking did not differ by gender, lesbian, gay, and bisexual youth were more than 3 times as likely as heterosexual youth to smoke cigarettes.
- American Indian/Alaska Native students were almost 4 times more likely than Asian students to be cigarette smokers.
- From 2004 to 2016, rates of youth cigarette smoking fell by about half – for King County overall, all 4 of the county's regions, and all racial/ethnic groups.

Cigarette smoking (school-age)

King County (average: 2014 & 2016)



Source: Healthy Youth Survey

* Significantly different from King County average

Alcohol, Tobacco, Marijuana, & Other Drugs

Continued

OPIOID AND OTHER DRUG-RELATED DEATHS

The overall number of drug overdose deaths in King County has increased in recent years. The number of overdose deaths was 332 in 2016, compared to 244 in 2010. Prescription opioid deaths have decreased but heroin- and methamphetamine-involved deaths have increased.

- There were 107 prescription opioid-involved deaths in 2016, compared to 138 in 2010.
- Heroin-involved deaths have more than doubled – from 51 to 118 – between 2010 and 2016.
- Methamphetamine-involved deaths in King County have increased dramatically in recent years, from 15 deaths in 2010 to 98 deaths in 2016.

INJECTION DRUG USE

Public Health-Seattle & King County (PHSKC) conducts a biannual survey of needle-exchange clients to monitor demographics, health, and behavior trends among people who inject drugs. In June 2017, PHSKC needle-exchange staff surveyed 427 needle-exchange clients. Among these respondents:

- The primary drug of choice was heroin or other opiates (64% of respondents), followed by methamphetamine (17%), or methamphetamine and heroin combined (10%).
- 20% of respondents had experienced a non-fatal overdose in the past 12 months.
- 62% reported owning a naloxone opioid overdose reversal kit in the past 12 months, an increase from 47% in 2015. In 2017, 30% of all respondents reported using naloxone to reverse an overdose.
- While 78% were interested in reducing or stopping opioid use and 62% were interested in stopping or reducing stimulant use, only 28% were currently in treatment for substance use disorder.

Pregnancy & Birth

A healthy community is one that ensures that all children thrive and reach their full potential. A mother's mental, physical, emotional, and socioeconomic well-being – before, during, and after pregnancy – can affect outcomes in infancy, childhood, and adulthood. Improving the health of mothers, infants, and children is a global public health concern and a priority in King County. Successful pregnancies and births are markers of overall community health. While King County has made progress in decreasing rates of poor birth outcomes, disparities persist, particularly among Black and American Indian/Alaska Native populations.

Infants born to Black or American Indian/Alaska Native mothers were more than twice as likely as those born to Asian or white mothers to die before their first birthday.

EARLY AND ADEQUATE PRENATAL CARE

Starting prenatal care early in pregnancy and continuing with regular visits improves the chances of a healthy pregnancy and birth. This indicator measures births for which i) prenatal care started before the end of the 4th month and ii) 80% or more of the recommended number of visits occurred.

From 2011 to 2015, more than 7 out of 10 expectant mothers (71.7%) received early and adequate prenatal care, a slight increase from the 2008-2012 average (69.7%) reported previously. King County has not yet achieved the Healthy People 2020 objective that at least 77.6% of pregnant women receive early and adequate prenatal care.

- The chances of receiving early and adequate prenatal care increased with age, from a low of 55.2% among mothers younger than 18 to 77.2% for mothers age 40 and older.

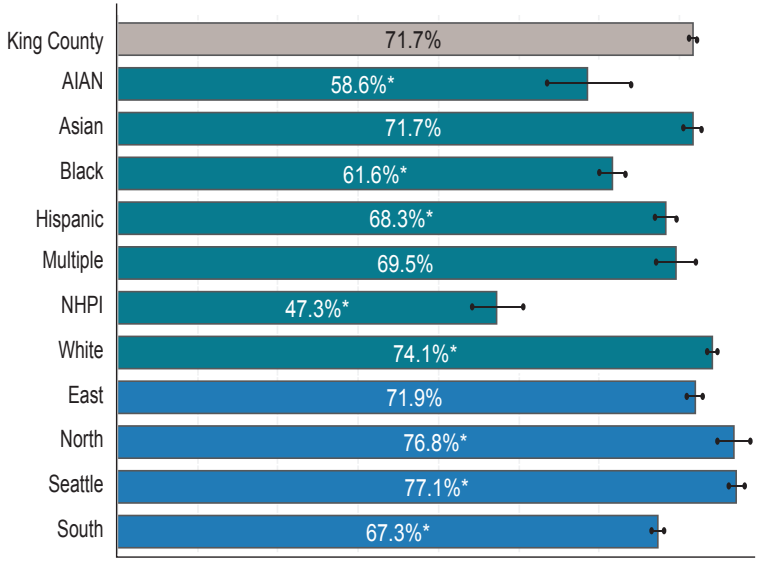
- American Indian/Alaska Native, Black, Hispanic, and Native Hawaiian/Pacific Islander mothers were less likely than Asian and white mothers to receive early and adequate prenatal care. These disparities have not changed since the previous report.

- The probability of mothers receiving early and adequate prenatal care was lowest in high-poverty neighborhoods and highest in the most prosperous neighborhoods.

- Since 2000, early and adequate care has increased in Seattle and decreased in East Region. After a 7-year decline, South Region has rebounded to its 2000 level.

Early and adequate prenatal care

King County (average: 2011-2015)



Source: Birth certificate data, Washington State Department of Health, Center for Health Statistics

* Significantly different from King County average

Pregnancy & Birth

Continued

LOW BIRTH WEIGHT

Any infant born weighing less than 2500 grams (about 5.5 pounds) is considered low birth weight. Low birth weight infants are at higher risk of infant mortality, respiratory disorders, and neurodevelopmental disabilities.

From 2011 to 2015, 6.5% of infants born in King County were low birth weight – unchanged since the previous report.

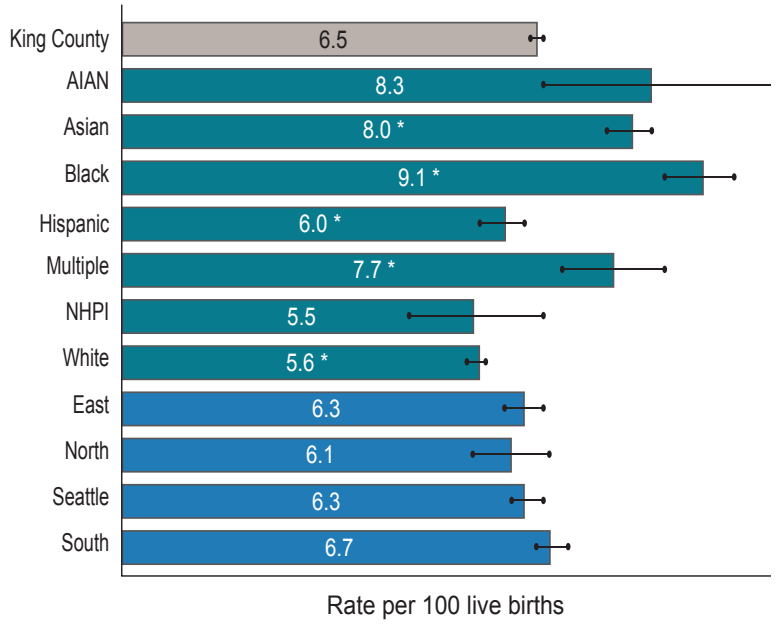
- Although King County meets the Healthy People 2020 objective of 7.8% or fewer infants born at low weight, 1,646 low birth weight babies were born in King County in 2015.

- Infants born to Black mothers were more likely to be low birth weight than infants born to mothers of all other racial/ethnic groups (except American Indians/ Alaska Natives).

- After increasing in the early 2000s, rates of low birth weight in King County plateaued from 2006 to 2015. Although patterns vary somewhat across King County regions, in no region has the rate of low birth weight infants consistently declined.

Low birth weight (all births)

King County (average: 2011-2015)



Source: Birth certificate data, Washington State Department of Health, Center for Health Statistics

* Significantly different from King County average

INFANT MORTALITY

The infant mortality rate is the number of babies who die before their first birthday per 1,000 live births in a given year. More than half of infant deaths are associated with labor and delivery-related conditions, birth defects, and prematurity. Because many of these deaths are preventable, infant mortality is a measure of the overall health of a population.

From 2011 to 2015, King County's average infant mortality rate was 4.1 deaths per 1,000 live births – representing no change since the last report. Infant mortality in King County has declined since 2000.

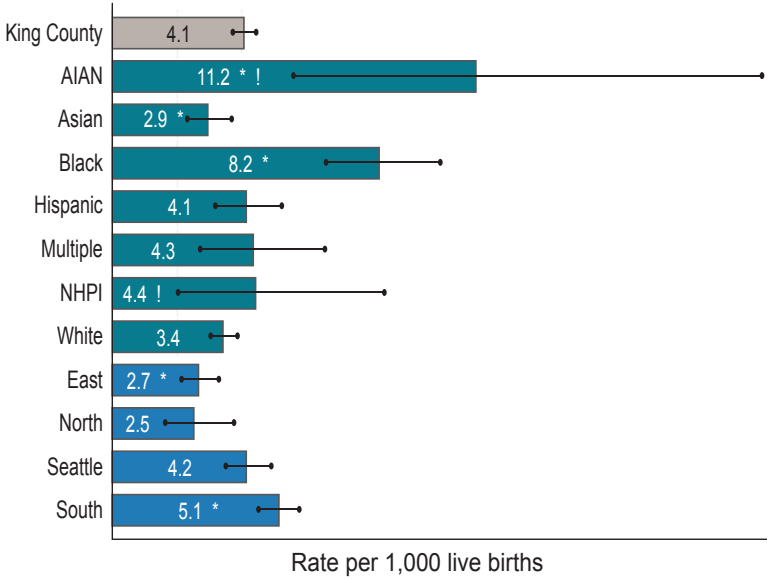
- Infants born to Black or American Indian/Alaska Native mothers were more than 2.5 times as likely as those born to Asian or white mothers to die before their first birthday. In a change from the last report, babies born to multiple-race mothers were no more likely than those born to white mothers to die in infancy.

- The infant mortality rate in low-poverty neighborhoods was just 60% of the rate in high-poverty neighborhoods. An increasing proportion of King County's high-poverty neighborhoods are in South Region, where the infant mortality rate exceeds the rates for East and North Regions.

- Infants born to mothers age 24 and younger are more likely than those born to older mothers to die in their first year.

Infant mortality

King County (average: 2011-2015)



Source: Linked birth-death certificate data, Washington State Department of Health, Center for Health Statistics

* Significantly different from King County average

! Interpret with caution; sample size is small, so estimate is imprecise

Physical Activity, Nutrition, & Weight

Physical inactivity, unhealthy diet, and obesity – all have been identified as risk factors for heart disease, cancer, and stroke, which are leading causes of death in King County. Physical inactivity, unhealthy diet, and obesity can also increase the risk of developing type 2 diabetes – the leading cause of blindness and kidney failure in the United States. Each of these risk factors is an appropriate target for prevention-focused interventions. As with many leading causes of death and disability, disparities by race/ethnicity, economic status, and geographic location are common and in some instances are increasing.

Fewer than 1 in 4 students in 8th, 10th, and 12th grades get the recommended 60 or more minutes of daily physical activity.

Physical Activity, Nutrition, & Weight

Continued

PHYSICAL ACTIVITY: YOUTH AND ADULTS

Regular physical activity helps control weight, strengthen bones and muscles, and boosts mental health and academic performance. It also reduces the risks of many chronic illnesses and, for older adults, improves their ability to conduct daily activities and helps prevent falls.

Youth Physical Activity

In 2014 and 2016, fewer than 1 in 4 students in 8th, 10th, and 12th grades got the recommended 60 or more minutes of daily physical activity. The Healthy People 2020 goal is 31.6% of adolescents meeting physical activity requirements.

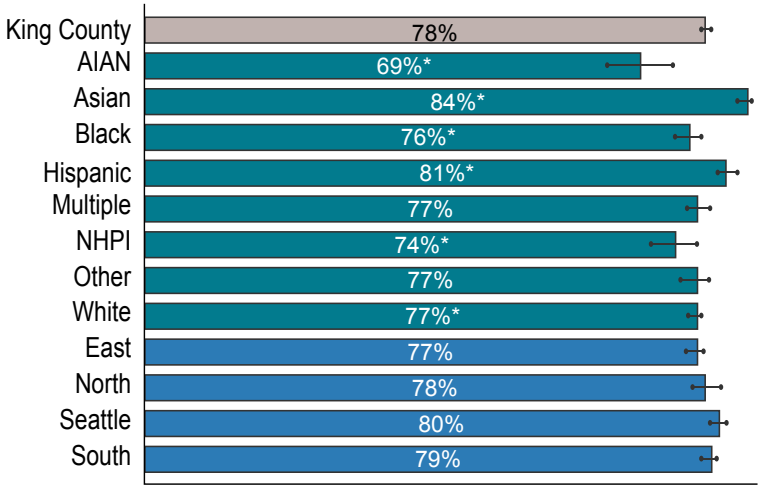
- As grade level increased, student participation in physical activity declined; by 12th grade, only 18% of students met recommendations.

- At all grade levels, female students were significantly less likely than male students to meet physical activity recommendations; by 12th grade, only 12% of female students met recommendations.

- Since 2006, the proportions of students meeting physical activity recommendations have increased for the county, in all 4 regions, and for all racial/ethnic groups. But the rate of improvement is slow, and there is still a long way to go to reach suggested standards.

Physical activity recommendation not met (school-age)

King County (average: 2014 & 2016)



Source: Healthy Youth Survey

* Significantly different from King County average

Physical Activity, Nutrition, & Weight

Continued

Adult Physical Activity

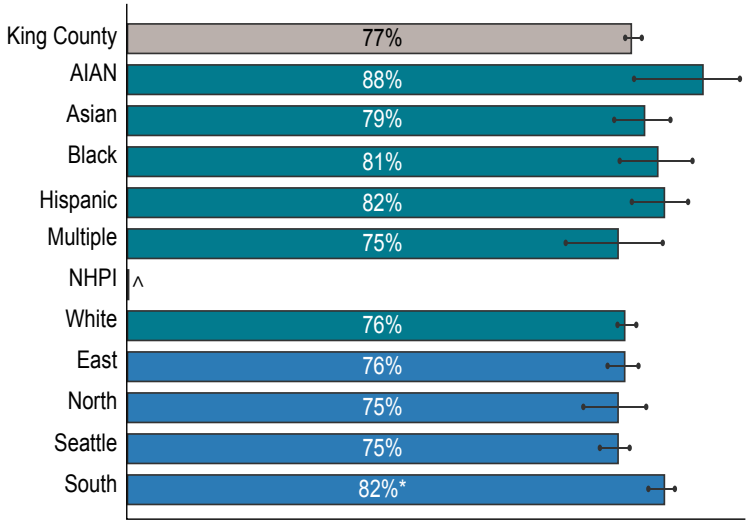
As with youth, fewer than 1 in 4 King County adults met federal physical activity recommendations (between 2011 and 2015), defined as muscle-strengthening exercises on 2 or more days per week and either 150 minutes of moderate-intensity or 75 minutes of vigorous-intensity aerobic activity per week.

- This rate has been consistent, without significant improvement since 2009.

- There were no significant differences by race/ethnicity – in no group did more than 25% of adults meet physical activity recommendations.

Physical activity recommendation not met (adults)

King County (average: 2011-2015)



Source: Behavioral Risk Factor Surveillance System

* Significantly different from King County average

^ Data is suppressed if too few cases to protect confidentiality and/or report reliable rates

Physical Activity, Nutrition, & Weight

Continued

SUGAR-SWEETENED BEVERAGE CONSUMPTION: YOUTH

Drinking sugar-sweetened beverages is associated with weight gain, dental cavities, and several chronic illnesses. In 2014 and 2016, an average of 15% of King County students in 8th, 10th, and 12th grades consumed sodas or sugar-sweetened beverages daily. This appears to continue a steady decline from 2004, when almost half of King County students reported drinking at least one soda on the previous day (changes in the question's recall period – previous day vs. the previous week – precludes direct comparison or trend analysis). To further curb consumption of these beverages, as of January, 2018, Seattle joins Philadelphia, San Francisco, and other cities in taxing sodas and other sugary drinks.

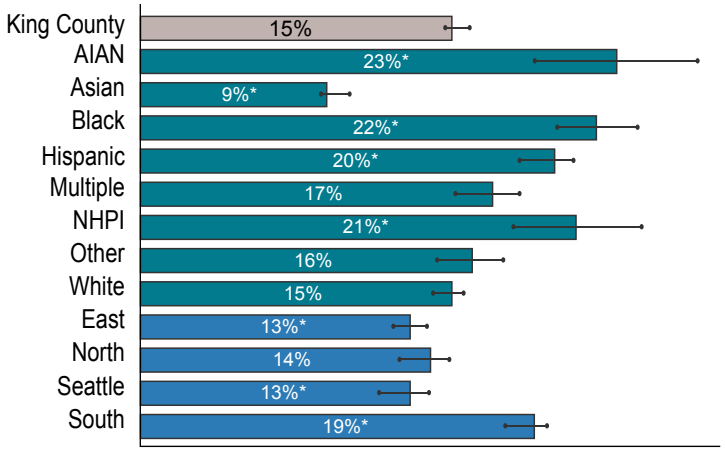
- Male students were 1.7 times more likely than females to drink sodas or sugar-sweetened beverages daily.

- Hispanic, Native Hawaiian/Pacific Islander, Black, American Indian/Alaska Native, and multiple-race students were more likely than Asians and whites to consume sodas or sugar-sweetened drinks every day.

- South Region students were more likely to report consuming soda daily than students in the other 3 regions.

Drank soda or sugar sweetened beverage daily (school-age)

King County (average: 2014 & 2016)



Source: Healthy Youth Survey

* Significantly different from King County average

Physical Activity, Nutrition, & Weight

Continued

OBESITY: YOUTH AND ADULTS

Obesity affects more than a third of American adults and is associated with excess individual medical costs and increased risk of premature death. If obesity trends continue to increase, the United States will be responsible for nearly half of global costs associated with overweight and obesity, which are projected to reach 1.2 trillion by 2025.[34]

Youth Obesity

Youth are considered obese if their Body Mass Index (BMI) is in the top 5% for their age and gender. Averaging 2014 and 2016 survey data, 9% of King County students attending public schools in 8th, 10th, and 12th grades were obese.

- Asian and white students were less likely to be obese than students of all other racial/ethnic groups. At all three grade levels, Native Hawaiian/Pacific Islander students were 3 to 4 times more likely than Asian or white students to be obese.

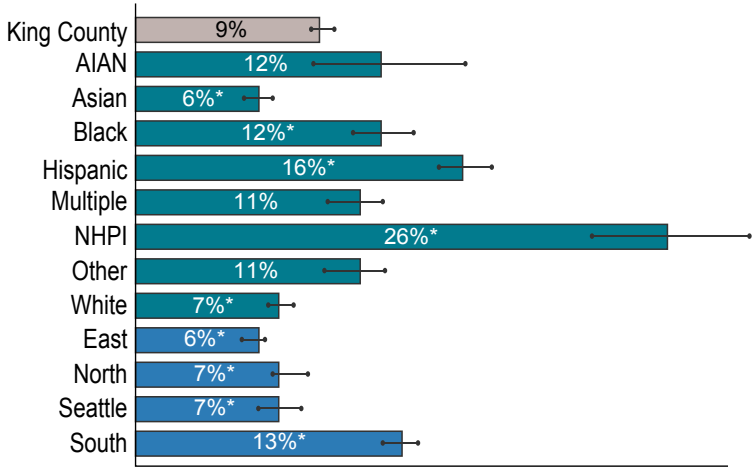
- Male students were more likely than female students to be obese.

- At all grade levels, students who identified as lesbian, gay or bisexual were significantly more likely to be obese than heterosexual students.

- While student obesity rates for the county as a whole have been flat since 2004, obesity rates for students in South Region have increased.

Obesity (school-age)

King County (average: 2014 & 2016)



Source: Healthy Youth Survey

* Significantly different from King County average

Physical Activity, Nutrition, & Weight

Continued

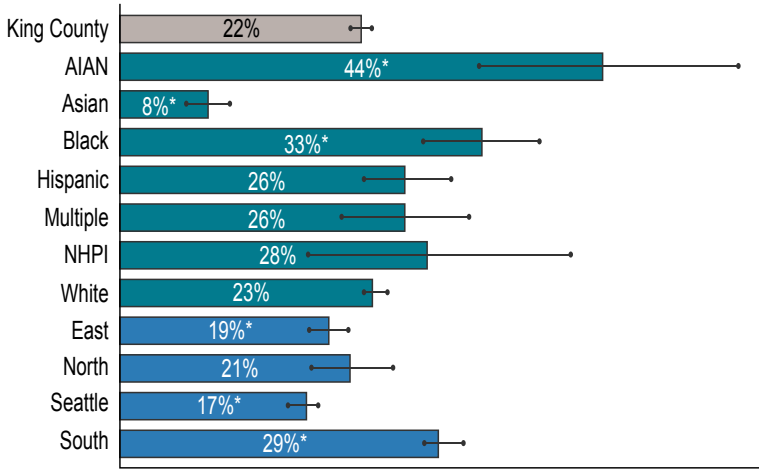
Adult Obesity

Obesity rates among King County adults increased from 2000 to 2009, but have been relatively stable since 2009. In the 2011-2015 period, as in previous years, 22% of King County adults were obese, reporting a Body Mass Index (BMI) greater than or equal to 30.

- Asian residents had the lowest obesity rates. With the highest rates in the county, American Indian/ Alaska Native residents were 5.5 times more likely than Asians, and twice as likely as whites, to be obese.
- At 28%, obesity is most prevalent among residents with the lowest annual household incomes (less than $15,000), and least prevalent among those with annual household income greater than $75,000 (19%).
- Although the overall obesity rate in King County plateaued after 2009, obesity rates among Hispanic and American Indian/Alaska Native residents continued to increase through 2015.

Obesity (adults)

King County (average: 2011-2015)



Source: Behavioral Risk Factor Surveillance System

* Significantly different from King County average

Violence & Injury Prevention

This section reports on hospitalizations from unintentional injuries and on hospitalizations and deaths related to suicide. Unintentional injuries account for 82% of the total injury hospitalizations in King County, with falls accounting for the majority of those hospitalizations. Suicide measures presented here are also relevant to mental health. For every case that results in hospitalization or death, many more injuries and suicide attempts are never reported. Hospitalization data exclude cases where emergency department treatment was received but the patient was not admitted to the hospital.

Data describing additional causes of hospitalization and death from intentional and unintentional injuries are available at http://www.kingcounty.gov/health/indicators.

The rate of suicide in King County is almost 5 times the homicide rate.

Violence & Injury Prevention

Continued

UNINTENTIONAL INJURY HOSPITALIZATIONS

In 2015, the most recent year for which we have data, King County hospitals reported a total of 10,832 admissions for unintentional injuries[vi] (excluding deaths) – a rate of 519.4 hospitalizations per 100,000 population. The county's 2011-2015 average annual rate was 514 per 100,000, down from the 2008-2012 average annual rate of 526.9 per 100,000 population.

- Adults in high-poverty neighborhoods were more likely than those in medium- or low-poverty neighborhoods to be hospitalized for unintentional injuries.

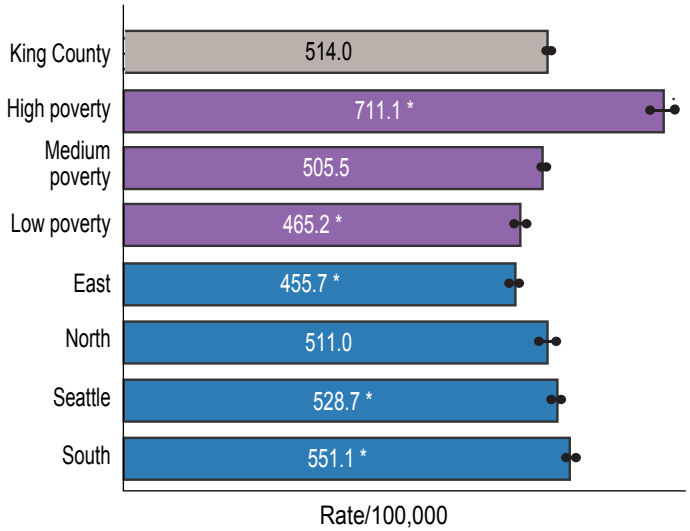
- For adults age 65 and older, the rate of hospitalization for unintentional injury was 4.2 times the county average.

- Overall, the county rate has declined since 2000, driven in part by a significant decline in South Region, though South Region rates remain higher than the other regions.

[vi] Included are injuries due to falls, fire, firearms, drowning, motor vehicle collision, poisoning, and suffocation.

Unintentional injury hospitalizations

King County (average: 2011-2015)



Source: Washington State Department of Health, Office of Hospital and Patient Data Systems

* Differs significantly from King County average

Violence & Injury Prevention

Continued

SUICIDE DEATHS

From 2011-2015, an average of 255 suicide deaths occurred in King County each year. The 2011-2015 average suicide death rate in King County was 12.2 per 100,000 population, compared to 11.5 per 100,000 population in 2008-2012.

- Over the same 2011-2015 period, King County's average annual suicide rate was 4.5 times the homicide rate, which was 2.7 deaths per 100,000 population.

- The suicide death rate for adults age 45 and older was 1.5 times the county average.

- Males were 2.8 times more likely than females to die from suicide.

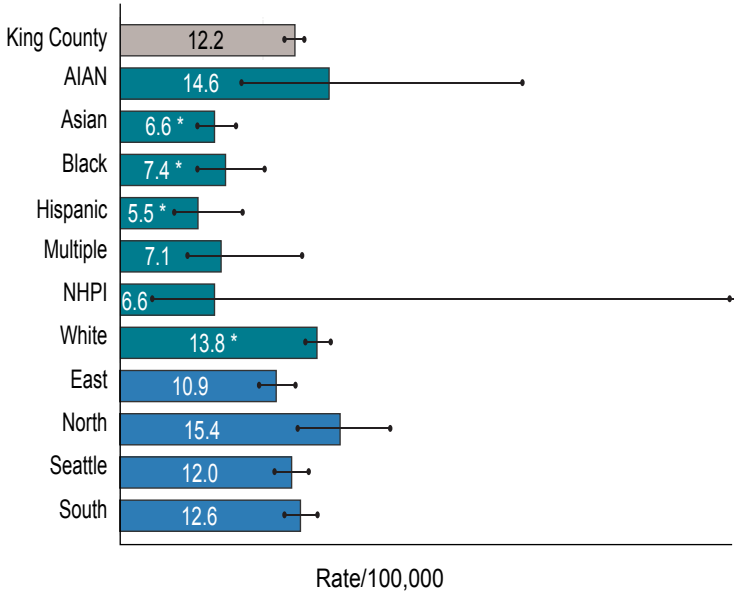
- The suicide rates for Hispanic, Asian, and Black populations were significantly lower than the county average, while the rate for whites exceeded the county average at 13.8 per 100,000. A very different pattern emerged for homicide deaths, where the average annual rate for Black residents (14.1 per 100,000 population) was 5.2 times the county average.

- The average suicide rate among American Indians/ Alaska Natives (AIAN) was 14.6 per 100,000 population – the highest of all racial/ethnic groups, but this difference failed to reach statistical significance, at least partially due to the small size of King County's AIAN population.

- The King County suicide death rate has been rising since 2000, driven primarily by a steady upward trend in South Region.

Suicide

King County (average: 2011-2015)



Source: Washington State Department of Health, Center for Health Statistics, Death Certificates

*Differs significantly from King County average

SUICIDE HOSPITALIZATIONS

From 2011-2015, an average of 808 non-fatal suicide hospitalizations occurred in King County each year, for an average rate of 39.6 per 100,000 population. The 2008-2012 average rate was 41.5 per 100,000 population.

- The suicide hospitalization rate among adults age 18-24 was significantly higher than all other age groups, and 1.7 times the county average. County residents in the youngest (less than 18 years old) and oldest (65+ years) age groups were least likely to be hospitalized for suicide.

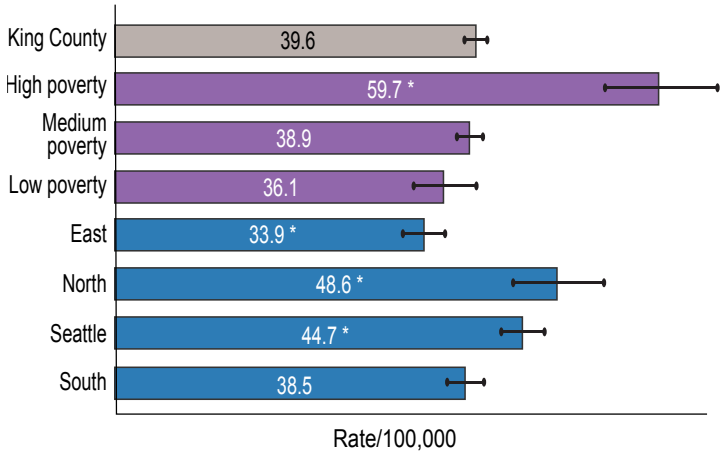
- Adults living in high-poverty neighborhoods were 1.7 times more likely than those in low-poverty areas to be hospitalized for suicide.

- Female residents were 1.6 times more likely than males to be hospitalized after a suicide attempt – the reverse of the pattern for suicide completions.

- Adults in North Region and Seattle were more likely than those in South and East regions to be hospitalized for suicide.

- Suicide hospitalization rates for the county as a whole decreased from 2000-2015. Over the same period, rates increased in East Region and decreased in South Region.

Suicide hospitalizations
King County (average: 2011-2015)



Source: Washington State Department of Health, Office of Hospital and Patient Data Systems

* Differs significantly from King County average

End Notes

REFERENCES

1. Angela Glover Blackwell on the American Dream. Moyers & Company. 2012. http://billmoyers.com/segment/angela-glover-blackwell-on-the-american-dream/. Accessed October 28, 2017.

2. Deaton A. On death and money: History, facts, and explanations. *JAMA*. 2016; 315(16):1703-5.

3. Aging in King County: Profile of the Older Population. Area Agency on Aging for Seattle and King County - Aging and Disability Services. http://www.agingkingcounty.org/data-reports/age-related-population-data/. Published 2017. Accessed October 29, 2017.

4. Centers for Medicare & Medicaid Services. National Health Expenditure Fact-Sheet. National Health Expenditure Data. https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html. Published 2017. Accessed October 29, 2017.

5. Miller G, Merlo C, Demissie Z, Sliwa S, Park S. Trends in beverage consumption among high school students — United States, 2007–2015. *MMWR*. 2017;66(4):112-116.

6. Centers for Disease Control and Prevention. Cancers Associated with Overweight and Obesity Make up 40 percent of Cancers Diagnosed in the United States. CDC Online Newsroom. https://www.cdc.gov/media/releases/2017/p1003-vs-cancer-obesity.html. Published 2017. Accessed October 29, 2017.

7. Christopher GC, Harris CM, Harris RT, et al. *The State of Obesity: Better Policies for a Healthier America, 2017*. Trust for America's Health; 2017.

8. Nutrition, Physical Activity, and Obesity. Data, Trends, and Maps. Centers for Disease Control and Prevention. https://nccd.cdc.gov/dnpao_dtm/rdPage.aspx?rdReport=DNPAO_DTM.ExploreByLocation&rdRequestForwarding=Form. Accessed November 9, 2017.

9. Balk G. Seattle once again nation's fastest-growing big city; population exceeds 700,000. *Seattle Times*. May 25, 2017: https://www.seattletimes.com/seattle-news/data/seattle-once-again-nations-fastest-growing-big-city-population-exceeds-700000/. Accessed November 15, 2017.

End Notes

Continued

10. *Statistical Profile on King County, 2015*. County Executive, Dow Constantine. King County, WA. http://www.kingcounty.gov/~/media/depts/executive/performance-strategy-budget/regional-planning/Demographics/KC-profile2016.ashx?la=en. Accessed September 21, 2017.

11. Maps of Regions & Cities, Cities & Neighborhoods, School Districts, Census Tracts. King County Geographies. Communities Count: Social & Health Indicators Across King County. http://www.communitiescount.org/index.php?page=maps-of-regions-cities-health-planning-areas. Published 2015. Accessed November 2, 2017.

12. Dwyer-Lindgren L, Stubbs RW, Bertozzi-Villa A, et al. Variation in life expectancy and mortality by cause among neighbourhoods in King County, WA, USA, 1990–2014: A census tract-level analysis for the Global Burden of Disease Study 2015. *Lancet Public Health*. 2017;2(9):e400-e410.

13. Vance-Sherman A. King County Profile. *City Profiles*. Employment Security Department, Washington State. 2015. https://fortress.wa.gov/esd/employmentdata/reports-publications/regional-reports/county-profiles/king-county-profile. Updated September 2015. Accessed November 2, 2017.

14. U.S. Bureau of Labor Statistics. Unemployment Rate in King County, WA. FRED, Federal Reserve Bank of St. Louis. https://fred.stlouisfed.org/series/LAUCN530330000000003A. Published September 8, 2017. Accessed October 25, 2017.

15. Workforce Information and Technology Services. *Monthly Employment Report for October 2017*. Washington State Employment Security Department; 2017.

16. Lewis C. How King County Became one of the Best Affordable Care Act Success Stories in the Country. Executive News. http://www.kingcounty.gov/elected/executive/constantine/news/release/2016/September/22-uninsured-rate-record.aspx. Published 2016. Accessed November 3, 2017.

17. Felt C. *King County's Changing Demographics: Investigating Our Increasing Diversity*. Seattle, WA; 2016.

18. De Luna R. Afraid to Get Baby Formula: Immigrants Fear Trump Policies. *KUOW*. http://kuow.org/post/afraid-get-baby-formula-immigrants-fear-trump-policies. Published July 23, 2017. Accessed September 15, 2017.

End Notes

Continued

19. Dorn RI, Kanikeberg K, Burke A. *Educating English Language Learners in Washington State 2009–10 Report to Legislature*. Olympia, WA: Migrant and Bilingual Education - Office of Superintendent of Public Instruction; 2011.

20. Gebeloff R, Evans T, Scheinkman A. Diversity in the Classroom. *New York Times*. December 6, 2016. Accessed September 17, 2017.

21. *2012 Projections - County Growth Management Population Projections by Age and Sex: 2010-2040*. Olympia, WA: Washington State Office of Financial Management, Forecasting Division; 2012.

22. Pan L, Sherry B, Njai R, Blanck HM. Food insecurity is associated with obesity among US adults in 12 states. *J Acad Nutr Diet*. 2012;112(9):1403-1409.

23. Basic Food Participation by Age, King County Cities (2002-2016). Communities Count: Social & Health Indicators Across King County. http://www.communitiescount.org/index.php?page=basic-food-viz. Published 2017. Accessed November 2, 2017.

24. Food Bank Visits, King County (2002-2016). Communities Count: Social & Health Indicators Across King County. http://www.communitiescount.org/index.php?page=food-bank-visits. Published 2017. Accessed November 2, 2017.

25. Light Rail Transforms Tukwila Commute. Communities Count: Social & Health Indicators Across King County. http://www.communitiescount.org/news/?m=201606. Published 2016. Accessed November 2, 2017.

26. Applied Survey Research. *Count Us In: Seattle/King County Point-In-Time Count of Persons Experiencing Homelessness*. Seattle, WA: All Home; 2017.

27. Student Homelessness: Summary & Data Highlights. Communities Count: Social & Health Indicators Across King County. http://www.communitiescount.org/index.php?page=student-homelessness. Published 2017. Accessed October 12, 2017.

28. Partners for Our Children. Children in Out-of-Home Care (Count). Child Well-Being Data Portal. http://www.vis.pocdata.org/graphs/ooh-counts. Published 2017. Accessed November 2, 2017.

29. Paradies Y, Ben J, Denson N, et al. Racism as a determinant of health: A systematic review and meta-analysis. *PLoS One*. 2015;10(9):e0138511.

30. Williams DR, Mohammed SA. Discrimination and racial disparities in health: Evidence and needed research. *J Behav Med*. 2009;32(1):20-47.

End Notes

Continued

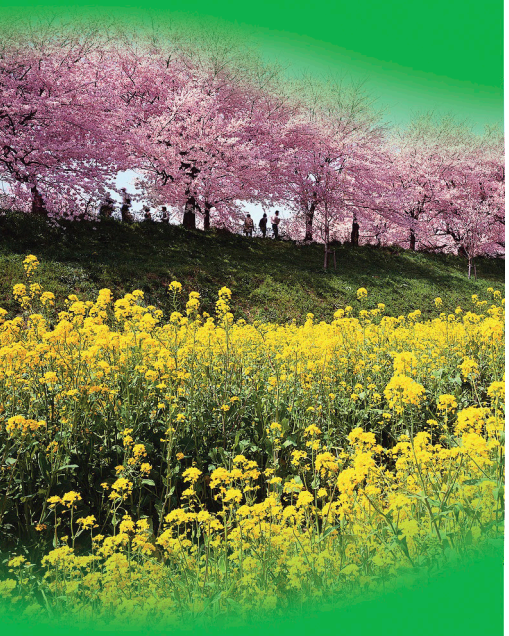
31. Bailey ZD, Krieger N, Agénor M, Graves J, Linos N, Bassett MT. Structural racism and health inequities in the USA: Evidence and interventions. Lancet. 2017;389(10077):1453-1463.

32. Institute of Medicine (US). Committee on Monitoring Access to Personal Health Care Services; Millman ML, editor. *Access to Health Care in America*. Washington (DC): National Academies Press (US); 1993. Available from: https://www.ncbi.nlm.nih.gov/books/NBK235888/

33. Health Insurance. Communities Count: Social & Health Indicators Across King County. http://www.communitiescount.org/index.php?page=health-insurance. Published 2015. Accessed October 12, 2017.

34. Boseley S. 2025, Global cost of obesity-related illness to hit $1.2tn a year from 2025. *The Guardian*. https://www.theguardian.com/society/2017/oct/10/treating-obesity-related-illness-will-cost-12tn-a-year-from-2025-experts-warn. Published October 9, 2017. Accessed October 20, 2017.

Appendix A: Methods



APPENDIX A: IDENTIFICATION OF HEALTH NEEDS & SELECTION OF INDICATORS

For the previous 2015/2016 King County Community Health Needs Assessment, a committee of representatives from Hospitals for a Healthier Community (HHC), facilitated by Public Health-Seattle & King County (PHSKC) staff, used a community health framework and population-based approach for the report to identify health needs and develop criteria for indicators used to measure health needs. The group finalized the selection of indicators with feedback from public health and hospital staff.

Committee members planned a succinct report focused on key indicators that relate to the hospitals' and communities' assets and resources and inform future collective strategies. These indicators were to be focused on population-based preventive strategies and promote policy/systems/environmental change for maximum population health impact. It was also recognized that partnerships between hospitals, community organizations, and communities are key to successful strategies to address common health needs.

Committee members from HHC and other representatives served as subject matter experts and helped identify population-level health needs.

To identify community concerns and assets, they interviewed stakeholders, consulted recent community-based reports, and pulled information from previous hospital CHNAs. The group reached consensus to focus particularly on access to care, preventable causes of death, maternal and child health, behavioral health, and violence & injury prevention. While hospitals and health systems reached consensus on a core set of topic areas, each hospital may also gather additional information specific to its service area.

Recognizing that the CHNA is not intended to provide comprehensive data for each specialized topic, indicators were selected according to the following criteria:

1. Availability of high-quality data that are population-based (where possible), measurable, accurate, reliable, and regularly updated. Data should focus on rates rather than counts.
2. Ability to make valid comparisons to a baseline or benchmark.
3. Prevention orientation with clear sense of direction for action by hospitals for individual, community,

Appendix A: Methods

Continued

system, health service, or policy interventions that will lead to community health improvement.

4. Ability to measure progress of a condition or process that can be improved by intervention/ policy/system change, and there exists a capacity to affect change.
5. Ability to address health equity, particularly by age, gender, race/ethnicity, geography, socioeconomic status, although not all demographic breakdowns may be available for all indicators.
6. Alignment with local and national healthcare reform efforts including the triple aim.

For the purpose of the 2018/2019 King County CHNA, a committee of HHC representatives, facilitated by PHSKC staff, revisited the original list of indicators and opted to remove a short list of 12 indicators for which timely and/or actionable data are not currently available in King County. A few additional indicators were added to the CHNA to reflect emerging or more widely accepted community health needs, such as the opioid epidemic. All removal and addition of indicators was conducted in a manner consistent with the aforementioned selection criteria.

The final set of indicators were analyzed, using appropriate statistical methods, by Public Health-Seattle & King County. Data were compiled from local, state, and national sources such as the U.S. Census Bureau, U.S. Centers for Disease Control and Prevention, Washington State Department of Health, and King County.

Appendix A: Methods

Continued

Community Assessments and Reports

For the 2018/2019 CHNA, recent reports including broad community needs assessments, strategic plans, or reports on specific health needs were reviewed for context and relevant assets, resources, and opportunities. The following reports were reviewed:

1. Advancing Equity and Opportunity for King County Immigrants and Refugees: A Report from the King County Immigrant and Refugee Task Force July 7, 2016
2. Aging and Disability Services 2014 Community Engagement
3. Aging the LGBTQ Way: A Forum on Equity, Respect & Inclusion, 2017
4. Allyship 2015 Housing & Safety Survey
5. Area Plan – Area Agency on Aging, Seattle-King County, 2016-2019
6. City of Seattle Health and Equity Assessment, June 2016
7. City of Seattle 2016 Homeless Needs Assessment
8. Count Us In – Seattle / King County Point-In-Time Count of Persons Experiencing Homelessness, 2017
9. Creating an Equitable Future in Washington State – Black Well-being and Beyond, 2015
10. Community Dialogues 2015-2016 Report
11. Group Health Cooperative Community Health Needs Assessment, 2016-2018
12. Food Assessment – Kent Washington, September 2016
13. Generations Aging with Pride: Focus Groups and Town hall feedback
14. Growing in Solidarity: Examining Food Inequities in Auburn
15. How King County Tackles Health Food Affordability, Stanford Center on Longevity. 2017
16. King County, Best Starts for Kids Community Conversations, 2016
17. King County Equity and Social Justice Strategic Plan, 2016-2022
18. King County Equity and Social Justice Strategic Plan Community Engagement Report (December 2015)
19. King County Local Food Initiative, 2016 Annual Report
20. King County Department of Community and Human Services, Unpublished data from community outreach, June – December, 2016
21. King County Update to Regional Health Improvement Plan, April 2016

Appendix A: Methods

Continued

22. King County Youth Action Plan, 2015
23. Living Well Kent Focus Group Executive Summary, December 2015
24. MultiCare Auburn Medical Center - Community Health Needs Assessment and Implementation Strategy, 2016
25. Northwest Hospital & Medical Center Community Health Needs Assessment 2016
26. Overlake Medical Center, Community Health Needs Assessment 2014-2015
27. Positive Aging – Sound Generations 2015-2016 Annual Report
28. 2017 Seattle Chinatown-International District Public Safety Survey Report
29. Seattle Cancer Care Alliance Community Health Needs Assessment, 2016
30. Seattle Children's Hospital 2016 Community Health Assessment
31. Seattle Chinatown-International District 2020 Healthy Community Action Plan
32. Seattle Youth Violence Prevention Needs Assessment, 2015
33. Swedish Community Health Needs Assessment 2016-2018
34. Swedish Community Health Needs Assessment – Ballard, 2016-2018
35. Swedish Community Health Needs Assessment – Edmonds, 2016
36. Swedish Community Health Needs Assessment – First Hill Campus and Cherry Hill Campus, 2016-2018
37. Swedish Community Health Needs Assessment – Issaquah, 2016-2018
38. Swedish Community Health Needs Assessment – Swedish Cancer Institute, 2016-2018
39. Transportation and Health Tool (US Department of Transportation). Updated October 27, 2015
40. Valley Medical Center 2017 Community Health Needs Assessment
41. Virginia Mason Community Health Needs Assessment 2016-2018
42. Voices Rising: African American Economic Security in King County, February 2017
43. Washington Hospital Healthcare System Community Health Needs Assessment, 2016
44. 2015 Washington State Housing Needs Assessment
45. White Center Community Development Association, 2016 Community Survey Report

Appendix B: Report Definitions & Structure

For each indicator, this report includes:

- A description of the indicator
- Overall estimate for King County
- Multiple-year averaged estimates for select sub-populations (e.g. race/ethnicity and region) in either a bar chart or map
- Narrative interpretation that highlights important findings – typically of disparities (by race, place, income, gender, or sexual orientation) and trends

The Community Health Indicators website includes enhanced information for each indicator in the report and additional indicators including (where applicable):

- King County estimate from the most recent year available, including rate and number of people affected (this estimate may differ from the multiple-year averaged estimates presented in the report). *NOTE: This is typically the only single-year data presented; for most analyses, data from multiple years are combined to improve the reliability of the estimates.*
- A bar chart that shows multiple-year averaged estimates for all demographic breakdowns (e.g. age, gender, region, race/ethnicity, and income or neighborhood poverty level as a measure of socioeconomic status).
- A map of multiple-year averaged estimates by neighborhoods/cities, ZIP codes, or regions.
- A line chart of rolling-averaged estimates for King County and each region over time to show trends (please see definition of rolling averages below).
- More detail about each data point appears in a tool tip box when the pointer hovers on a bar or line.
- The following symbols are used in graphs throughout the report (*, ^, !):

  * Denotes values that are significantly different from the King County average

  ^ There are too few cases to protect confidentiality and/or report reliable rates

  ! While rates are presented, there are too few cases to meet a precision standard, and results should be interpreted with caution.

- To protect confidentiality, presentation of data follows reliability and suppression guidelines.

Appendix B: Report Definitions & Structure

Continued

Confidence Interval (also known as error bar) is the range of values that includes the true value 95% of the time. If the confidence intervals of two groups do not overlap, the difference between groups is considered statistically significant (meaning that chance or random variation is unlikely to explain the difference). For some indicators, primarily those from the Census or the American Community Survey, results are reported with a 90% confidence interval, showing the range that includes the true value 90% of the time.

Confidence intervals on the CHI website are turned off by default. Users may turn them on by clicking the appropriate radio button.

Crude, Age-Specific, and Age-Adjusted Rates

- Rates are usually expressed as the number of events per 100,000 population. When this applies to the total population (all ages), the rate is called the **crude rate**.

- Infant mortality, maternal smoking, and other maternal/child health measures are calculated with live births as the denominator and presented as a rate per 1,000 live births (infant mortality) or percent of births (preterm, low birth weight, etc.).

- When the rate applies to a specific age group (e.g., age 15-24), it is called the **age-specific rate**.

- The crude and age-specific rates present the actual magnitude of an event within a population or age group.

- When comparing rates between populations, it is useful to calculate a rate that is not affected by differences in the age composition of the populations. This is the **age-adjusted rate**. For example, if a neighborhood with a high proportion of older people also has a higher-than-average death rate, it will be difficult to determine if that neighborhood's death rate is higher than average for residents of all ages or if it simply reflects the higher death rate that naturally occurs among older people. The age-adjusted rate mathematically removes the effect of the population's age distribution on the indicator.

- Prevalence rates from the Behavioral Risk Factor Surveillance Survey (BRFSS) are expressed as percent of the adult population, usually ages 18+. Exceptions to the age range are noted. These rates are not age-adjusted.

- Prevalence rates from the Healthy Youth Survey (HYS) are for public school students in the specified grades, and weighted to the population. HYS is only asked of students in grades 6 (abbreviated version), 8, 10, and 12 every other year.

Appendix B: Report Definitions & Structure

Continued

Geographies: Whenever possible, indicators are reported for King County as a whole and for 4 regions within the county. If enough data are available for a valid analysis, they may also be reported by smaller geographic areas (cities, neighborhoods within large cities, and groups of smaller cities and unincorporated areas). Education data are reported by school district. For more detail, plus maps, see About King County Geographies or our geographic definitions page.

Cities/Neighborhoods (also known as Health Reporting Areas or HRAs): In 2011, new King County Health Reporting Areas (HRAs) were created to coincide with city boundaries in King County. These areas, recently re-named "Cities/Neighborhoods," are based on aggregations of U.S. Census Bureau-defined blocks. Where possible, Cities/Neighborhoods correspond to cities and, for larger cities, to neighborhoods within cities, and delineate unincorporated areas of King County. These geographical designations were created to help cities and planners as they consider issues related to local health status or health policy. Cities/Neighborhoods are used whenever we have sufficient sample size to present the data. These are represented in the report as "city/neighborhood" data.

Federal Poverty Guidelines, issued by the Department of Health and Human Services, are a simplified version of the federal poverty thresholds. The guidelines are used to determine financial eligibility for various federal, state, and local assistance programs. For a family of 4, the federal poverty guideline was $24,250 in 2015; in 2016 it was $24,300.

Neighborhood poverty levels are based on the proportion of households in a Census tract in which annual household income (as reported in the U.S. Census Bureau's American Community Survey) falls below the federal poverty threshold.

- **High poverty:** 20% or more households in the neighborhood below poverty threshold. Using this criterion, 14.0% of King County households are in high-poverty neighborhoods.
- **Medium poverty:** 5% to 19% of households below poverty threshold. Using this criterion, 62.7% of King County households are in medium-poverty neighborhoods.
- **Low poverty:** fewer than 5% of households below poverty threshold. Using this criterion, 23.3% of King County households are in low-poverty neighborhoods.

*An interactive map of King County census tracks can be found on the Communities Count website (http://www.communitiescount.org/)

This neighborhood-level characteristic is used where individual measures of income or poverty level are not available. The high-poverty area follows the

Appendix B: Report Definitions & Structure

Continued

definition of a Federal Poverty Area. The 5% limit for low-poverty areas was chosen to create a group markedly different from Federal Poverty Areas, and thus sensitive to differences in health outcomes that may be associated with socio-economic differences, while maintaining enough tracts in each group for robust comparisons.

For area-based measures of poverty, a census tract is considered a neighborhood. Data sources where census tract information are not available use ZIP codes to designate the neighborhood.

Race/Ethnicity and Discrimination: Race and ethnicity are markers for complex social, economic, and political factors that can influence community and individual health in important ways. Many communities of color have experienced social and economic discrimination and other forms of racism that can negatively affect the health and well-being of these communities. We continue to analyze and present data by race/ethnicity because we believe it is important to be aware of racial and ethnic group disparities in these indicators.

Race/Ethnicity Terms: Federal standards mandate that race and ethnicity (Hispanic origin) are distinct concepts requiring 2 separate questions when collecting data from an individual. "Hispanic origin" is meant to capture the heritage, nationality group, lineage, or country of birth of an individual (or his/her parents) before arriving in the United States. Persons of Hispanic ethnicity can be of any race. 2010 Census terms: (One race) white, Black or African-American, American Indian and Alaska Native, Asian, Native Hawaiian and Other Pacific Islander, Some Other Race; (Two or more races); Hispanic or Latino origin, White alone (Not Hispanic or Latino). Persons of Hispanic ethnicity are also counted in their preferred race categories. Racial/ethnic groups are sometimes combined when sample sizes are too small for valid statistical comparisons of more discrete groups. For small groups (American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander) in which a high proportion of King County residents are that race and one or more others, the grouping, "(race) alone or in combination" is sometimes used to include all who identify as that group.

Some surveys collect racial/ethnic information using only one question on race. These terms are:

Terms: Hispanic, white non-Hispanic, Black, American Indian/Alaska Native (AIAN), Asian, Native Hawaiian/ Pacific Islander (NHPI), white, and Multiple Race (Multiple).

Appendix B: Report Definitions & Structure

Continued

Limitations of Race/Ethnicity Categories: When asked to identify their race and ethnicity in surveys, respondents are often offered a narrow range of options (see terms above); those broad categories are then used to make expansive racial/ethnic comparisons. The vast diversity within racial/ethnic categories does not allow us to distinguish among ethnic groups or nationalities within categories. Combining groups with wide linguistic, social, and cultural differences – such as African immigrants and Black Americans; Vietnamese, Korean, and East Indians in one Asian category; and white Americans with eastern Europeans, for example – does not allow for a careful analysis of the potential disparities within groups, or the varied sociocultural influences on those disparities. In addition, some racial/ethnic samples in King County are too small for meaningful comparisons or generalizations.

Rolling Averages: When the frequency of an event varies widely from year to year, or sample sizes are small, the yearly rates are aggregated into averages – often in 3-year intervals – to smooth out the peaks and valleys of the yearly data in trend lines. For example, for events occurring from 2001 to 2015, rates may be graphed as three-year rolling averages: 2001-2003, 2002-2004…2011-2015. Adjacent data points will contain overlapping years of data. Statistical tests comparing data points with overlapping times are not appropriate. Increases or decreases in rates are determined statistically using data for single years.

Rounding Standards: Rates from the Behavioral Risk Factor Surveillance Survey (BRFSS) and Heathy Youth Survey (HYS) are rounded to the nearest full integer (for example, 15%). Vital statistics and hospitalization rates are rounded to one decimal point (for example, 15.4%), as are estimates from the American Community Survey (ACS)/Census.

Statistical Significance: Differences between sub-population groups and the overall county are examined for each indicator. Unless otherwise noted, all differences mentioned in the text are statistically significant (unlikely to have occurred by chance).

The potential to detect differences and relationships (termed the statistical power of the analysis) is dependent in part on the number of events and size of the population, or, for surveys, the number of respondents, or sample size. Differences that do not appear to be significant might reach significance with a large enough population or sample size.

Citation Request:

The data published in this Community Health Needs Assessment report and on the Community Health Indicators website may be reproduced without permission. Please use the following citation when reproducing:

"Retrieved (date) from Public Health – Seattle & King County, Community Health Indicators.
www.kingcounty.gov/health/indicators"

Appendix C: About Hospitals for a Healthier Community

A collaborative of hospitals and health systems and Public Health - Seattle & King County have joined forces to identify the greatest needs of the communities they serve and develop plans to address them. Working together they leverage their expertise and resources to address the most critical health needs in our county. A shared approach to community benefits can avoid duplication and focus available resources on a community's most important health needs.

Current Priorities

Access to care: Members continue to prioritize Medicaid expansion and ensure that residents have access to health insurance through Washington Healthplanfinder (https://www.wahealthplanfinder.org/).

Needs assessment: Members are working together to assess the health needs of our King County communities and will develop strategies to address these priority areas. The collaborative report will be presented and available to the public in 2018. Individual hospitals will also be publishing their own community health needs assessments.

Participating Hospitals and Health Systems

EvergreenHealth

CHI Franciscan Health
St. Elizabeth Hospital
St. Francis Hospital
Highline Medical Center
Regional Hospital

Kaiser Permanente

MultiCare Health System
Auburn Medical Center
Covington Medical Center

Navos

Overlake Medical Center

Seattle Cancer Care Alliance

Seattle Children's

Swedish Medical Center
Ballard Campus
Cherry Hill Campus
First Hill Campus
Issaquah Campus

UW Medicine
Harborview Medical Center
Northwest Hospital & Medical Center
UW Medical Center
Valley Medical Center

Virginia Mason

Coronary Heart Disease & Hypertension

Coronary heart disease is the second leading cause of death in Washington State. Coronary heart disease is usually caused by atherosclerosis which can result in decreased blood flow through the blood vessel. This results in decreased oxygen supply to the heart muscle and can cause reduced heart muscle function and destruction of heart muscle cells (myocardial infarction or 'heart attack'). Deaths from coronary heart disease can be prevented or delayed by modifying known risk factors, such as high blood pressure, high blood cholesterol, tobacco use, physical inactivity, obesity and diabetes.

In 2015, the coronary heart disease death rate in Washington State was 80 per 100,000 people.

Males, Native Hawaiian and other Pacific Islanders (NHOPI), American Indians and Alaska Natives (AIAN), blacks, people over 65 years old, and people living in areas with low incomes or less education had the highest coronary heart disease death rates compared to other Washingtonians.

DOH, along with partner agencies, is working to reduce modifiable risk factors, implementing the *Healthier Washington* Plan for Improving Population Health and the Washington State Plan for Healthier Communities, and working to improve emergency cardiac care.

1 in 4

Washington adults has been told by a health professional they have high blood pressure, a modifiable risk factor for coronary heart disease

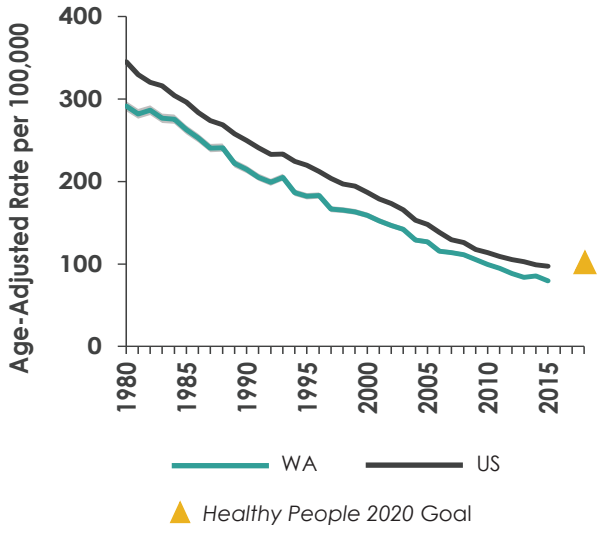
Coronary heart disease is the 2nd leading cause of death in Washington

Coronary Heart Disease

Time Trends

- In 2015, the age-adjusted coronary heart disease death rate in Washington was 80 per 100,000 people.
- Washington has a lower rate of coronary heart disease deaths compared to the U.S.
- The coronary heart disease death rate in Washington has declined substantially over the past 36 years, has met the *Healthy People 2020* goal, and likely will continue to meet it.

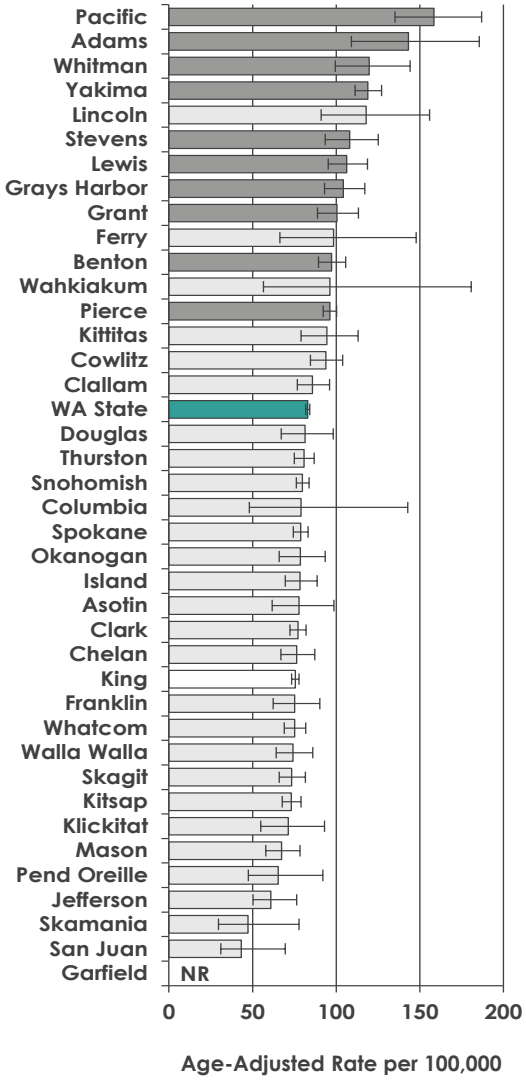
Coronary Heart Disease Deaths
Washington State & US
Death Certificates, 1980-2015



Geographic Variation

- In 2013-2015, coronary heart disease death rates in Adams, Benton, Grant, Grays Harbor, Lewis, Pacific, Pierce, Stevens, Whitman, and Yakima counties were higher than the state rate.
- King County had a lower rate than the state.

Coronary Heart Disease Deaths
Washington Counties
Death Certificates, 2013-2015



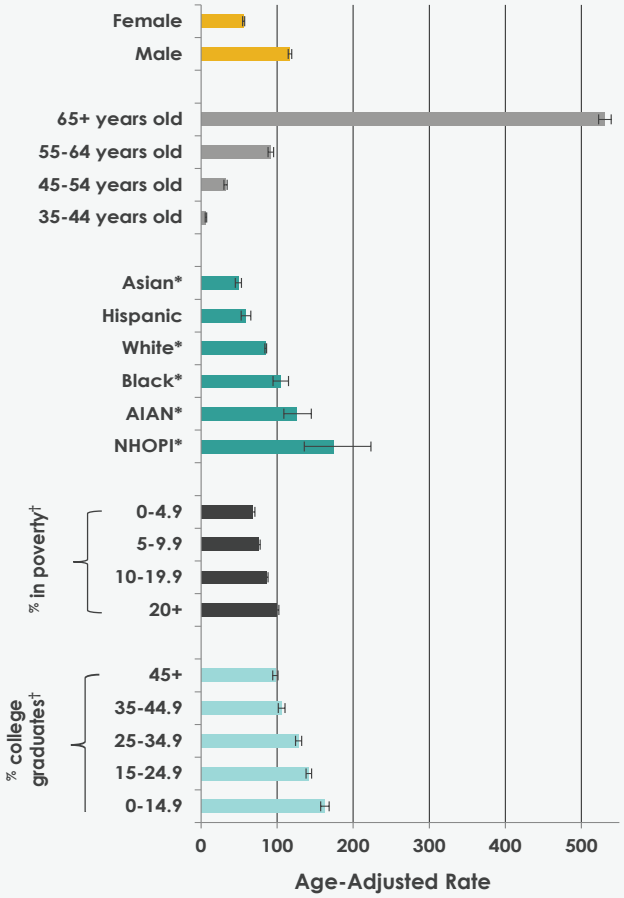
WA State | Lower than WA State
Same as WA State | Higher than WA State

NR: Not reported if RSE ≥ 30% or to protect privacy

Disparities

- In 2013-2015, males had a higher coronary heart disease death rate compared to females.
- Coronary heart disease death rates were highest among those 65 years and older, and even higher among those 85 years and older (1,944 per 100,000 people).
- NHOPI, AIAN, and blacks had the highest coronary heart disease death rates.
- Coronary heart disease death rates increased as residential area levels of education and household income decreased.

Coronary Heart Disease Deaths
Washington State
Death Certificates, 2013-2015



**Non-Hispanic* (all races) | *AIAN:* American Indian/Alaska Native | *NHOPI:* Native Hawaiian/Other Pacific Islander

†Among census tract residents, 2013-2015 data

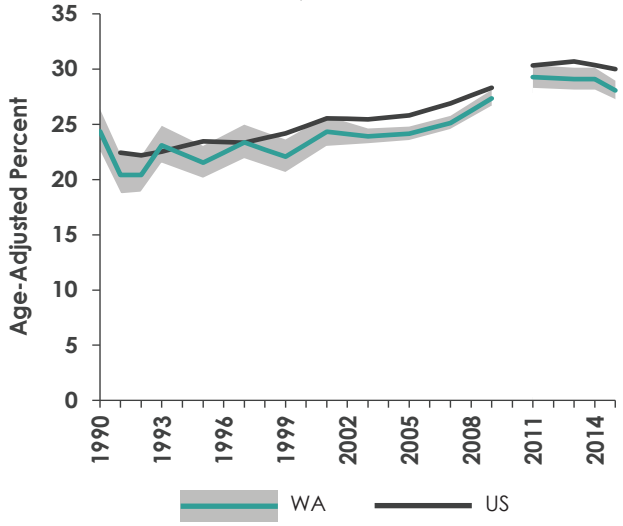
In 2015, 28% (± 1%) of Washington adults reported they had ever been told by a health professional they had high blood pressure, also known as hypertension. Hypertension among Washington adults slightly increased from 1990 – 2010, but has recently been stable. Males, blacks, adults over 65 years old, and adults with low incomes and education are more likely to report having hypertension than other Washington adults.

Hypertension

Time Trends

- In the 2015 BRFSS, the age-adjusted percent of Washington adults reporting ever having hypertension was 28% (±1%).
- Washington has a lower percent of adults reporting hypertension than the U.S.
- Self-reported hypertension among Washington adults slightly increased from 1990-2010. These data are not directly comparable with more recent data due to a change in survey methods. Data since 2011 show the percent to be relatively stable.

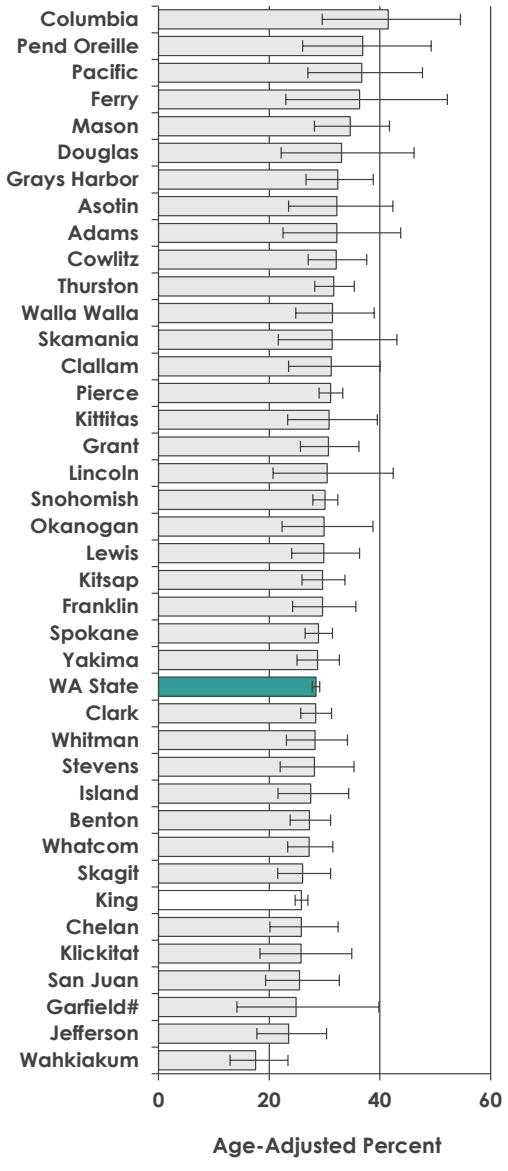
Self-Reported Hypertension
Washington State & US
BRFSS, 1990-2015



Geographic Variation

- In the 2013 and 2015 BRFSS combined, self-reported hypertension was lower in King County compared to the state.
- No county had a higher prevalence than the state.

Self-Reported Hypertension
Washington Counties
BRFSS, 2013 & 2015



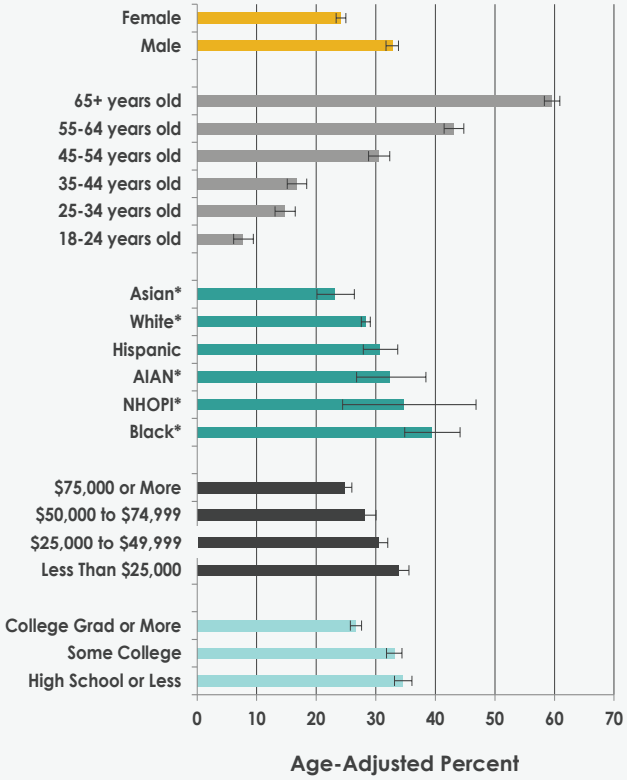
WA State
Same as WA State
Lower than WA State
Higher than WA State

#Relative standard error (RSE) is between 25% and 29%

Disparities

- In the 2013 and 2015 BRFSS combined, more males reported having hypertension than females.
- Self-reported hypertension was highest among adults 65 years and older.
- A higher percent of black adults reported hypertension than whites.
- Self-reported hypertension increased as levels of income and education decreased.

Self-Reported Hypertension
Washington State
BRFSS, 2013 & 2015



Non-Hispanic (all races) | *AIAN:* American Indian/Alaska Native | *NHOPI:* Native Hawaiian/Other Pacific Islander

How is Washington addressing coronary heart disease & hypertension?

DOH and its partners are working to prevent heart disease by addressing many of the modifiable risk factors including high blood pressure; using tobacco or being exposed to secondhand smoke; diabetes, prediabetes, or metabolic syndrome; high cholesterol; being overweight or obese; and lack of physical activity. This is being achieved by implementing the Plan for Improving Population Health based on the Prevention Framework; aligning with the federal public-private Million Hearts partnership to prevent one million cardiovascular events by 2022; and efforts to implement the 2014 Washington State Plan for Healthy Communities. The overarching goals of the plan are:

- Increasing the number of Washingtonians who are healthy at every stage of life

  Strategies include:

  - Increasing access to safe and affordable physical activity where people learn, live, play, work and worship.
  - Reducing tobacco and alcohol advertising, reducing promotions and product placement, and enforcing youth access laws for these products.
  - Increasing the number of places that protect employees, customers, patrons and others from secondhand smoke.
  - Increasing access to healthy foods and beverages where people learn, live, play, work and worship.

- Achieving health equity by eliminating health disparities

  Strategies include:

  - Developing new assessments and systems, so DOH can determine the need for systems to track progress of healthy communities' activities, with a focus on data needed to identify health disparities as well as successful efforts to achieve health equity.
  - Using data to monitor population health.
  - Evaluating interventions, programs, and activities for their impact on health equity.
  - Obtaining and prioritizing sustainable funding.
  - Increasing the number of community-based organizations—including local health jurisdictions, tribal health services, nongovernmental organizations and state agencies—providing population-based primary prevention services.
  - Supporting linkage of clinical and community prevention efforts to mobilize services, resources, and self-management programs in community-based organizations that serve economically and socially disadvantaged populations.
  - Investing resources to build strong and trusting relationships with communities.

- Working to improve emergency cardiac care by increasing the number of people who obtain the correct treatment after a cardiac event.

  To achieve this goal, some important strategies were identified to improve the effective delivery and use of clinical and other preventive services to prevent disease, detect disease early, reduce or eliminate risk factors, and mitigate or manage complications.

  - Enhance and maintain health systems to increase timely access to preventive care, screening and treatment.
  - Increase public and health professional awareness of the importance of screening and follow-up.
  - Promote and provide support to build capacity and availability of healthcare, education, resources and services.

- Offering in-person blood pressure training to individuals representing a variety of organizations (i.e., community-based organizations, Community Health Workers, Health Ministers, and Community Health Representatives), who work within diverse communities, through funding from federal cooperative agreements. This 2.5-hour interactive hands-on, in-person blood pressure training uses automated monitoring devices. This training provides key health messaging about measuring blood pressure accurately, and the importance of sharing the measurements with primary care using paper or electronic tracking methods. Training participants increases their health literacy regarding the meaning of blood pressure readings, and their relationship to heart disease and stroke risk. Participants who complete the training promote control and management of blood pressure in their communities.
- Making a suite of materials available to health systems, clinics and clinical team members to support accurate and consistent blood pressure self-management in English and five additional languages.

See also Tobacco & Vapor Product Use, Binge Drinking & Excess Alcohol Use, Physical Activity, Fruit & Vegetable Intake, and Diabetes & Prediabetes

Evidence-based interventions to address coronary heart disease and hypertension are available in the CDC Community Guide.

Technical Notes

Confidence Intervals: Definition and examples are described in Appendix C

Percent Living in Poverty and Percent College Graduates: Definition and use is described in Appendix C

Race and Ethnicity: Classification described in Appendix C

Relative Standard Error: Definition and how it was used is described in Appendix C

Death and dying in the US: the barriers to the benefits of palliative and hospice care

Albert J Finestone
Gail Inderwies

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In August 2006, after a trip to the New Jersey Shore, Peggy was having great difficulty catching her breath. In consultation with her children, Peggy decided that she was ready for hospice care. But, she did not want to relinquish her independence just because shortness of breath and a weakening heart overtook her daily stride. However, a single episode at home had thrown Peggy into crisis. Since Peggy lived alone, hospice care at home presented a host of challenges including safety and how to manage her unstable cardiopulmonary condition. Peggy was an ideal candidate for the hospice's TeleCare (see box) monitoring program which provided a passive monitoring system, a medication dispenser, and vital signs monitoring for blood pressure, weight, and blood oxygen levels. In addition, the hospice authorized routine draws of BNP (beta naturetic peptide) and BMP (basic metabolic profile) with GFR (glomerular filtration rate) to manage her symptoms aggressively. Medications were adjusted accordingly to maximize quality of life and minimize symptoms. Though some would consider this treatment aggressive, it was the aggressive treatment of Peggy's symptoms that allowed for an extended quality of life. There was sufficient evidence to support this action based on the concept of risk and reward, especially as there was a minimum of invasive therapies required. In Peggy's case she went from being homebound and short of breath to living her life up to her final days.

TeleCare monitoring enabled a hospice patient like Peggy to not only live independently, but also to leverage the hospice staff's ability to care for her. The nurse case manager could identify Peggy's changing medical status for immediate intervention before symptoms escalated into a crisis. Making more informed and timely adjustments to Peggy's treatment protocol allowed for intensive treatment of her symptoms and improved her overall quality of life. In Peggy's case TeleCare monitoring played an important part in her living longer, more comfortably, and with peace of mind. Peggy had witnessed her father suffocate with emphysema and she feared that would also be her fate. But with her hospice care augmented with Telecare, Peggy's children agreed that their mother never struggled to breathe. Peggy lived at home for another 2 months, and it was there she was able to celebrate her last birthday, close to her children and family.

What is hospice?

The hospice concept was pioneered in 1967 by English physician, nurse and social worker Dr. Dame Cicely Saunders. In the US, the hospice movement emerged in the mid 1970s. In 1982, Congress initiated the hospice benefit under TEFRA (Tax Equity and Fiscal Responsibility Act), a landmark public policy decision to include hospice care in the Medicare program. Hospice core services include professional nursing care, personal assistance with activities of daily living, various forms of rehabilitation therapy, dietary counseling, psychosocial and spiritual counseling for both patient and family, volunteer

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services, respite care, provision of medical drugs and devices necessary for palliative care, and family bereavement services after the patient's death. Hospice care is provided by an interdisciplinary care team comprising nurses, social workers, pastoral counselors, nursing assistants, and other health professionals under the management of the patient's own primary care physician or one affiliated directly with hospice program.

Care for the dying is a complex enterprise that must involve multiple professionals and nonprofessionals. The physical, emotional, and social needs of the dying person are addressed by acknowledging the fear, anxiety, loneliness, and isolation that is experienced during an end-stage illness.

Most elderly patients are eligible for Medicare Hospice benefits (MHB). For an individual to be elected for hospice care, a physician must certify that the patient is likely to die within 6 months if the terminal disease follows its anticipated course. The patient or the patient's representative in turn agrees to waive all other Medicare coverage related to their terminal illness under part "A" which is Medicare Hospital Benefits. A hospice patient's primary physician can bill under Medicare part "B". Hospice patients may be hospitalized for a brief period of time. Medicare payment for hospice requires that a patient be reassessed periodically, initially after each of the first two 90-day periods, and then 60 days after that to document continued decline in condition and determine whether hospice care continues to be appropriate.

The state of end-of-life care in the US

Despite the powerful and valuable Medicare Hospice Benefit, there is a persistent culture of ICU (Intensive Care Unit) hospitalization for end-of-life care for these patients (Seferian and Afessa 2006), an expensive and often futile strategy. In my experience (AJF) nursing homes are reluctant to have patients die while under their care. Hence, when a patient with a terminal illness in a nursing home becomes close to death, emergency services are called, and the patient is transferred to the nearest hospital and admitted to the ICU where expensive and futile services are provided. Hospice choice will avoid this unnecessary detour. It has been estimated that Medicare payments made to beneficiaries in the last year of life are almost 7 times greater than those made for all Medicare beneficiaries (Lubitz and Riley 1993). In addition to the recognition of overuse of technology in terminally ill patients, there is also a growing perception of a significant lack of symptom control and psychological support for patients who die in conventional hospital settings (Solomon et al 1993; SUPPORT Principal Investigators 1995; Lynn et al 1997; Reynolds et al 2002; Teno et al 2004).

Benefits of hospice care

There is ample evidence to support a higher quality of life in hospice patients compared with terminally ill patients in the hospital setting. Numerous studies evaluating quality of end of life in settings other than the hospital show that family members are consistently more likely to report a favorable dying experience of the decedent when hospice or palliative care is chosen, compared with hospitalization (Dawson 1991; Hanson et al 1997; Nolen-Hoeksema et al 2000; Teno et al 2004). Here is growing evidence that hospice provides high quality care with high consumer satisfaction (Casarett and Quill 2007). Research has suggested that for certain diagnosis such as CHF, compared with patients who do not choose hospice care, hospice patients live longer for an average of 29 days (Connor et al 2007), and that hospice care may be associated with a modest cost-saving (Pyenson et al 2004).

Underutilization of hospice in the US

Despite the clear advantages in quality of life for terminally ill patients, and the cost benefits associated with palliative and hospice care, the decision to utilize hospice is made by only an estimated fraction of the patients who stand to benefit. Only approximately 20%–25% of people who die in the US utilize hospice services (Foley and Gelbard 2001; Hanson 2004). The median utilization of hospice is only 22 days, and over one-third of hospice patients receive fewer than 8 days of services (Russell and LeGrand 2006). Ten percent of hospice patients are enrolled in the last 24 hours of their life (NHPCO 2006; National Trend Study 2004). Over one-third of patients receiving hospice care in 2002 were over the age of 85 years, and the overwhelming majority (82%) were white (Connor et al 2004). There is therefore clear evidence that hospice is poorly utilized in the US, and that this underutilization is at least partially dependent upon demographic factors including race or ethnicity, misconceptions of financial and eligibility requirements, and difficulty in discussing or accepting hospice as a treatment option.

The demographic divide in the US

Many studies report the observation that minority groups are less likely than white Americans to benefit from hospice or palliative care. African Americans and Latinos are more likely to die at home than European Americans, but are significantly less likely to receive hospice care (Enguidanos et al 2005). During the period 1995 to 2001, the use of hospice services by African Americans and Latinos was significantly less than by European Americans, and, though European American use

of hospice increased during this period, African American use actually decreased (Colon and Lyke 2003). The difference appears to be when end-of-life decision making is initiated. When ethnic groups who choose to use hospice were compared in one study, there were no differences between European Americans and Latino patients in average duration of hospice use, and African Americans utilized hospice, on average, longer than either. Furthermore, there was no greater likelihood that services would be terminated prematurely among ethnic minorities when compared with European Americans (Colon and Lyke 2003; Johnson et al 2005). An important recent report by Kapo and co-investigators suggests that the return rate to hospice may be lower in African Americans compared with all other users (Kapo et al 2005). Elderly minorities in this group were more likely to die in an inpatient setting than their European counterparts (Jonson et al 2005).

A large number of factors have been identified for the underutilization of hospice by ethnic minorities and greater utilization of inpatient settings by elderly minorities. Some of the differences in the making of end-of-life decisions may be related to associated or indirect factors, such as differences in the availability of a full-time caregiver, in marital status, in general economic or educational status, or language use (Colon and Lyke 2003). However, a large number of cultural and social factors, that are race or ethno-specific, have also been identified as possible determinants of hospice underutilization. These include a lack of knowledge of hospice, cultural, or religious beliefs about end of life and death, the desire for autonomy, and, importantly, perceptions and mistrust of healthcare and healthcare professionals (especially among African Americans) (Burrs 1995; Gordon 1996; Reese et al 1999; Born et al 2004; Torke et al 2005; Winzelberg et al 2005; Duffy et al 2006; Rhodes et al 2006). These ethnic, social, and cultural complexities in end-of-life perceptions place a burden on health-care professionals to remain sensitive to diverse factors during clinical decision-making. However, it is poorly understood how physicians, nurses, and other healthcare professionals working specifically within racially diverse, low-income communities see their role in this process.

Barriers to hospice use

Because life expectancy for patients with most end-stage diseases cannot be predicted with specificity, there has been recent focus on how the Medicare mandated assignment of a 6-month time frame as discussed previously has itself become a barrier to care (Casarett and Quill 2004). Because the culture of medicine is that physicians and other health professional are trained to prolong life, referral to hospice maybe viewed as a medical failure or depriving patients of hope. There are consumer barriers to access to hospice, with various attitudes, and misinformation, including that they must forgo all treatment. The National Hospice Foundation reveals 75% of Americans do not know that hospice care can be provided in the home and 90% do not realize that hospice care is fully covered through Medicare.

100% mortality in this world

The association of hospice with death is a major impediment to hospice enrollments as fear of death is a pervasive human emotion. Palliative care and hospice patients are often not capable of engaging in the types of interactions required to make end-of-life choices independently, and the influence of others is crucial both physically and psychologically. The role of family in the choice of, and evaluation of, hospice care has long been recognized (Connor et al 2005). However, next to the influence of friends and relatives, healthcare professionals are logically the most influential group during end-of-life decisions. It has been suggested that quality of end-of-life care results when, among other things, health-care professionals promote shared decision-making (Teno et al 2001). However, a great deal of evidence exists to suggest that the influence of healthcare professionals on decision-making in ethnic minorities may be significantly different than their role among white patients and their families, resulting from a substantial cultural mistrust (Cort 2004; Welch et al 2005). It has been recognized that there is a greater need for healthcare professionals to be cognizant of diverse cultural and social issues that relate to end of life decision-making, such as distrust of the medical system, methods for communicating news about life-threatening illness, autonomy, and attitudes toward advanced directives (a number of guidelines are available, including [Searight and Gafford 2005]). There is a strong precedent for using patient- and family-based surveys to inform healthcare providers on strategies and possible improvements (Lanford et al 2001; Jenkinson et al 2002). What is needed are similar strategies that directly measure the perception and roles of various healthcare professionals in the clinical decision-making process as it pertains to end of life and palliative care.

Conclusion

Providers and patients must recognize that death is inevitable. Hospice should not be viewed as care of last resort but rather as an alternative option that comes after aggressive treatment of the terminal illness has failed.

Unfortunately, many Americans have their access to hospice and other forms of palliative care blocked by lack of information, misunderstanding, financial limitation, and other less tangible factors including fear. This summary has

addressed some of the issues preventing more wide spread use of this valuable palliative and hospice care option.

Telecare

In a recent pilot program sponsored by Keystone Hospice in Wyndmoor, PA, USA, the Telecare Program reduced the risks of providing services to vulnerable elderly individuals with the use of simple monitoring and medication compliance technology. The program combines technology to monitor activity and ambient temperature in the home, track and dispense medication doses, and monitor vital signs with home care support.

The approach is three-tiered:

- **Passive activity monitoring:** Wireless motion detectors strategically placed in the home track functional activities of daily living and ambient temperature. Getting out of bed, eating, using the bathroom, taking medication, tasks necessary for independent living, and ambient temperature. A baseline analysis of the individual's safe independent status is recorded. When activity deviates from the known pattern, alerts are sent to caregivers. Data aremonitored 24 hours a day by a call center for emergency situations such as suspected bathroom fall, lack of wake up, or extremes in ambient temperature.
- **Medication management:** Using the MD2, the device that reminds, dispenses, monitors, and safeguards daily doses of medications. The MD2 holds up to sixty doses of medication and is a reliable and effective device for increasing medication adherence and reducing medication error. Caregivers are able to monitor compliance and are alerted to missed doses of medication.
- **Vital signs monitoring:** Low cost tools (glucose meter, blood pressure, scale) are adapted to send measurements over phone lines to physician and care manager. These measurements create a longitudinal record for accuracy of disease assessment. When monitored with more frequency, trending is evident. Intervention by the physician or care manager can occur before crisis.

Benefits identifed during the course of the project were:

- Move care from facilities into the home, decrease use of expensive services, emergency room visits, inpatient stays.
- Decreased costs long-term care, avoid precipitous nursing home placement, increased safety, quality of life, and independence.

A case in point – Peggy.

References

Born W, Greiner K, et al. 2004. Knowledge, attitudes, and beliefs about endof-life care among inner city African Americans and Latinos. *J Palliat Med*, 7:247–56.

Burrs F. 1995. The African American experience: breaking the barriers to hospices. *Hosp J*, 10:15–18.

Casarett D, Quill T. 2007. "I'm not ready for hospice": strategies for timely and effective hospice discussions. *Ann Intern Med*, 146:443–9.

Colon M, Lyke J. 2003. Comparison of hospice use and demographics among European Americans, African Americans, and Latinos. *Am J Hosp Palliat Care*, 20:182–90.

Connor S, Tecca M, et al. 2004. Measuring hospice care: The National Hospice and Palliative Care Organization National Hospice Data Set. *J Pain Symptom Manage*, 28:316–28.

Connor S, Pyenson B, et al. 2007. Comparing hospice and non-hospice patient survival among patients who die within a three-year window. *J Pain Symptom Manage*, 33:238–46.

Connor S, Teno J, et al. 2005. Family evaluation of hospice care: results from voluntary submission of data via website. *J Pain Symptom Manage*, 30:9–17.

Cort M. 2004. Cultural mistrust and use of hospice care: challenges and remedies. *J Palliat Med*, 7:63–71.

Dawson N. 1991. Need satisfaction in terminal care settings. *Soc Sci Med*, 32:83–7.

Duffy S, Jackson F, et al. 2006. Racial/ethnic preferences, sex preferences, and perceived discrimination related to end of life care. *J Am Geriatr Soc*, 54:150–7.

Enguidanos S, Yip J, et al. 2005. Ethnic variation in site of death of older adults dually eligible for Medicaid and Medicare. *J Am Geriatr Soc*, 53:1411–16.

Foley K, Gelbard HE. 2001. Institute of Medicine Report: Improving palliative care for cancer. Washington, DC: National Academy Press.

Gordon A. 1996. Hospice and minorities: a national study of organizational access and practice. *Hosp J*, 11:49–70.

Hanson L. 2004. Palliative care: Innovation in care at the end of life. *North Carolina Medical Journal*, 65:202–8.

Hanson L, Danis M, et al. 1997. What is wrong with end of life care? Opinions of bereaved family members. *J Am Geriatr Soc*, 45:1339–44.

Jenkinson C, Coulter J, et al. 2002. Patients' experiences and satisfaction with health care: results of a questionnaire study of specific aspects of care. *Qual Saf Health Care*, 11:335–9.

Johnson K, Kuchibhatala M, et al. 2005. Ethnic differences in the place of death of elderly hospice enrollees. *J Am Geriatr Soc*, 53:2209–15.

Kapo J, Macmoran H, et al. 2005. Lost to follow-up: Ethnic disparities in continuity of hospice care at the end of life. *J Palliat Med*, 8:603–8.

Koppen J. 2007. Thoughts on the afterlife among US adults 50+. *AARP Magazine.*

Lanford A, Clausen R, et al. 2001. Measuring and improving patients' and families' perceptions of care in a system of pediatric hospitals. *Jt Comm J Qual Improv*, 27:415–29.

Lubitz J, Riley G. 1993. Trends in Medicare payments in the last year of life. *N Engl J Med*, 328:1092–6.

Lynn J, Teno J, et al. 1997. Perceptions by family members of the dying experience of older and seriously ill patients. *Ann Intern Med*, 126:97–106.

NHPCO Facts and Figures: Hospice Care in America. 2006. National Hospice and Palliative Care Organization.

National Hospice and Palliative Care Organization National Data Set: National Trend Study. 2004.

Nolen-Hoeksema S, Larson J, et al. 2000. Predictors of family members' satisfaction with hospice. *Hosp J*, 15:29–48.

Pyenson B, Connor S, et al. 2004. Medicare cost in matched hospice and non-hospice cohorts. *J Pain Symptom Manage*, 28:200–10.

Reese D, Ahern R, et al. 1999. Hospice access and use by African Americans: Addressing cultural and institutional barriers through participatory action research. *Soc Work*, 44:549–59.

Reynolds K, Henderson M, et al. 2002. Needs of the dying in nursing homes. *J Palliat Med*, 5:895–901.

Rhodes R, Teno J, et al. 2006. Access to hospice for African Americans: Are they informed about the option of hospice? *J Palliat Med*, 9:268–72.

Russell K, LeGrand S. 2006. I'm not that sick! Overcoming the barriers to hospice discussions. *Cleveland Clinic J Med*, 73:517–24.

Searight H, Gafford J. 2005. Cultural diversity at the end of life: issues and guidelines for family physicians. *Am Fam Physician*, 71:515–22.

Seferian E, Afessa B. 2006. Adult intensive care use at the end of life: a population based study. *Mayo Clinic Proc*, 81:896–901.

Solomon M, O'Donnell L, et al. 1993. Decisions near end of life: professional views on life-sustaining treatments. *Am J Public Health*, 83:14–23.

SUPPORT Principal Investigators. 1995. A controlled trial to improve care for seriously ill hospitalized patients. The study to understand prognoses and preferences for outcomes and risks of treatments (SUPPORT). *JAMA*, 274:15918 (Erratum in: *JAMA*, 1996. 275:1232).

Teno J, Casey V, et al. 2001. Patient-focused, family-centered end-of-life medical care: views of the guidelines and bereaved family members. *J Pain Symptom Manage*, 22:738–51.

Teno J, Clarridge B, et al. 2004. Family perspectives on end-of-life care at the last place of care. *JAMA*, 291:88–93.

Torke A, Garas, et al. 2005. Medical care at the end of life: views of African American patients in an urban hospital. *J Palliat Med*, 8:593–602.

Welch L, Teno J, et al. 2005. End-of-life care in black and white: race matters for medical care of dying patients and their families. *J Am Geriatr Soc*, 53:145–53.

Winzelberg G, Hanson L, et al. 2005. Beyond autonomy: diversifying end-of-life decision-making approaches to serve patients and families. *J Am Geriatr Soc*, 53:1046–50.

NHPCO *Original Article*

Comparing Hospice and Nonhospice Patient Survival Among Patients Who Die Within a Three-Year Window

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Abstract
There is a widespread belief by some health care providers and the wider community that medications used to alleviate symptoms may hasten death in hospice patients. Conversely, there is a clinical impression among hospice providers that hospice might extend some patients' lives. We studied the difference of survival periods of terminally ill patients between those using hospices and not using hospices. We performed retrospective statistical analysis on selected cohorts from large paid claim databases of Medicare beneficiaries for five types of cancer and congestive heart failure (CHF) patients. We analyzed the survival of 4493 patients from a sample of 5% of the entire Medicare beneficiary population for 1998–2002 associated with six narrowly defined indicative markers. For the six patient populations combined, the mean survival was 29 days longer for hospice patients than for nonhospice patients. The mean survival period was also significantly longer for the hospice patients with CHF, lung cancer, pancreatic cancer, and marginally significant for colon cancer ($P = 0.08$*). Mean survival was not significantly different (statistically) for hospice vs. nonhospice patients with breast or prostate cancer. Across groups studied, hospice enrollment is not significantly associated with shorter survival, but for certain terminally ill patients, hospice is associated with longer survival times. The claims-based method used death within three years as a surrogate for a clinical judgment to recommend hospice, which means our findings apply to cases where a clinician is very sure the patient will die within three years, and it points to the need to validate these findings.* J Pain Symptom Manage 2007;33:238–246.

Key Words
Survival, hospice, palliative care, cancer, congestive heart failure

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Introduction

The purpose of hospice is to effectively provide palliative care to terminally ill patients and their families, which includes meeting patients' physical, social, spiritual, and emotional needs. The goal of hospice is neither to prolong life nor to hasten the dying process, but

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rather is to maximize patients' quality of life as they travel along this last journey. However, there is a perception among some health care providers that symptom control in palliative care, especially the use of opioids and sedatives, may cause patients to die sooner than they would otherwise. Conversely, preliminary evidence has suggested that the lives of some patients might actually be extended through the use of hospice care.[1–4]

There is a growing body of evidence to counter the argument that the use of opioid and sedative medications for symptom relief hastens death,[5–9] even in patients who are receiving high doses of morphine and other opioids.[5,7] There have been few studies published, however, that have evaluated the effect of hospice care on increasing the longevity of terminally ill patients. In a study on the cost differences between patients who do and who do not elect to receive Medicare-paid hospice benefits,[10] we discovered that costs were lower for patients receiving hospice care and that these costs were not associated with shorter time until death. In fact, in this sample of 8700 patients drawn from the Medicare 5% sample database, the use of hospice appeared to be associated with longer time until death.

Because cost was the focus of our original study, only patients who died during the two-year study period (i.e., 1999 and 2000) were included, which limited the value of the data for a survival study. The fact that patients who chose hospice showed longer mean and median time until death by days to months for all 16 diagnosis categories studied prompted us to investigate our findings further. In the current study, we used a similar methodology to that described in our previous work;[10] however, we limited the cohorts to six that had sufficient numbers for analysis and expanded the study period to include data from 2001 and 2002 in addition to 1999 and 2000 to better measure the survival period.

Methods

In this retrospective cohort study, we used an innovative prospective/retrospective case control method and Medicare administrative data to measure time until death starting from dates that were narrowly defined within the data. We performed a Kaplan-Meier analysis of the cohorts and used multiple regression models to evaluate the difference of survival periods of terminal illness patients between those using hospices and those not using hospices. For each disease cohort, a set of specific clinical events was used to define an indicative event and a date to measure the beginning point for time to death.

Sources of the Data

From the Centers for Medicare and Medicaid Services, we used Medicare 5% sample data in 1998, 1999, 2000, 2001, and 2002. This data set contains all Medicare-paid claims generated by a statistically representative sample of Medicare beneficiaries. Member identification codes are consistent from year to year and allow for multiyear longitudinal studies. Moreover, this information is generated for both inpatient and outpatient settings. Information includes diagnosis codes, procedure codes, and diagnosis-related group (DRG) codes, along with site of service information, and the amounts paid by Medicare. We used data from 1998 to 1999 to identify cohort members and find the indicative dates of the diagnostics associated with terminal illness. We used the 2000, 2001, and 2002 data to measure the survival periods after the indicative dates.

Additional data were obtained from the Health Care Financing Administration Standard Analytic File of Medicare 5% sample hospice claim data in 1999, 2000, 2001, and 2002, which contain more detailed information on the hospice claims, including hospice start and end dates.

Patient Cohorts

Medicare beneficiaries were identified from 1999 claim data if they met indicative marker criteria for any of the six diseases and died within three years of the indicative marker date. The restriction of the data to people who died within three years of the indicative marker was meant to be a surrogate for clinical judgment, as claim data are not a completely accurate predictor of terminal decline. Strictly speaking, this data restriction means our results apply to cases where a clinician is very sure the patient will die within three years.

The diseases were congestive heart failure (CHF), breast cancer, colon cancer, lung cancer, prostate cancer, and pancreatic cancer. Patients were identified as having one of the six diseases if they had at least one inpatient hospital claim or at least two Part B claims with different service dates with the following ICD-9 codes:

- CHF—428 as the primary diagnosis code;
- breast cancer—174.0–174.9 in any position of the claim;
- colon cancer—153.0–153.9 in any position of the claim;
- lung cancer—162.0–162.9 in any position of the claim;
- prostate cancer—185 in any position of the claim; and
- pancreatic cancer—157.0–157.9 in any position of the claim (except 157.4, islet cell cancer).

Part B claims in the Current Procedural Terminology (CPT) 70,000 or 80,000 series or with Healthcare Common Procedure Coding System (HCPCS) codes beginning with a letter were excluded to avoid potential false positive identification through laboratory or radiology claims. Patients with more than one disease were assigned using the hierarchy: pancreas, colon, lung, breast, prostate, and CHF.

We included only patients who had eligibility in 1998, an indicative date in 1999 and who died within three years after the indicative date. We had no information on whether any of the survivors beyond three years may have chosen hospice after three years. We excluded patients who died within 15 days after the indicative date, as these patients would have had limited opportunity to participate in hospice. We performed a look back to 1998 and excluded patients who had an indicative date in 1998 in an attempt to use the first indicative date for each cohort member.

Patients were divided into hospice and nonhospice cohorts. Patients included in the hospice group were those who had at least one claim for hospice services within three years after the indicative date. The other patients were classified in the nonhospice group.

Indicative Markers

We chose "indicative markers" for the six diagnoses that identified a point in the disease progression under which a patient could shortly thereafter be advised to consider obtaining hospice care. A thorough description of how these indicative markers were derived for each diagnosis is presented in our earlier paper.[10] In brief, the indicative date for each patient was defined as the date that indicated the beginning of the terminal stage of the disease. Any patient without an indicative date was excluded from the study.

For breast cancer, the indicative date was defined as the maximum date that indicated a switch to another combination of chemotherapy drugs within one to two quarters of the initial chemotherapy. Chemotherapy claims were defined as Part B claims having HCPCS codes of J9000–J9999 (except J9170, Docetaxel). A chemotherapy claim was considered a switching chemotherapy claim if 1)the chemotherapy claim was for a different class of chemotherapy drug from the class of the prior chemotherapy claim *and* 2) the switching chemotherapeutic claim began during the 1–180-day interval after the prior chemotherapy claim.

For colon cancer, the indicative date was defined for three scenarios. First, if there were no colon resection claim, then the indicative date was the minimum date of chemotherapy claims. Second, if a chemotherapy claim occurred within one quarter of the colon resection, then the indicative date was the minimum date of the chemotherapy claims. Third, if the first and second scenario did not apply, then the indicative date was the first date of an intestinal stent claim. Colon resection claims were identified by current procedural terminology (CPT) codes 44140–44160. Chemotherapy claims were identified by CPT codes 96400–96549 and by HCPCS J9000–J9999. Intestinal stent claims were identified by CPT codes 45327, 45345, and 45387.

For lung cancer, the indicative date was defined as the last claim service date of switching chemotherapy or biopsy followed by chemotherapy claims. The definition of switching chemotherapy was the same for lung cancer as for breast cancer, and the definition of chemotherapy claims was also the same as for breast cancer. The definition for a biopsy followed by a chemotherapy claim contained three criteria: 1)the beneficiary had a biopsy claim; 2)a chemotherapy claim followed the

biopsy claim; and 3)the beneficiary had no lung resection claim. The biopsy claim was identified by CPT codes 32405, 10022, and 32400. The lung resection claim was identified by CPT codes 32440, 32480, 32482, 32484, 32486, 32488, 32501, 32520, 32522, and 32525.

For prostate cancer, the indicative date was defined as the minimum date of strontium claims. Strontium claims were identified by a strontium 89 HCPCS code of A9600. For pancreatic cancer, the indicative date was the minimum date of claims having an ICD-9 of 157.0–157.9 (except 157.4, islet cell cancer).

For CHF, the indicative date was defined as the maximum date of a ventilatory management claim when all of the following three criteria were met: there was no coronary artery bypass graft (CABG) claim in the same or next quarter; there was no myocardial infarction (MI) claim in the same quarter; and there was an inpatient claim with a primary diagnosis code of 428 within the same quarter. A ventilatory management claim was identified by intubation and Ventilator Management CPT codes of 94656, 94657, and 31500. CABG claims were identified by CPT codes of 33510 and 33536. A MI claim was defined by the inpatient claim having MI ICD-9 in any position (i.e., acute MI ICD-9: 410.0–410.9).

The hospice and nonhospice cohorts produced by each colon cancer indicative date definition had similar distributions, as did the cohorts using the CHF indicative dates. Thus, there does not appear to be a bias generated by the options within these diseases. We note that it is possible that the final "chemo switching" approach we used for breast and lung cancer may produce shorter survival for nonhospice cohorts if they received more chemo switches after failed therapies.

Statistical Analysis

We analyzed the data using SAS™ statistical software (SAS Institute Inc., Cary, NC) and Excel™ (Microsoft Corporation, Redmond, WA). The dependent variable in our analysis was the length of survival in days. The survival period was defined as the duration between the indicative date and the date of death. The independent variables included the patient's diagnosis, age, sex, race, and use of hospice. Gehan *P* values for the difference of the two survival curves weighted by the number of survivors were calculated to analyze the survival periods of hospice and nonhospice patients. This test was performed using SAS™ PROC LIFETEST.

A multiple regression model was used to determine the factors that influence survival periods. We limited the model to nine variables to minimize Mallow's $C(p)$ statistic. The nine variables used in the model were CHF, breast cancer, colon cancer, lung cancer, pancreatic cancer, age category 80–89 years, age category 90+ years, white, and use of hospice. A separate multiple regression model was used to determine the factors that influence survival days for the hospice cohort. This model was also limited to nine variables, which were CHF, breast cancer, colon cancer, lung cancer, pancreatic cancer, age category 60–69 years, age category 70–79 years, Hispanic status, and length of hospice stay.

Results

We identified 4493 patients who met our criteria for the six diseases. Of these patients, 2095 (47%) received hospice care for at least one day. Table 1 summarizes characteristics

Table 1
Description of Study Population (Sample Size)

Variable	Hospice ($n = 2095$)	Nonhospice ($n = 2260$)
Disease		
CHF	83 (4%)	457 (20%)
Breast cancer	158 (8%)	136 (6%)
Colon cancer	337 (16%)	215 (10%)
Lung cancer	700 (33%)	586 (26%)
Pancreatic cancer	493 (24%)	386 (17%)
Prostate cancer	324 (15%)	480 (21%)
Age (years)		
<60	72 (3%)	111 (5%)
60–64	115 (5%)	109 (5%)
65–69	440 (21%)	451 (20%)
70–74	554 (26%)	514 (23%)
75–79	482 (23%)	482 (21%)
80–84	268 (13%)	337 (15%)
85–89	119 (6%)	185 (8%)
90+	45 (2%)	71 (3%)
Mean age	73.5	73.9
% Female	45	41
Race		
White	1860 (89%)	1897 (84%)
Black	167 (8%)	259 (11%)
Hispanic	24 (1%)	50 (2%)
Asian	14 (1%)	15 (1%)
Other	30 (1%)	39 (2%)

of the patients. The most common diagnosis was lung cancer for both the hospice cohort and nonhospice cohort (33% and 26%, respectively), and the least common diagnosis was breast cancer (8% and 6%, respectively). The number of patients with colon, lung, and pancreatic cancer was generally higher for the hospice cohort than the nonhospice cohort (a difference of 6%–7% between the cohorts for each diagnosis). The number of patients with CHF was considerably higher for the nonhospice cohort than for the hospice cohort (20% vs. 4%). The age groups were similar for both hospice and nonhospice cohorts, with a mean age of 74 years for both cohorts. Females accounted for 45% of the hospice cohort and 41% of the nonhospice cohort. Whites comprised the majority of the sample (89% and 84% in the hospice and nonhospice cohorts). For the hospice cohort, the mean length of stay in hospice was 43 days but varied by cohort.

Survival Periods

For the entire sample of all disease cohorts, the mean number of survival days was eight days longer for hospice patients than for nonhospice patients (337 vs. 329 days, $P = 0.00079$). This difference includes the effects of many factors including demographics and sample sizes of the two cohorts. When we normalized these other factors, the difference in days increases to 29 days, as we show later in the regression.

The survival period was significantly longer for the hospice cohort than for the nonhospice cohort for the following diseases: CHF (402 vs. 321 days, $P = 0.0540$), lung cancer (279 vs. 240 days, $P < 0.0001$), and pancreatic cancer (210 vs. 189 days, $P = 0.0102$). The survival period was longer for the hospice cohort than nonhospice cohort for colon cancer, and the difference approached but did not reach statistical significance (414 vs. 381 days, $P = 0.0792$). Survival plots for CHF, lung cancer, pancreatic cancer, and colon cancer are presented in Figs. 1–4. There was no statistically significant difference between the hospice and nonhospice cohorts for breast cancer (422 vs. 410 days, $P = 0.6136$) or prostate cancer (514 vs. 510 days, $P = 0.8266$).

Regression Models

The second regression was performed only for hospice cohorts to determine the factors that influence survival days, which are presented in Table 2. The R square was 14.6%. The coefficient of hospice was 29 days, indicating that hospice patients lived longer than patients not using hospice by 29 days. The results of the regression for the hospice cohort are also presented in Table 3.

In the model, the coefficient of length of hospice stay was 0.8. It is not self-evident that the longer hospice days result in the longer survival days, because we define the survival days at the indicative date. However, the results of the regression show that there is a positive correlation between length of hospice stay and the survival days. This result combined with the coefficient of 29 days for the overall regression suggests that a hospice patient lived longer by 0.8 times the number of days in

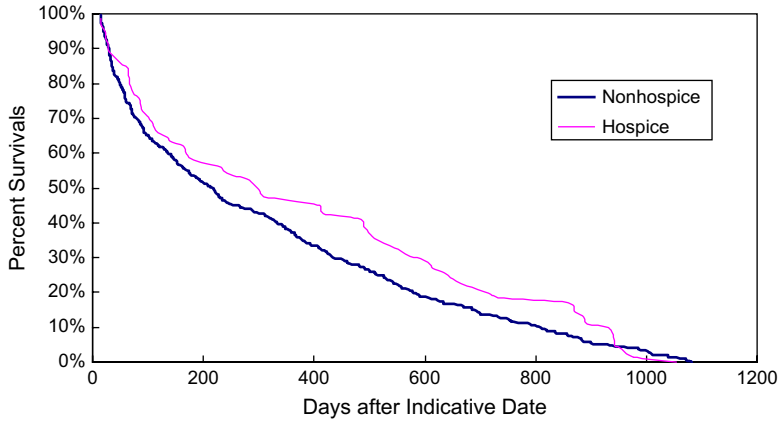

Fig. 1. Survival curve for patients with CHF.

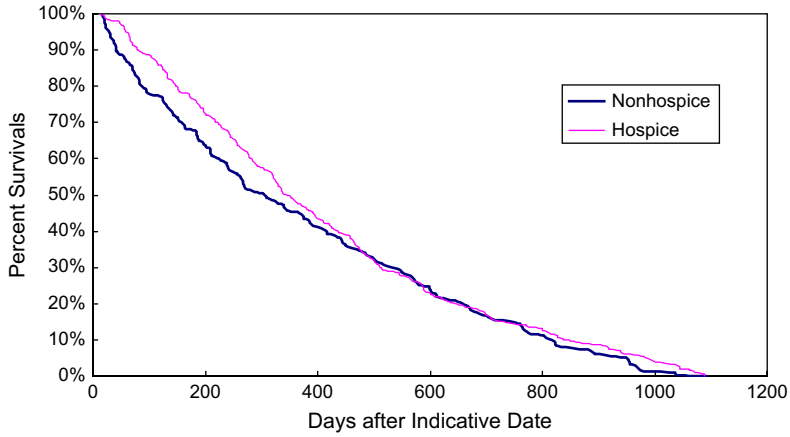

Fig. 2. Survival curve for patients with colon cancer.

hospice. The 0.8 coefficient is close to the overall hospice coefficient (29 days) divided by the average length of hospice days (43 days) (29/43 = 0.7). The positive parameter for the length of hospice stay in the regression model suggests that hospice does not shorten life.

Discussion

Although hospice aims neither to prolong life nor to hasten death, there has been a clinical perception among hospice providers that the use of hospice may actually prolong terminally ill patients' lives, despite the fact that these patients have made the decision to forego further curative treatment. Our findings suggest that hospice may indeed have a positive impact on patients' longevity or at least not hasten death. We found that for certain well-defined terminally ill populations, patients who choose hospice care live an average of 29 days longer than similar patients who do not choose hospice. This pattern persisted over four of the six disease categories studied, though there was substantial variation in the mean length of survival according to diagnosis. Of note, the largest difference in survival between the hospice and nonhospice cohort was for the CHF patients, where relatively few patients chose hospice care. CHF patients who eventually chose hospice had a mean survival of 402 days compared with 321 days for those who did not.

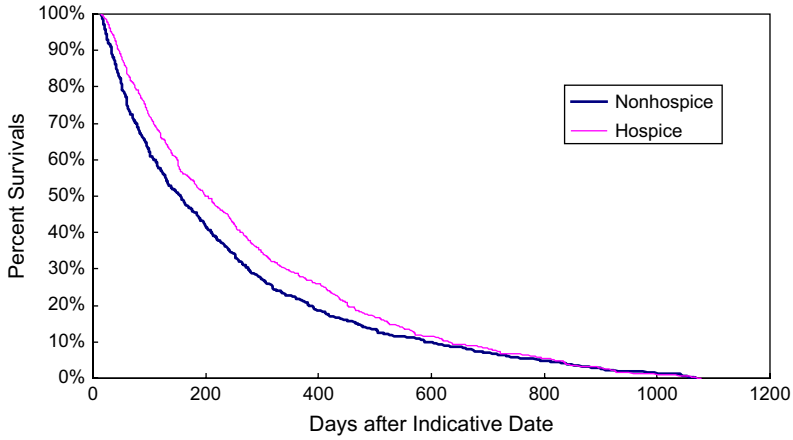

Fig. 3. Survival curve for patients with lung cancer.

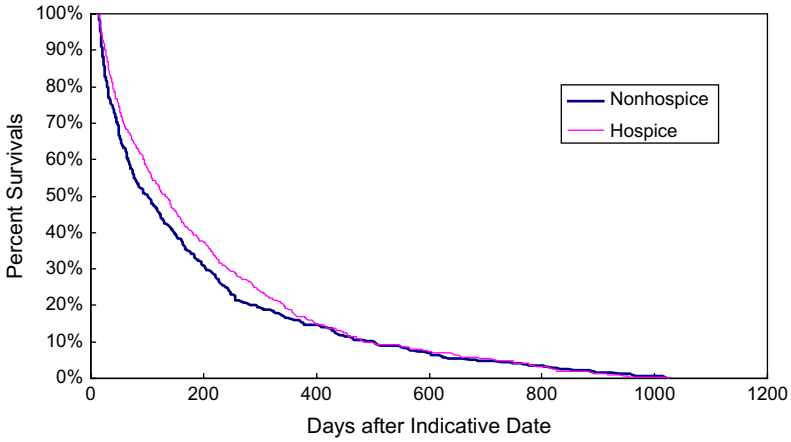

Fig. 4. Survival curve for patients with pancreatic cancer.

Our results are conditional for individuals dying within three years after the indicative event. This means that if a clinician is very sure an individual will die within three years, he or she should think of a recommendation for hospice with longer survival for the selected cohorts. We believe that this is a fairly strong statement because the three-year survival period we examined is long compared to the average length of hospice stay (43 days in our cohorts).

Our findings are important in helping to dispel the myth that hospice care hastens a patient's death. This myth may stem in part from

Table 2
Results of Overall Regression and Regression of Hospice Cohort

	Overall Regression[a]			Regression of Hospice Cohort[b]		
	Parameters	SE	*P*-Value	Parameters	SE	*P*-Value
Intercept	526	15	<0.0001	454	18	<0.0001
Variables						
CHF	−173	15	<0.0001	−106	32	0.0008
Breast cancer	−104	19	<0.0001	−92	25	0.0002
Colon cancer	−122	15	<0.0001	−104	20	<0.0001
Lung cancer	−261	13	<0.0001	−241	18	<0.0001
Pancreatic cancer	−316	13	<0.0001	−305	18	<0.0001
Prostate cancer	[c]	—	—	[c]	—	—
Age (years)						
<60	[c]	—	—	[c]	—	—
60–69	[d]	—	—	54	16	0.0009
70–79	[d]	—	—	32	14	0.0239
80–89	−17	10	0.1057	[d]	—	—
90+	−72	26	0.0054	[d]	—	—
Female	[c]	—	—	[c]	—	—
Male	[d]	—	—	[d]	—	—
White	−20	—	—	[d]	—	—
Black	[d]	—	—	[d]	—	—
Hispanic	[d]	—	—	−102	53	0.0539
Asian	[d]	—	—	[d]	—	—
Other race	[c]	—	—	[c]	—	—
Hospice	29	9	0.0008	—	—	—
Length of hospice stay	—	—	—	0.8	0.1	<0.0001

SE = standard error.
[a] $C(p)$ value of 8.7985, R-square value of 0.1457; all variables are logical (0 or 1).
[b] $C(p)$ value of 8.0347, R-square value of 0.1828; all variables other than length of hospice stay are logical (0 or 1).
[c] Eliminated for redundancies of variables.
[d] Eliminated to minimize $C(p)$.

Table 3
Lengths of Hospice Stay for Cohorts

	Number of Hospice Patients = "Count"	ALOHS = μ	Standard Deviation
CHF	83	49	100
Breast cancer	158	40	57
Colon cancer	337	43	62
Lung cancer	700	38	63
Pancreatic cancer	493	47	70
Prostate cancer	324	46	70
All above	2095	43	67

ALOHS = Average length of hospital stay.

the fact that hospice professionals not uncommonly admit patients who are in very poor shape and near death. Indeed, many patients continue to be referred late for hospice or palliative care. The use of opioids and sedatives to alleviate symptoms has also contributed to this perception, though a growing body of literature has amassed to counter this association.[5–9]

Clinical observation suggests that numerous factors may contribute to the increased longevity we found in patients electing to receive hospice care. First, patients who are already in a very weakened condition avoid the risks of overtreatment when they make the decision to enter hospice. This factor may be particularly relevant to terminally ill oncology patients who forego aggressive cure-directed therapies. Intensive medical interventions such as high-dose chemotherapy or bone marrow transplantation always carry a significant danger of mortality. Second, entering hospice may improve the monitoring and treatment patients receive. The Medicare hospice benefit allows patients to receive medications that might not be covered in the absence of Part D or other insurance, along with interdisciplinary care coordination that rarely occurs in the traditional Medicare program. Third, several studies have suggested that psychosocial supports may tend to prolong life,[11–13] although not all studies have found an association.[14,15] Nonetheless, for people who are on the edge of survival, constant attention to their emotional well-being and physical health may increase their desire to continue living. Studies of patients with coronary heart disease[16,17] and breast cancer[13] have found that low levels of social support increased the risk of morbidity or death. Without hospice, patients may feel that they are a burden to their family.

Although our findings were consistent across four of the diagnosis categories we studied, it is not clear whether these findings would be replicated in patients with other disease states. In this study we chose very narrowly defined patient cohorts, and further research should be undertaken to determine whether these findings are applicable to other kinds of patients. Not all patients demonstrated increased survival, and it is probably a subset of patients who may benefit. Future research in this area will elucidate the applicability of these findings to other patients.

The methodology used in this study is subject to limitation in the ability to control for selection bias. We do not precisely know if some factors related to the decision to use hospice may be responsible for the results. However, by selecting patients prior to death with the same clinical circumstances rather than selecting patients who died and performing a look back, we believe we have overcome selection bias, at least in part.

This study provides important information to dispel the myth that hospice hastens death and suggests that hospice is related with the longer length of survival by days or months in certain terminally ill patients. This extra time might be particularly important to patients and their families, as it may allow some people to use the end of life as a time of resolution and closure.

Acknowledgments

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References

1. Christakis NA, Iwashyna TJ, Zhang JX. Care after the onset of serious illness: a novel claims-based dataset exploiting substantial cross-set linkages to study end-of-life care. J Palliat Med 2002;5:515–529.

2. Christakis NA. Predicting patient survival before and after hospice enrollment. Hosp J 1998;13: 71–87.

3. Connor S. Hospice: Practice, pitfalls, and promise. Philadelphia, PA: Taylor and Francis, 1998. 118–119.

4. Forster LE, Lynn J. The use of physiologic measures and demographic variables to predict longevity among inpatient hospice applicants. Am J Hosp Care 1989;6:31–34.

5. Bercovitch M, Waller A, Adunsky A. High dose morphine use in the hospice setting: a database survey of patient characteristics and effect on life expectancy. Cancer 1999;86:871–877.

6. Thorns A, Sykes N. Opioid use in last week of life and implications for end-of-life decision-making. Lancet 2000;356:398–399.

7. Morita T, Tsunoda J, Inoue S, Chihara S. Effects of high dose opioids and sedatives on survival in terminally ill cancer patients. J Pain Symptom Manage 2001;21:282–289.

8. Good PD, Ravenscroft PJ, Cavenagh J. Effects of opioids and sedatives on survival in an Australian inpatient palliative care population. Intern Med J 2005;35:512–517.

9. Vitetta L, Kenner D, Sali A. Sedation and analgesia-prescribing patterns in terminally ill patients at the end of life. Am J Hospice Palliat Med 2005; 22:465–473.

10. Pyenson B, Connor S, Fitch K, Kinzbrunner B. Medicare cost in matched hospice and non-hospice cohorts. J Pain Symptom Manage 2004;28:200–210.

11. Spiegel D, Bloom JR, Kraemer HC, Gottheil F. Effect of psychosocial treatment on survival of patients wit metastatic breast cancer. Lancet 1989; 2:888–891.

12. Berkman LF, Leo-Summers L, Horwitz RI. Emotional support and survival after myocardial infarction. A prospective, population-based study of the elderly. Ann Intern Med 1992;117:1003–1009.

13. Kroenke CH, Kubzansky LD, Schernhammer ES, Holmes MD, Kawachi I. Social networks, social support, and survival after breast cancer diagnosis. J Clin Oncol 2006;24:1105–1111.

14. Goodwin PJ, Leszcz M, Ennis M, et al. The effect of group psychosocial support on survival in metastatic breast cancer. N Engl J Med 2001;345: 1719–1726.

15. Kissane DW, Love A, Hatton A, et al. Effect of cognitive-existential group therapy on survival in early-stage breast cancer. J Clin Oncol 2004;22: 4255–4260.

16. Brummett BH, Barefoot JC, Siegler IC, et al. Characteristics of socially isolated patients with coronary artery disease who are at elevated risk for mortality. Psychosom Med 2001;63:267–272.

17. Burg MM, Barefoot J, Berkman L, et al. Low perceived social support and post-myocardial infarction prognosis in the enhancing recovery in coronary heart disease clinical trial: the effects of treatment. Psychosom Med 2005;67:879–888.

Hospice Utilization in the United States: A Prospective Cohort Study Comparing Cancer and Noncancer Deaths

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OBJECTIVES: Reliable national estimates of hospice use and underuse are needed. Additionally, drivers of hospice use in the United States are poorly understood, especially among noncancer populations. Thus the objectives of this study were to (1) provide reliable estimates of hospice use among adults in the United States; and (2) identify factors predicting use among decedents and within subsamples of cancer and noncancer deaths.

DESIGN: We conducted a prospective cohort study using the Health and Retirement Study survey. Excluding sudden deaths, we used data from the 2012 survey wave to predict hospice use in general, and then separately for cancer and non-cancer deaths.

SETTING: Study data were provided by a population-based sample of older adults from the U.S.

PARTICIPANTS: We constructed a sample of 1,209 participants who died between the 2012 and 2014 survey waves.

MEASUREMENTS: Hospice utilization was reported by proxy. Exposure variables included demographics, functionality (activities of daily living [ADLs]), health, depression, dementia, advance directives, nursing home residency, and cause of death.

RESULTS: Hospice utilization rate was 52.4% for the sample with 70.8% for cancer deaths and 45.4% for noncancer deaths. Fully adjusted model results showed being older (odds ratio [OR] = 1.54), less healthy (OR = .79), having dementia (OR = 1.52), and having cancer (OR = 5.47) were linked to greater odds of receiving hospice. Among cancer deaths, being older (OR = 1.64) and female (OR = 2.54) were the only predictors of hospice use. Among noncancer deaths, increased age (OR = 1.58), more education (OR = 1.56), being widowed (OR = 1.55), needing help with ADLs (OR = 1.13), and poor health (OR = .77) were associated with hospice utilization.

CONCLUSION: Findings suggest hospice remains underutilized, especially among individuals with noncancer illness. Extrapolating results to the US population, we estimate that annually nearly a million individuals who are likely eligible for hospice die without its services. Most (84%) of these decedents have a noncancer condition. Interventions are needed to increase appropriate hospice utilization, particularly in noncancer care settings. **J Am Geriatr Soc 68:783-793, 2020.**

Key words: hospice; healthcare utilization; end-of-life care; Health and Retirement Study

Hospice is an interdisciplinary medical and supportive care service for patients with a life expectancy of 6 months or less that focuses on symptom management, patient preferences, and supporting family caregivers.[1] Hospice has grown dramatically since it first appeared in the United States in 1974. As of 2017, 4515 Medicare-certified hospices were serving approximately 1.5 million beneficiaries.[1] Despite this growth and that hospice has consistently demonstrated a superior ability to manage symptoms,[2,3] reduce costs,[4] and maintain high levels of satisfaction,[5] concerns about underutilization remain.[6-8] In 2015, only 46% of US deaths involved hospice.[9] Providers and researchers have struggled to understand the drivers of utilization to help improve access, overcome obstacles to enrollment, and ensure timely referrals. Although previous studies identified numerous correlates of hospice use including age,[10] race,[11] physician-patient communication,[12] presence of an advance directive,[11] and geography,[13,14] our knowledge about the primary drivers of utilization remains incomplete. In fact, no study has examined hospice utilization using prospective individual-level data from a national population-based-study.

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Prior research on hospice utilization in the United States relies heavily on Medicare claims data that are largely limited to adults 65 years and older, and typically does not include Medicare Advantage beneficiaries.[15] Additionally, prior estimates of utilization have included individuals who were not potential candidates for hospice, such as those who died suddenly (eg, due to accidents, cardiac arrest). Furthermore, some denominators for rates of hospice use have included all Medicare beneficiaries, both living and deceased.[16] Although such rates are helpful markers for trends in healthcare utilization, they have limited value for estimating the penetration of hospice services among the full population of eligible decedents and the underuse of its services. This is particularly important because access to timely, high-quality end-of-life care, including hospice, has been recognized as a significant public health concern.[17,18]

Historically, hospices largely cared for patients with advanced cancer.[19] Consequently, many hospice policies and practices evolved to address the needs of oncology patients.[19] More recently, the fastest growing segment of hospice patients is those with a noncancer illness, such as heart disease or dementia.[13] In fact, the proportion of hospice patients with a noncancer diagnosis increased from 34.6% in 1995 to 69.9% in 2017.[1,20,21] Despite this shift in the hospice case mix, research at the national level examining determinants of hospice among individuals with a noncancer condition is lacking. Such research is needed because existing data are mostly based on patients with cancer that may not be generalizable to persons with a life-limiting noncancer illness. Prognostic precision, illness trajectories, and care-related needs differ substantially for persons with a life-limiting noncancer diagnosis compared with persons with cancer.[22,23]

Using prospective data from a nationally derived sample of decedents from the Health and Retirement Study (HRS), we sought to (1) estimate hospice use among adults 50 years or older within the United States, and (2) identify individual-level factors predicting hospice use among the general decedent population as well as within subsamples of cancer and noncancer deaths. We also describe the relationship between hospice utilization and age stratified by cause of death.

METHODS

Sample

We used data from the HRS, a nationally representative longitudinal cohort survey of older adults in the United States with biennial data collection.[24,25] HRS researchers initially used a national probability proportionate to size sampling approach that began with selection at the county level.[26] Black and Hispanic individuals were oversampled to ensure adequate representation of minority groups. The HRS includes nursing home and assisted living facility residents. Detailed information about the HRS methodology are reported elsewhere.[27]

From the HRS, we constructed a sample of 1209 participants who died between the 2012 and 2014 survey waves. In 2014, HRS researchers conducted Exit Wave interviews with the person most familiar with the decedent, usually next of kin, to provide information about end-of-life care. Our study combines data from the 2012 Core Wave (pre-death) and 2014 Exit Wave (post-death). Thus the bulk of study variables was collected directly from participants while they were living during the 2012 wave of data collection but who then died before the 2014 wave. Mortality ascertainment for the HRS is considered "essentially complete."[28]

Outcome Variable

The primary outcome, hospice utilization (Yes/No), was based on proxy response from the 2014 Exit Wave. Hospice was defined as specialized care for "patients with terminal illness and their families" and "not the same as home health." Thus hospice use could occur at home, in a facility, or in other setting.

Exposure Variables

Demographic information was compiled from the © 2019 The American Geriatrics SocietyTracker file and the 2012 Core Wave RAND data file.[29,30] To meet test assumptions, race and education were recoded (white vs nonwhite and "no high school degree" vs "high school degree or more") before multivariable modeling. Household wealth was categorized into quartiles. Help with activities of daily living (ADLs) was based on needing assistance with five activities: walking, bathing, eating, getting out of bed, and toileting. Affirmative responses were summed with higher scores indicating greater ADL debility. Using a single item, health was self-rated with responses ranging from 1 = poor to 5 = excellent. Pain (Yes/No) was ascertained from responses to the question "Are you often troubled with pain?" Depressive symptoms were evaluated using the eight-item Center for Epidemiological Studies-Depression scale; higher scores signify more depressive symptoms. Dementia was ascertained using data regarding whether the respondent had been diagnosed with Alzheimer's disease or other dementia. Proxies provided data for cases with advanced dementia. Nursing home residency (Yes/No) was determined based on whether the respondent was currently living in a nursing home.

Data regarding age at death, Medicare coverage, geographic region, cause of death, and presence of an advance directive were gathered from the 2014 Exit Wave. Age was coded into 10-year increments for adjusted models. Geographic region, based on residence before death, was categorized according to US Census regions (Northeast, Midwest, South, and West). Cause of death (cancer vs noncancer) was ascertained using the proxy response to "What was the major illness that led to [the decedent's] death?" Presence of advance directives was determined from whether decedents had documented preferences for end-of-life care in writing before receiving hospice services.

Additional Measures

From the Exit Wave, measures of sudden death, location of death, and length of stay for hospice enrollees were used for sample construction and description. Sudden death was determined using proxy response to "About how long was it between the start of the final illness and the death?" The

Table 1. Sample Characteristics and Unadjusted Associations with Hospice Use

Characteristics	Full sample (N = 1209) N (%)	Analytic sample (N = 1025) N (%)	Enrolled in hospice? (N = 537) Yes (%)
Age, y, *M* (SD)	79.8 (11.1)	80.4 (10.8)	**82.0 (10.3)**[a]
Sex (%)			
Male	585 (48.4)	479 (46.7)	52.4
Female	624 (51.6)	546 (53.3)	52.4
Race (%)			
White	953 (78.8)	819 (79.9)	**54.5***
African American	206 (17.0)	167 (16.3)	**45.5**
Other	50 (4.1)	39 (3.8)	**38.5**
Ethnicity (%)			
Non-Hispanic	1,104 (91.3)	937 (91.4)	**53.4***
Hispanic	105 (8.7)	88 (8.6)	**42.0**
Education (%)			
No degree	331 (27.4)	290 (28.3)	**46.6***
GED/High school	657 (54.3)	540 (52.7)	**53.7**
College	157 (13.0)	138 (13.5)	**58.7**
Master's +	61 (5.0)	54 (5.3)	**53.7**
Missing	3 (.2)	3 (.3)	
Marital status (%)			
Married	488 (40.4)	405 (39.5)	**49.4****
Single/Separated/Divorced	189 (15.6)	154 (15.0)	**44.8**
Widowed	444 (36.7)	391 (38.1)	**58.6**
Missing	88 (7.3)	75 (7.3)	
Wealth quartiles (%)			
Low	276 (22.8)	228 (22.2)	**47.4***
Middle/Low	284 (23.5)	249 (24.3)	**50.6**
Middle/High	282 (23.3)	235 (22.9)	**55.3**
High	279 (23.1)	238 (23.2)	**56.3**
Missing	88 (7.3)	75 (7.3)	
Self-rated health (%)			
Poor	355 (29.4)	314 (30.6)	**60.5****
Fair	344 (28.5)	279 (27.2)	**47.3**
Good	266 (22.0)	224 (21.9)	**50.4**
Very good	132 (10.9)	113 (11.0)	**48.7**
Excellent	23 (1.9)	19 (1.9)	**36.8**
Missing	89 (7.4)	76 (7.4)	
Cause of death (%)			
Cancer	282 (23.3)	271 (26.4)	**72.3*****
Noncancer	904 (74.8)	742 (72.4)	**45.4**
Missing	23 (1.9)	12 (1.2)	
Geographic region (%)			
Northeast	178 (14.7)	145 (14.1)	44.8†
Midwest	291 (24.1)	254 (24.8)	57.9
South	526 (43.5)	443 (43.2)	51.7
West	202 (16.7)	173 (16.9)	52.6
Missing	12 (1.0)	10 (1.0)	
Advance directive (%)			
Yes	499 (41.3)	446 (43.5)	**52.7*****
No	612 (50.6)	499 (48.7)	**47.1**
Uncertain completion date	73 (6.0)	69 (6.7)	**91.3**
Missing	25 (2.1)	11 (1.1)	
Depression			
CES-D (0-8), *M* (SD)	2.7 (2.2)	2.7 (2.2)	2.7 (2.2)[b]
ADL help			
Count (0-5), *M* (SD)	1.2 (1.7)	1.5 (1.8)	**1.4 (1.8)**[c]
Medicare coverage (%)			
Yes	1,038 (85.9)	896 (87.4)	**53.7***
No	128 (10.6)	97 (9.5)	**42.3**

(Continues)

Table 1 (Contd.)

Characteristics	Full sample (N = 1209) N (%)	Analytic sample (N = 1025) N (%)	Enrolled in hospice? (N = 537) Yes (%)
Missing	128 (10.6)	97 (9.5)	**42.3**
Trouble with pain (%)			
Yes	499 (41.3)	424 (41.4)	55.4†
No	616 (51.0)	522 (50.9)	49.8
Missing	94 (7.8)	79 (7.7)	
Dementia (%)			
Yes	245 (20.3)	214 (20.9)	**60.3****
No	964 (79.7)	811 (79.1)	**50.3**
In nursing home 2012[d] (%)			
Yes	198 (16.4)	179 (17.5)	57.5
No	923 (76.3)	771 (75.2)	51.2
Missing	88 (7.3)	75 (7.3)	

Note: Column percentages are presented for the sample. Percentages may not total 100% due to rounding. Analytic sample excludes cases of sudden death (n = 173) and cases with missing hospice use data (n = 11). Statistical tests compare differences between hospice users and nonusers. Statistically significant ($P < .05$) differences in hospice use are shown in bold. Higher ADL help values indicate greater debility.

Abbreviations: ADL, activity of daily living; CES-D, Center for Epidemiological Studies-Depression scale; GED, General Education Diploma; SD, standard deviation.

†$P < .10$; *$P < .05$; **$P < .01$; ***$P < .001$.

[a]Compared with 78.6 years (SD = 11.1) among nonhospice decedents; $P < .001$.

[b]Compared with 2.7 (SD = 2.2) among nonhospice decedents; $P = .944$.

[c]Compared with 1.0 (SD = 1.7) among nonhospice decedents; $P = .001$.

[d]Residing in a nursing home includes inpatient hospice settings.

answers "1 to 2 hours" or "less than 1 day" were considered sudden deaths.

Analysis

Descriptive statistics (frequencies/percentages, means/standard deviation [SD]) were used to summarize the full decedent sample including all HRS participants 50 years and older who died between the 2012 and 2014 surveys (N = 1209; response rates = 89.1% in 2012 and 87.1% in 2014). Eleven cases (.9%) were removed from analyses involving hospice utilization because proxies were unsure whether the decedent had hospice services. Among decedents who did not use hospice, 23.6% died suddenly compared with 3.9% of hospice users ($P < .001$). After excluding sudden deaths, the sample was further reduced by 14.4% (removing 173 cases), leaving a final analytic sample of 1025 cases with which to examine hospice utilization. On average the time between completion of the 2012 Core Wave and decedent death was 12 months (SD = 7.1).

Bivariate tests appropriate to the measures (χ^2, Mann-Whitney U test, or t test) were used to examine unadjusted associations between study variables and hospice utilization. Separate unadjusted analyses of utilization for cancer and noncancer deaths were performed. We then constructed three multivariable logistic regression models predicting hospice utilization before death. Model 1 included the full decedent sample. Models 2 and 3 examined predictors of hospice use among cancer deaths and noncancer deaths, respectively. A comparison of sudden and non-sudden deaths among nonhospice users are provided in Supplementary Table S1.

For regression analyses, predictor variables were selected using (1) core demographic variables, barring those demonstrating strong multicollinearity; and (2) all clinical factors associated with hospice utilization at the $P < .10$ level in bivariate analyses. Location of death was not included in regression models because it is an assumed function of hospice utilization rather than a precipitating factor. Medicare coverage was omitted from regression models due to a strong confounding association with age. Based on regression results, a post hoc analysis investigated the relationship between hospice utilization and age stratified by cause of death. Analyses were conducted using SPSS software, v.24.

RESULTS

Sample Description

Decedents were on average 80 years of age (SD = 11; range = 50-105 y) at death, and most were female (52%; Table 1). Three-quarters of deaths (75%) were not cancer related. Approximately one-third of deaths (32%) occurred at home, 31% in the hospital, and 20% in a nursing home. For the 1198 cases with known hospice utilization status, 46.7% had enrolled in hospice. Figure 1 illustrates duration of the final illness, by cause of death and hospice use. More noncancer decedents experienced sudden death (17.2%) relative to cancer deaths (3.5%; $P < .001$). After excluding sudden deaths for the analytic sample, 52.4% of cases had used hospice with 70.8% for cancer deaths and 45.4% for noncancer deaths (Table 2 lists the subsample characteristics). Among the 537 hospice users, 74% received hospice services for less than 1 month, 41.7% received hospice less than 1 week, and only 7.2% received hospice for more than 6 months.

Among deaths without hospice, 84.4% died from a noncancer illness, and nearly all (94.7%) deaths without hospice experienced high symptom burden, debility, poor

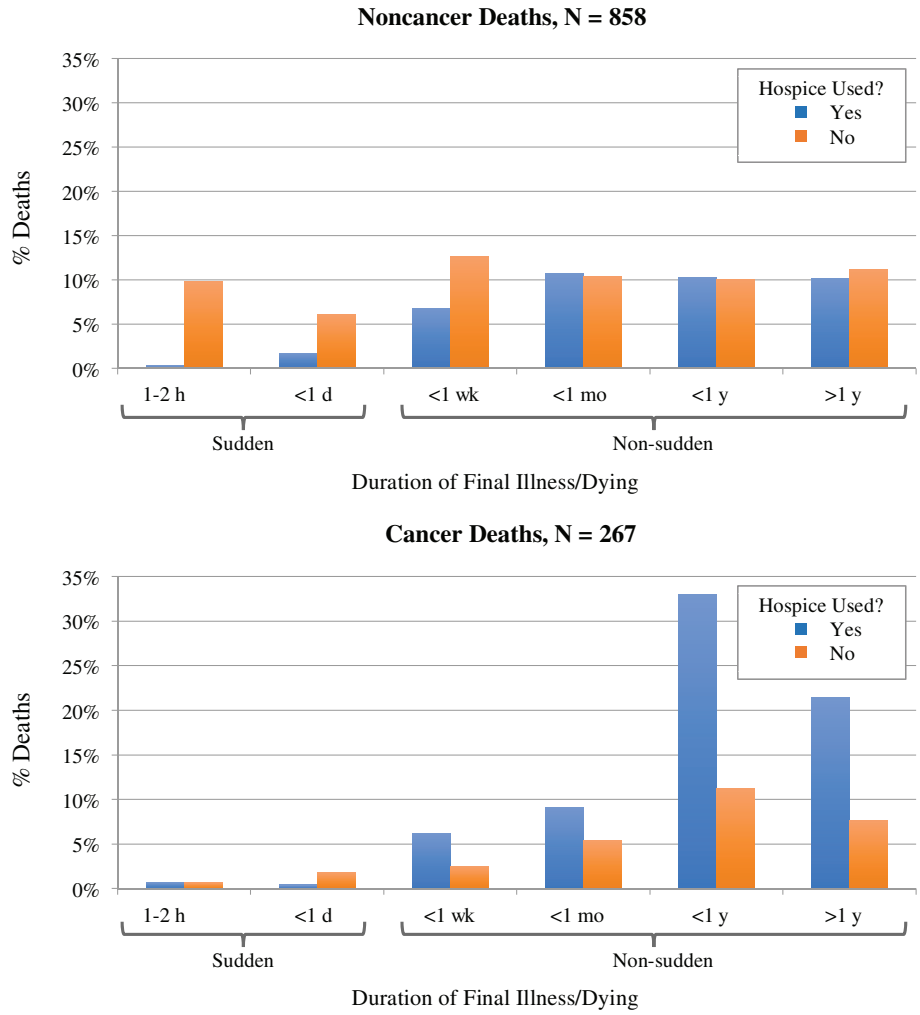

Figure 1. Distribution of deaths according to duration of final illness and hospice use.

health, advanced age, or critical care before death (Supplementary Table S1). Among nonhospice decedents with advance directives (N = 213), 87.3% specified "no extensive measures."

Unadjusted Associations with Hospice Use

Age, race, ethnicity, education, marital status, wealth, self-rated health, cause of death (cancer vs noncancer), advance directives, needing help with ADLs, and having Medicare coverage were all associated with hospice utilization ($P < .05$ for all; Table 1). Location of death was also associated with hospice use. Hospice enrollees were less likely to die in a hospital (15.4% of hospice decedents vs 84.6% of nonhospice decedents) and more likely to die at home (66.4% of hospice decedents compared with 33.6% of nonhospice decedents; $P < .001$) Geographic region and pain were not associated with hospice use at the $P < .05$ level but met criteria for inclusion in regression analyses ($P < .10$ for both).

Adjusted Predictors of Hospice Use

In the fully adjusted model (Table 3), being older, less healthy, having dementia, and having cancer as a cause of death were linked to greater odds of receiving hospice. For every 10-year increase in age, odds of hospice enrollment increased 54% (odds ratio = 1.54; 95% confidence interval = 1.28-1.83; $P < .001$). Cancer decedents were 5.5 times more likely to use hospice relative to noncancer decedents ($P < .001$). Respondents who reported better health in 2012 were less likely to enroll in hospice ($P = .002$). In terms of geographic differences, decedents in the Northeast were less likely to use hospice than those in the South ($P = .021$).

In the adjusted model of cancer deaths, age and sex were the only statistically significant predictors of hospice utilization ($P = .017$ and $P = .013$, respectively). For every 10-year increase in age, an individual had a 64% higher odds of using hospice. Among cancer decedents, women were 2.5 times more likely than men to enroll in hospice.

Among noncancer deaths, increased age, greater educational attainment, being widowed, needing help with more ADLs, and lower self-rated health were associated with receipt of hospice services ($P < .05$). For every 10-year increase in participant age, they were 58% more likely to receive hospice. Similar to results from the full model, noncancer decedents in the Northeast were less likely to receive hospice than those in the South. Widowed persons were 55% more likely to use hospice than married individuals.

Table 2. Decedents Characteristics by Cause of Death and Unadjusted Associations with Hospice

Characteristics	Cancer decedents: Sample N = 271 N (%)	Cancer decedents: Enrolled in hospice? N = 196 Yes (%)	Noncancer decedents: Sample N = 742 N (%)	Noncancer decedents: Enrolled in hospice? N = 337 Yes (%)
Age, y, *M* (SD)	76.2 (9.7)	**77.1 (9.5)**[a]	81.1 (11.1)	**84.8 (9.5)**[b]
Sex (%)				
Male	161 (59.4)	68.9	313 (42.2)	44.7
Female	110 (40.6)	77.3	429 (57.8)	45.9
Race (%)				
White	203 (74.9)	74.9	609 (82.1)	**47.9*****
African American	55 (20.3)	63.6	109 (14.7)	**36.7**
Other	13 (4.8)	69.2	24 (3.2)	**20.8**
Ethnicity (%)				
Non-Hispanic	250 (92.3)	73.2	677 (91.2)	46.4†
Hispanic	21 (7.7)	61.9	65 (8.8)	35.4
Education (%)				
No degree	65 (24.0)	72.3	221 (81.5)	**39.8***
GED/High school	153 (56.5)	71.2	381 (51.3)	**46.7**
College	39 (14.4)	74.4	98 (13.2)	**52.0**
Master's + missing	13 (4.8)	76.9	40 (5.4)	**47.5**
Missing	1 (.4)		2 (.3)	
Marital status (%)				
Married	129 (47.6)	72.1	272 (36.7)	**39.0****
Single/Separated/Divorced	42 (15.5)	64.3	107 (14.4)	**39.3**
Widowed	76 (28.0)	78.9	313 (42.2)	**53.4**
Missing	24 (8.9)		50 (6.7)	
Wealth quartiles (%)				
Low	41 (15.1)	63.4	183 (24.6)	43.7
Middle/Low	57 (21.0)	75.4	190 (25.6)	43.7
Middle/High	73 (26.9)	76.7	158 (21.3)	46.8
High	76 (28.0)	72.4	160 (21.6)	48.4
Missing	24 (8.9)		51 (6.9)	
Self-rated health: poor (%)				
Fair	81 (29.9)	79.0†	228 (30.7)	**54.8****
Good	63 (23.2)	71.4	214 (28.8)	**40.7**
Very good	60 (22.1)	73.3	164 (22.1)	**42.1**
Excellent	37 (13.7)	62.2	73 (9.8)	**41.1**
Missing	5 (1.8)	60.0	13 (1.8)	**30.8**
Fair	25 (9.2)		50 (6.7)	
Geographic region (%)				
Northeast	29 (10.7)	72.4	114 (15.4)	37.7†
Midwest	78 (28.8)	69.2	175 (23.6)	52.6
South	116 (42.8)	73.3	319 (42.0)	44.5
West	46 (16.9)	73.9	126 (17.0)	45.2
Missing	2 (.7)		8 (1.1)	
Advance directive (%)				
Yes	110 (40.6)	**75.5****	333 (44.9)	**45.3*****
No	139 (51.3)	**65.5**	351 (47.3)	**40.2**
Uncertain completion date	22 (8.1)	**100**	47 (6.3)	**87.2**
Missing	0 (.0)		11 (1.5)	
Depression				
CES-D (0-8), *M* (SD)	2.4 (2.1)	2.4 (2.1)[c]	2.8 (2.2)	3.0 (2.3)[d]
ADL help:				
Count (0-5), *M* (SD)	.6 (1.3)	.6 (1.3)[e]	1.3 (1.8)	**1.8 (1.9)**[f]
Medicare coverage (%)				
Yes	225 (83.0)	72.9	663 (89.4)	**47.5*****
No	40 (14.8)	70.0	54 (7.3)	**20.4**
Missing	6 (2.2)		25 (3.4)	

(Continues)

Table 2 (Contd.)

Characteristics	Cancer decedents: Sample N = 271 N (%)	Cancer decedents: Enrolled in hospice? N = 196 Yes (%)	Noncancer decedents: Sample N = 742 N (%)	Noncancer decedents: Enrolled in hospice? N = 337 Yes (%)
Trouble with pain (%)				
Yes	103 (38.0)	77.7	314 (42.3)	49.0†
No	143 (52.8)	69.2	375 (50.5)	42.4
Missing	25 (9.2)		53 (7.1)	
Dementia (%)				
Yes	20 (7.4)	75.0	191 (25.7)	**59.2*****
No	251 (92.6)	72.1	551 (74.3)	**40.7**
In nursing home 2012[g] (%)				
Yes	12 (4.4)	66.7	165 (22.2)	**56.4****
No	235 (86.7)	73.2	527 (71.0)	**42.1**
Missing	24 (8.9)		50 (6.7)	

Note: Column percentages are presented for the sample. Percentages may not total 100% due to rounding. Statistical tests compare differences between hospice users and nonusers. Statistically significant ($P < .05$) differences in hospice use are shown in bold. Higher ADL help values indicate greater debility.
Abbreviations: ADL, activities of daily living; CES-D, Center for Epidemiological Studies-Depression scale; GED, General Education Diploma; SD, standard deviation.
†$P < .10$, *$P < .05$, **$P < .01$, ***$P < .001$.
[a]Compared with 73.6 years (SD = 9.7) among nonhospice decedents; $P = .006$.
[b]Compared with 79.8 years (SD = 11.0) among nonhospice decedents; $P < .001$.
[c]Compared with 2.5 (SD = 2.1) among nonhospice decedents; $P = .783$.
[d]Compared with 2.7 (SD = 2.2) among nonhospice decedents; $P = .179$.
[e]Compared with .6 (SD = 1.4) among nonhospice decedents; $P = .966$.
[f]Compared with 1.1 (SD = 1.7) among nonhospice decedents; $P < .001$.
[g]Residing in a nursing home includes inpatient hospice settings.

Hospice Use across Age Groups: Cancer vs Noncancer Deaths

Figure 2 illustrates the relationship between age and hospice use by diagnosis for the United States. In general, individuals with advanced age had higher rates of hospice use, although the trend line for cancer deaths exhibits a stepwise increase with plateauing between the 55 and 64 and 65 and 74 age groups, and between the 75 and 84 and 85 or older age groups. Within each age group, individuals who died of cancer consistently had higher hospice utilization rates than noncancer deaths. The disparity in hospice use between cancer and noncancer decedents was greatest within the youngest age groups.

DISCUSSION

Based on national data, our results suggest hospice is highly underutilized, particularly for individuals with a noncancer condition. The crude hospice utilization rate for our entire sample, 46.7%, is comparable with other contemporary estimates of hospice use (46% from 2015 Medicare data).[9] However, we submit that a rate of 52.4%, which excludes patients who would be ineligible for hospice due to sudden death, is a better estimate of hospice utilization in the United States. Hence nearly half (48%) our sample died without enrollment in hospice. Based on 2014 mortality data from the Centers for Disease Control and Prevention,[31] this translates to an estimated 1 million US adults 50 years of age or older who likely qualified for hospice but died without receiving its beneficial services (966,689 [95% CI = 904,355-1,029,023]. Note: Parameter estimates assumed a proportionate distribution of cause of death and hospice utilization among cases with missing data.) Extrapolating from our findings, a large majority of these deaths, 84% (818,120 [95% CI = 763,998-872,242]) are among persons with a noncancer illness. Although cancer decedents have a relatively high rate of hospice utilization, we estimate that 27% of cancer deaths, approximately 148,569 (95% CI = 119,664-177,474) US decedents, were eligible for hospice but did not receive its services. Although all eligible patients may not desire enrollment in hospice, these estimates of underuse in the United States can guide policy, research, and practice to ensure high-quality hospice care is made available to all eligible individuals in a timely manner.

Diagnosis was the strongest predictor of hospice use in our fully adjusted model. We found persons with cancer were more than 5 times more likely to use hospice relative to individuals with a noncancer illness. Furthermore, persons with noncancer diseases were consistently much less likely to use hospice across all age groups under study. In fact, the hospice utilization rate was more than 20% lower for noncancer deaths across all age groups. Several possible explanations exist for the observed discrepancy in hospice utilization based on diagnosis. Providers of healthcare for many common noncancer illnesses may lack awareness about the utility of hospice services, resulting in a lack of recommendations to patients who might desire and benefit from this treatment.[32] Low utilization by noncancer patients may also be the result of poor prognostic accuracy for common noncancer illnesses (eg, heart failure, dementia). Cancer trajectories are more predictable than noncancer diseases trajectories.[22,33] Thus it is easier for

Table 3. Adjusted Odds Ratios Predicting Hospice Utilization

	Full model	Cancer deaths	Noncancer deaths
Predictors	OR (95% CI)	OR (95% CI)	OR (95% CI)
Age, 10-y increments	**1.54*** (1.28-1.83)**	**1.64* (1.09-2.47)**	**1.58*** (1.28-1.94)**
Sex, female vs male	1.03 (.74-1.42)	**2.54* (1.22-5.31)**	.86 (.58-1.27)
Race (Ref. white)			
Nonwhite	.81 (.53-1.22)	1.02 (.48-2.18)	.77 (.46-1.28)
Ethnicity (Ref. non-Hispanic)			
Hispanic	.69 (.39-1.23)	.50 (.14-1.78)	.78 (.40-1.52)
Education (Ref. no degree)			
High school+	1.23 (.86-1.77)	.52 (.224-1.19)	**1.56* (1.02-2.38)**
Marital status (Ref. married)			
Single/divorced/ separated	1.06 (.66-1.69)	.89 (.35-2.26)	1.20 (.68-2.11)
Widowed	1.36 (.94-1.98)	.91 (.39-2.01)	**1.55* (1.00-2.39)**
Wealth (quartiles 1-4)	1.09 (.933-1.28)	1.15 (.80-1.64)	1.07 (.89-1.28)
Region (Ref. South)			
Northeast	**.58* (.37-.92)**	1.28 (.45-3.69)	**.51* (.29-.87)**
Midwest	.99 (.68-1.44)	.74 (.34-1.58)	1.18 (.75-1.83)
West	.93 (.60-1.42)	.95 (.37-2.47)	.94 (.57-1.53)
Advance directive (Ref. no)			
Yes, had advance directive	1.05 (.77-1.43)	.65 (.33-1.26)	1.18 (.82-1.71)
Dementia	**1.52* (1.01-2.28)**	.86 (.23-3.18)	1.51 (.98-2.34)
Trouble with pain	1.21 (.86-1.68)	1.35 (.66-2.75)	1.19 (.82-1.73)
ADL help (0-5)	1.08 (.98-1.20)	.89 (.67-1.18)	**1.13* (1.01-1.26)**
Self-rated health (1-5)	**.79** (.67-.92)**	.80 (.59-1.08)	**.77** (.63-.93)**
Cause of death (Ref. noncancer)			
Cancer	**5.47*** (3.72-8.02)**		

Note: Statistically significant predictors are displayed in bold. All models exclude sudden deaths. Higher ADL help values indicate that the respondent was receiving assistance with more functional domains. For Self-rated health, higher scores represent better reported health. Cases in which participant completed written instructions after hospice enrollment or the timing of completion was unknown were dropped from multivariable models.

Abbreviations: ADL, activity of daily living; CI, confidence interval; OR, odds ratio.

*$P < .05$; **$P < .01$; ***$P < .001$.

physicians to prognosticate when an oncology patient's life expectancy is 6 months or less, a Medicare criterion for enrollment.

Treatments for noncancer chronic illnesses may also be less burdensome than conventional cancer treatments such as surgery, chemotherapy, or radiation. Families may not consider hospice as an option if the patient's quality of life is not diminished by standard treatments. Healthcare providers need to better identify noncancer patients who would qualify for and benefit from hospice. This requires improved prognostication,[19] better patient-provider communication (eg, goals of care conversations),[12,34] engaging attending physicians,[34] greater adoption of open access policies,[35] and improving hospice outreach.[35] Research is also needed on barriers to hospice use among noncancer patient populations and how to overcome them.

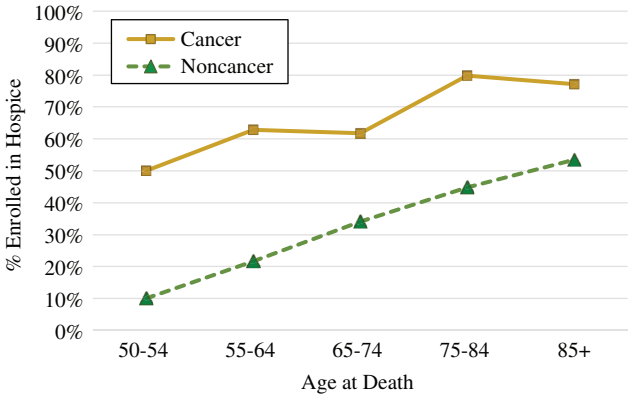

Figure 2. Hospice utilization rate across age groups: cancer vs noncancer deaths. [Color figure can be viewed at wileyonlinelibrary.com]

Our analysis found younger individuals are substantially less likely to receive hospice services. This finding is consistent with previous research because younger patients with advanced cancer tend to pursue more aggressive treatments than older patients.[36-38] This could be due to societal expectations that it is normal for older individuals to die from chronic illness but not younger individuals.[39] This assumption may lead younger patients and their providers to pursue more aggressive treatment rather than opting for hospice when eligible.[40] Further, younger individuals are less likely to have advance directives that often provide written instructions to forgo disease-modifying treatment.[41]

Research has linked hospice use to advance directives with treatment-limiting instructions.[11] However, because hospice providers often facilitate the completion of an advance directive, this association may be biased. In adjusted models we found that age played a key role in predicting hospice utilization, whereas having a completed advance directive was not statistically significant. Because age confounds the association between advance directives and hospice use, future research is needed to examine the direct and indirect effects of age and the presence of advance directives on hospice enrollment.

Female cancer decedents were 2.5 times more likely to enroll in hospice compared with men. Thus sex appears to have a strong independent effect on hospice enrollment. Sex and gender-based differences may converge to create this effect. Men are more likely than women to forgo routine checkups, seek aggressive care, delay needed care, and decline supportive assistance.[38,42,43] Men may also want to be perceived as "fighters."[43] These disparities in utilization may also be the result of differing manifestations of sex-specific cancer

(eg, ovarian vs prostate) that have differing symptoms, treatment options, and mortality rates.[44]

Needing ADL assistance and lower self-rated health were both predictive of hospice use in the full model and among noncancer deaths. These may be observable indicators that doctors use to determine life expectancy and, in turn, hospice eligibility. Needing assistance may also lead providers and families to seek supportive resources including hospice to meet patient needs.[45]

Racial and ethnic disparities in utilization were observed in unadjusted tests but not in adjusted models. Although black and Hispanic individuals are less likely to enroll in hospice,[46] disparities may be explained by other sociodemographic factors, such as economic status, geography, and education. These factors warrant additional study to fully understand whether, and how, minority populations are underserved at the end of life. In both adjusted and unadjusted analyses of noncancer deaths, education and geography were associated with hospice use. Research is needed to address these disparities within noncancer populations. Given past concerns that hospice may be underutilized by individuals without a partner,[25,35,47] it is promising that we found widowed persons were more likely to enroll in hospice relative to married individuals. The death of a partner may give individuals an opportunity to witness the burdens of disease-modifying treatments or the benefits of hospice.

In the fully adjusted model and subsample of noncancer deaths, decedents in the Northeast were less likely to receive hospice compared with those in the South. Others have observed similar geographic variations, hypothesizing that differences are due to service availability, cultural impressions about hospice, or higher rates of hospice use in the South due to its large concentration of older adults, particularly in Florida.[10,48] Availability of other forms of supportive care for seriously ill patients may negatively impact utilization in these regions. Research is needed to examine how the expansion of nonhospice palliative care (both hospital and community based) impacts hospice utilization. Furthermore, if a substantial proportion of patients are receiving end-of-life care from nonhospice palliative care sources, data are needed to determine whether outcomes are comparable with hospice.

Results should be considered with respect to study limitations. The HRS is limited to adults 50 years and older; thus findings cannot be generalized to younger persons. Using prospective data was a strength of the study. However, the 2012 Core Wave was administered, on average, 1 year before death, and factors leading to hospice (eg, pain) may not have been present during the 2012 survey. Posthumous data were provided by proxies, typically a spouse. Although a death is generally a very memorable experience,[49] self-report bias may negatively affect the accuracy of details about the dying experience including cause of death or exact duration of the final illness. However, evidence has demonstrated that, when using clinical adjudication of medical records as the gold standard, proxy-reported information about the decedent's cause of death is more accurate than death certificates.[50] For noncancer decedents, proxies may have reported the start of the final illness was closer to death because of an underrecognition of the presence and severity of chronic conditions. The study also did not include larger contextual factors such as policy issues or health system characteristics.

Although it is possible we are overestimating the underuse of hospice, based on the available evidence, a large majority of nonhospice decedents had indications of a limited life expectancy and preferences consistent with hospice. All nonhospice decedents in our analytic sample (100%) had a duration of dying of at least several days (75% had a duration of dying >1 wk, 52% >1 mo, and 25% >1 y). Additionally, other possible indicators of limited life expectancy, such as functional impairment (66% needed help with two or more ADLs) and nursing home residency (32%), suggest a large portion of nonhospice decedents would have qualified for hospice. Regarding goals of care, among nonhospice decedents who had advance directives, 87% of those directives indicated "no extensive measures" that is consistent with the hospice model of care.

In conclusion, despite tremendous growth of hospice in recent decades, our findings suggest that this effective service remains highly underutilized in the United States, especially among noncancer patients. We estimate that, annually, nearly a million adults who likely qualify for hospice die without receiving its services. The large majority (84%) of these individuals die from a principal illness other than cancer. These findings are particularly disconcerting because access to high-quality end-of-life care, such as hospice, is a critical public health concern.[17,18] Given that prognostic uncertainty is a well-known factor preventing timely hospice referrals, particularly for noncancer diagnoses, we echo earlier calls to modify the Medicare hospice benefit eligibility to include patients based on symptom burden and care needs,[51] those with a life expectancy more than 6 months,[52] or those undergoing concurrent disease-modifying treatment.[53,54] We further advocate for interventions to ensure that every hospice-eligible person is informed about hospice and given an opportunity to discuss whether their goals of care are consistent with what it provides.[6]

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REFERENCES

1. National Hospice and Palliative Care Organization. NHPCO facts and figures 2018 edition (revision July 2, 2019): Hospice care in America. https://39k5cm1a9u1968hg74aj3x51-wpengine.netdna-ssl.com/wp-content/uploads/2019/07/2018_NHPCO_Facts_Figures.pdf. 2019. Accessed July 8, 2019.
2. Kumar P, Wright AA, Hatfield LA, Temel JS, Keating NL. Family perspectives on hospice care experiences of patients with cancer. J Clin Oncol. 2016;35(4):432-439.
3. Cagle JG, Pek J, Clifford M, Guralnik J, Zimmerman S. Correlates of a good death and the impact of hospice involvement: findings from the National Survey of Households Affected by Cancer. Support Care Cancer. 2015;23:809-818.
4. Kelley AS, Deb P, Du Q, Carlson MD, Morrison RS. Hospice enrollment saves money for Medicare and improves care quality across a number of different lengths-of-stay. Health Aff. 2013;32(3):552-561.
5. Wright AA, Keating NL, Ayanian JZ, et al. Family perspectives on aggressive cancer care near the end of life. JAMA. 2016;315(3):284-292.
6. Finestone AJ, Inderwies G. Death and dying in the US: the barriers to the benefits of palliative and hospice care. Clin Interv Aging. 2008;3(3):595-599.
7. Hughes MT, Smith TJ. The growth of palliative care in the United States. Annu Rev Public Health. 2014;35:459-475.
8. Park NS, Jang Y, Ko JE, Chiriboga DA. Factors affecting willingness to use hospice in racially/ethnically diverse older men and women. Am J Hosp Palliat Med. 2016;33(8):770-776.
9. NHPCO. Facts and Figures: Hospice Care in America. National Hospice and Palliative Care Organization: Alexandria, VA; 2018.
10. Virnig BA, Kind S, McBean M, Fisher E. Geographic variation in hospice use prior to death. J Am Geriatr Soc. 2000;48(9):1117-1125.
11. Nicholas LH, Langa KM, Iwashyna TJ, Weir DR. Regional variation in the association between advance directives and end-of-life Medicare expenditures. JAMA. 2011;306(13):1447-1453.
12. Wright AA, Zhang B, Ray A, et al. Associations between end-of-life discussions, patient mental health, medical care near death, and caregiver bereavement adjustment. JAMA. 2008;300(14):1665-1673.
13. Aldridge MD, Canavan M, Cherlin E, Bradley EH. Has hospice use changed? 2000-2010 utilization patterns. Med Care. 2015;53(1):95-101.
14. Wang SY, Aldridge MD, Gross CP, et al. Geographic variation of hospice use patterns at the end of life. J Palliat Med. 2015;18(9):771-780.
15. Zuckerman RB, Stearns SC, Sheingold SH. Hospice use, hospitalization, and Medicare spending at the end of life. J Gerontol B Psychol Sci Soc Sci. 2015;71(3):569-580.
16. Halt Buzas & Powel, LTD. National Hospice and Palliative Care Organization: more than impeccable accounting. https://www.cpas4you.com/wp-content/uploads/2015/04/NHPCO-2015-Version.pdf. Accessed May 12, 2019.
17. Cohen J, Deliens L, eds. A Public Health Perspective on End of Life Care. New York, NY: Oxford University Press; 2012.
18. Morhaim DK, Pollack KM. End-of-life care issues: a personal, economic, public policy, and public health crisis. Am J Public Health. 2013;103(6):e8-e10.
19. Pizzo PA, Walker DM, Bomba PA. Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life. Washington, DC: Institute of Medicine; 2015.
20. Han B, Remsburg RE, McAuley WJ, Keay TJ, Travis SS. National trends in adult hospice use: 1991-1992 to 1999-2000. Health Aff (Millwood). 2006;25(3):792-799.
21. United States General Accounting Office. Report to Congressional Requesters: Medicare: More Beneficiaries Use Hospice, But for Fewer Days of Care. GAO/HEHS-00-182; 2000. https://www.gao.gov/new.items/he00182.pdf
22. Lunney JR, Lynn J, Foley DJ, Lipson S, Guralnik JM. Patterns of functional decline at the end of life. JAMA. 2003;289(18):2387-2392.
23. Cagle JG, Bunting M, Kelemen A, Lee J, Terry D, Harris R. Psychosocial needs and interventions for heart failure patients and families receiving palliative care support: a systematic review. Heart Fail Rev. 2017;22(5):565-580.
24. Kelley AS, Langa KL, Smith AK, et al. Leveraging the Health and Retirement Study to advance palliative care research. J Palliat Med. 2014;17:506-511.
25. Ornstein KA, Aldridge MD, Mair CA, Gorges R, Siu AL, Kelley AS. Spousal characteristics and older adults' hospice use: understanding disparities in end-of-life care. J Palliat Med. 2016;19(5):509-515.
26. Heeringa S, Connor, J. Technical description of the health and retirement study sample design; 1995 https://hrs.isr.umich.edu/sites/default/files/biblio/HRSSAMP.pdf. Accessed August 29, 2019.
27. HRS Survey Design and Methodology. https://hrs.isr.umich.edu/documentation/survey-design. Accessed August 29, 2019.
28. Survey Research Center University of Michigan. Validating mortality ascertainment in the Health and Retirement Study, 2016. https://hrs.isr.umich.edu/sites/default/files/biblio/Weir_mortality_ascertainment.pdf. November 3, 2016. Accessed November 26, 2018.
29. Health and Retirement Study. Health and Retirement Study Tracker 2014. 2017. http://hrsonline.isr.umich.edu/modules/meta/tracker/desc/trk2014.pdf. July 2017. Accessed November 26, 2018.
30. Pantoja P, Bugliari D, Campbell N, et al. RAND HRS Income and Wealth Imputation, Version P. Santa Monica, CA: Rand Center for the Study of Aging; 2016.
31. Centers for Disease Control and Prevention. Deaths: Final Data for 2014. 2016. https://www.cdc.gov/nchs/data/nvsr/nvsr65/nvsr65_04.pdf. June 30, 2016. Accessed November 26, 2018.
32. Kavallieratos D, Mitchell EM, Carey TS, et al. "Not the 'grim reaper service'": an assessment of provider knowledge, attitudes, and perceptions regarding palliative care referral barriers in heart failure. J Am Heart Assoc. 2014;3(1):e000544.
33. Teno JM, Weitzen S, Fennell ML, Mor V. Dying trajectory in the last year of life: does cancer trajectory fit other diseases? J Palliat Med. 2001;4(4):457-464.
34. Kirolos I, Tamariz L, Schultz EA, Diaz Y, Wood BA, Palacio A. Interventions to improve hospice and palliative care referral: a systematic review. J Palliat Med. 2014;17(8):957-964.
35. Aldridge Carlson MD, Barry CL, Cherlin EJ, McCorkle R, Bradley EH. Hospices' enrollment policies may contribute to underuse of hospice care in the United States. Health Aff. 2012;31(12):2690-2698.
36. Chen RC, Falchook AD, Tian F, et al. Aggressive care at the end-of-life for younger patients with cancer: impact of ASCO's Choosing Wisely campaign. J Clin Oncol. 2016;34(18):LBA10033.
37. Lee J, Cagle JG. Factors associated with opinions about hospice among older adults: race, familiarity with hospice, and attitudes matter. J Palliat Care. 2017;32:101-107.
38. Miesfeldt S, Murray K, Lucas L, Chang CH, Goodman D, Morden NE. Association of age, gender, and race with intensity of end-of-life care for Medicare beneficiaries with cancer. J Palliative Med. 2012;15(5):548-554.
39. World Health Organization. Preventing Chronic Diseases: A Vital Investment, 2005. http://www.who.int/chp/chronic_disease_report/full_report.pdf?ua=1. 2005. Accessed May 12, 2019.
40. Head BA, LaJoie S, Augustine-Smith L, et al. Palliative care case management: increasing access to community-based palliative care for Medicaid recipients. Prof Case Manag. 2010;15(4):206-217.
41. Mack JW, Weeks JC, Wright AA, Block SD, Prigerson HG. End-of-life discussions, goal attainment, and distress at the end of life: predictors and outcomes of receipt of care consistent with preferences. J Clin Oncol. 2010;28(7):1203-1208.
42. Vaidya V, Partha G, Karmakar M. Gender differences in utilization of preventive care services in the United States. J Womens Health (Larchmt). 2012;21(2):140-145.
43. Wenger LM, Oliffe JL, Bottorff JL. Psychosocial oncology supports for men: a scoping review and recommendations. Am J Mens Health. 2016;10(1):39-58.
44. American Cancer Society. Cancer Facts & Figures 2017. https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2017/cancer-facts-and-figures-2017.pdf. 2017. Accessed December 7, 2018.
45. Gill TM, Han L, Leo-Summers L, Gahbauer EA, Allore HG. Distressing symptoms, disability, and hospice services at the end of life: prospective cohort study. J Am Geriatr Soc. 2018;66(1):41-47.
46. Rizzuto J, Aldridge MD. Racial disparities in hospice outcomes: a race or hospice-level effect? J Am Geriatr Soc. 2018;66(2):407-413.
47. Kotwal AA, Abdoler E, Diaz-Ramirez LG, et al. Til death do us part: end-of-life experiences of married couples in a nationally representative survey. J Am Geriatr Soc. 2018;66(12):2360-2366.
48. Connor SR, Elwert F, Spence C, Christakis NA. Geographic variation in hospice use in the United States in 2002. J Pain Symptom Manage. 2007;34(3):277-285.
49. Higginson I, Priest P, McCarthy M. Are bereaved family members a valid proxy for a patient's assessment of dying? Soc Sci Med. 1994;38(4):553-557.
50. Halanych JH, Shuaib F, Parmar G, et al. Agreement on cause of death between proxies, death certificates, and clinician adjudicators in the Reasons for Geographic and Racial Differences in Stroke (REGARDS) study. Am J Epidemiol. 2011;173(11):1319-1326.
51. Groninger H. A gravely ill patient faces the grim results of outliving her eligibility for hospice benefits. Health Aff (Millwood). 2012;31(2):452-455.
52. Melnick A. Statement of the National Coalition for Hospice and Palliative Care to the Institute of Medicine (IOM) in Support of recommendations in Dying in

America: Improving Quality and Honoring Preferences Near the End of Life. https://www.nationalcoalitionhpc.org/wp-content/uploads/2016/07/Coalition-IOM-Statement-Final-3-13-15.pdf. 2015. Accessed December 7, 2018.
53. Gawande A. Quantity and quality of life: duties of care in life-limiting illness. JAMA. 2016;315(3):267-269.
54. Centers for Medicare & Medicaid Services. Medicare Care Choices Model. https://innovation.cms.gov/initiatives/Medicare-Care-Choices/. 2017. Accessed December 7, 2018.

SUPPORTING INFORMATION

Additional Supporting Information may be found in the online version of this article.

Supplementary Table S1: Comparison of sudden vs non-sudden deaths among nonhospice users (N = 639).

NHPCO *Original Article*

Medicare Cost in Matched Hospice and Non-Hospice Cohorts

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Abstract
Hospice care is perceived as enhancing life quality for patients with advanced, incurable illness, but cost comparisons to non-hospice patients are difficult to make. The very large Medicare expenditures for care given during the end of life, combined with the pressure on Medicare spending, make this information important. We sought to identify cost differences between patients who do and do not elect to receive Medicare-paid hospice benefits. We introduce an innovative prospective/retrospective case-control method that we used to study 8,700 patients from a sample of 5% of the entire Medicare beneficiary population for 1999–2000 associated with 16 narrowly defined indicative markers. For the majority of cohorts, mean and median Medicare costs were lower for patients enrolled in hospice care. The lower costs were not associated with shorter duration until death. For important terminal medical conditions, including non-cancers, costs are lower for patients receiving hospice care. The lower cost is not associated with shorter time until death, and appears to be associated with longer mean time until death. J Pain Symptom Manage 2004;28:200–210. *© 2004 U.S. Cancer Pain Relief Committee. Published by Elsevier Inc. All rights reserved.*

Key Words
Medicare, costs, hospice, duration until death

Introduction

The Medicare Hospice Benefit, enacted in 1982, was intended to provide compassionate and cost-effective care for Medicare beneficiaries with incurable advanced illnesses. Medicare's very large expenditures on dying beneficiaries,[1] combined with federal funding pressures, have given new prominence to end-of-life care. Since Medicare began its hospice benefit, it has been thought to be unethical to conduct randomized hospice/non-hospice studies, as a right to hospice care is presumed. Therefore, investigations have been limited to studies that can very closely match populations and overcome selection bias.

The Medicare hospice benefit is potentially available to all Medicare beneficiaries after a physician certifies that the beneficiary is expected to live fewer than 180 days. Hospice services are provided by the patient's choice of the

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Medicare-certified hospice agencies available in the patient's locale. Under the program, the vast majority of services are provided in the patient's place of residence. Approximately 95% of the days of hospice care delivered in the US are at the routine home care level.[2] The hospice provides all needed services, including prescription drugs and palliative care and receives a flat payment amount for each day the patient is enrolled in hospice. The amount varies somewhat by locale. The patient can elect to stop receiving hospice care and return to traditional Medicare coverage at any time.

The cost analysis of patients enrolled in the Medicare Hospice Benefit has been debated since the benefit began in 1982. Changes in hospice care such as the growth of palliative treatments (e.g., chemotherapy, radiation and pain management therapies) and increased enrollment of non-cancer beneficiaries (e.g., end-stage chronic obstructive pulmonary disease [COPD], congestive heart failure [CHF], Alzheimer's disease) have created a new context for the debate. Early studies of hospice care[3,4] implied Medicare savings with increased home care and reduced hospitalization, futile treatment and diagnostics. These studies were criticized for lack of rigorous matching criteria and the effects of selection bias.[5] More recent studies find mixed results. Hospice use is associated with decreased cost in oncology populations but may not be for some other diagnoses.[6–8]

The costs for patients enrolled in the Medicare Hospice Benefit vary depending on where services are rendered (home, nursing home or hospital) and duration of hospice enrollment, among other factors. Substituting hospice for conventional care is more likely to show hospice most favorably if patients are on hospice just long enough to avoid unnecessary services. Hospice services provided to patients just before death can be an additional expense, as can hospice care provided for many months or years. A period of at least 2–3 months of hospice care may be optimal from both a cost and clinical standpoint.[9,10]

In addition to cost analysis, the effect of hospice care on length of life has been raised in connection with the quality of care. Anecdotal evidence suggests that some patients live longer after receiving hospice care.[11–14] Patients with chronic organ failure may benefit from attention to psychosocial concerns and personal care from hospice programs. Terminally ill oncology patients who forego aggressive cure-directed therapies and who receive greater psychosocial support may have greater survival.[15] No definitive survival data has been previously presented to support these findings and reports of increased survival of breast cancer patients in support groups have been questioned.[16]

Effectively matching populations for cost and longevity comparisons requires identifying a similar point in patients' terminal decline.[17] Attempts to develop accurate tools to predict the timing of death have generally been unsuccessful.[18] SUPPORT investigators used a computer-generated algorithm to model the probability of death.[19] This method found that estimating probabilities of death was not clinically useful. The National Hospice and Palliative Care Organization (NHPCO) published expert opinion guidelines for determining 6-month prognosis for selected non-cancer terminal illnesses.[20] These guidelines were modified by Centers for Medicare and Medicaid Services (CMS) fiscal intermediaries for use as local medical review policies that define payment criteria. However, the NHPCO guidelines and subsequent payment policies have also been found to have weak predictive validity.[21] "Look-back studies," which compare costs for hospice and non-hospice patients for a set period before death, have been criticized because of inadequate control for potential selection bias and failure to account for survival differences. The use of algorithms applied to administrative data to predict future costs has likewise had limited success[22] and we have avoided such approaches. For these reasons, we conceived the methodology of the present study to examine cost for subsets of patients that most clinicians would recognize as suitable for hospice care.

Methods

In this study, we used established actuarial methods and administrative data to measure both costs and time until death starting from dates narrowly defined by claims data. We established cohorts of patients with diagnoses and, in most cases, paired treatments that indicated advanced illness. For each patient, unique dates for specific clinical events were used to measure the beginning point for time until death and cost through death.

The goal of our methodology was to identify patients who might, within days or months, reasonably choose hospice care. For each disease cohort, we sought to identify patients and, for each patient, a similar point in time from which we could begin to measure costs and length of life. Such a methodology avoids the biases of an approach of tabulating costs backwards from the date of death for a specified preceding time period, where the treatments received could bias the time until survival.

The use of administrative data allowed us to identify relatively large numbers of patients, even for very narrowly defined cohorts. The Medicare 5% sample database contains demographic and medical claim details for almost 2 million Medicare beneficiaries, of which about 100,000 die each year. While these data contain details of dates of service, diagnostic (ICD-9) and procedural (CPT or HCPCS) information, the data do not contain typical clinical information (such as laboratory values or stage of disease).

Physician advice is often an important element in a patient's decision to join a hospice, and we assembled a group of physicians active in hospice care who worked with medical coding and data experts. The group was charged with identifying patient characteristics, recognizable through the Medicare data that would strongly suggest the patient would soon be eligible for hospice care. While the majority of patients who choose the Medicare hospice benefit are dying of cancer, we did not limit the study to cancer patients. The advisory group ultimately developed subsets of 16 diagnoses (Table 1) where some combination of medical claims would define an unambiguous starting point for tabulating cost and time until death and where the patient could soon face a decision about enrolling in the Medicare Hospice Benefit. Within each diagnosis, we selected *an indicative marker* in the end-stage of these incurable, advanced diseases on the basis of specific diagnosis, treatments and response to treatments. These *indicative markers* represented unambiguous (from a data standpoint) points in the end stage of these 16 diagnoses. The criteria for creating indicative markers were:

- the defining event had to appear as medical claims. In practice, this generally meant some combination of a hospital admission or physician intervention, and
- the defining event would generally occur near the end of life but before an individual would have made a choice to enroll in the Medicare hospice benefit.

For most diagnoses, a minority of patients was selected for inclusion in the analysis, because most did not receive the pre-defined medical interventions. Within a given diagnostic cohort, we compared cost and time until death for patients choosing or not choosing hospice care—starting with the date of the indicative marker. We restricted the cohorts to patients who died within the calendar year of the indicative marker or the next calendar year.

The diagnostic definitions both described relatively narrow cohorts and allowed identification of a unique date for each individual. Our indicative marker methodology produced cohorts that, for most diseases, represent small subsets of patients who died of the disease. We believe that the complicated set of circumstances we used to define the cohorts provides a very significant degree of homogeneity within the cohorts. This complexity for identifying patients in effect lessens the need for risk adjustment, which is fortunate because the standard risk adjustment methodologies are not designed for use with dying patients.

Indicative Markers

We used the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), the Current Procedural Terminology, Fourth Edition (CPT), and the Health Care Financing Administration Common Procedure Coding System (HCPCS) to create "indicative markers" for 17 diagnoses by an expert panel of oncologists, hospice medical directors, actuaries and Medicare insurance coding specialists. The indicative marker consisted of either an ICD-9-CM code alone or an ICD-9-CM code combined with CPT and/or HCPCS codes.

The panel was instructed to identify the circumstances, which could be identified with the available Medicare claims data, under which a patient could shortly thereafter be advised to consider obtaining hospice care. The majority of suggested circumstances proved impractical because they depended upon data that were

Table 1
Definitions of Indicative Conditions and Markers

Condition	Administrative Claims Data Indicative Marker for Study Inclusion
Malignant neoplasm of esophagus	Beneficiaries with ICD-9-CM (ICD-9) for cancer of the esophagus except those with CPT for radical esophagectomy with interpositioning. The exception was made because that procedure may be performed with the expectation of cure or long-term survival
Malignant neoplasm of stomach	Beneficiaries with ICD-9 for stomach cancer except those with CPT for partial or subtotal gastrectomy and have claims for chemotherapy (chemo) starting within 1st quarter of surgery
Malignant neoplasm of colon	Beneficiaries with ICD-9 for colon cancer and have claims for chemo and either: – no previous colon resection – colon resection >1 quarter before start of chemotherapy
Malignant neoplasm of rectum	Beneficiaries with ICD-9 for cancer of the rectum and have claims for chemotherapy and/or radiation therapy (RT) and either: – no previous rectal resection – rectal resection >1 quarter prior to chemo and/or RT
Malignant neoplasm of liver and intra-hepatic bile ducts	Beneficiaries with ICD-9 for liver and intra-hepatic bile duct cancer
Malignant neoplasm of gallbladder and extra-hepatic bile ducts	Beneficiaries with ICD-9 for gallbladder and extra-hepatic bile duct cancer
Malignant neoplasm of pancreas	Beneficiaries with ICD-9 for pancreatic cancer except cases with islet cell cancer
Malignant neoplasm of trachea, bronchus and lung	Beneficiaries with ICD-9 for lung cancer and have claims for chemotherapy, which indicate a switch to another combination of chemotherapy drugs within 1–2 quarters of the initial chemotherapy
Malignant neoplasm of female breast	Beneficiaries with ICD-9 for breast cancer and have claims for chemotherapy, which indicate a switch to another combination of chemotherapy drugs within 1–2 quarters of the initial chemotherapy
Malignant neoplasm of ovary and other uterine adnexa	Beneficiaries with ICD-9 for ovarian and uterine cancer and claims indicate treatment course (at minimum) of primary abdominal surgery followed by chemotherapy
Malignant neoplasm of prostate	Beneficiaries with ICD-9 for prostate cancer and HCPCs J codes for all chemotherapies except leuprolide (includes cases receiving strontium 89)
Malignant neoplasm of brain	Beneficiaries with ICD-9 for brain cancer and claims indicate a diagnostic/treatment sequence of brain biopsy or debulking or craniotomy, followed by RT
Congestive heart failure (CHF)	Beneficiaries with ICD-9 for CHF and have claims indicating 1 or >hospitalizations involving: – invasive monitoring – intubation and ventilatory management Exclusions: cases with CPT for CABG within 1 quarter prior to hospitalization and cases in which hospitalization for invasive monitoring or intubation indicate primary diagnosis of acute MI
Chronic obstructive pulmonary disease (COPD)	Beneficiaries with ICD-9 for COPD and have claims indicating 1 or more hospitalizations requiring intubation and ventilatory management
Alzheimer's disease	Beneficiaries claims indicating 1 or more admissions with primary diagnosis of sepsis and/or aspiration pneumonia along with a secondary diagnosis of Alzheimer's disease
Stroke	Beneficiaries with 1 or more admissions with primary diagnosis of sepsis and/or aspiration pneumonia along with a secondary diagnosis of stroke

not available in the Medicare 5% sample. For example, any cohort definitions that depended upon laboratory values, stage of a disease or other clinical measure were rejected.

We selected these markers based on the practicality of obtaining the required information from administrative data and perceived relevance to hospice (judged to have a life expectancy of less than one year but not facing imminent death). We established the indicative markers prior to conducting the data analysis. Data extraction for one of the 17 diagnoses resulted in fewer than 20 individuals; therefore, we report the results for 16 out of the 17 diagnoses.

For cancer of the liver, gallbladder and pancreas, the first hospital claim or the first of at least two physician outpatient claims, appearing with ICD-9-CM codes for these "indicative diagnoses," was used as the starting point to tabulate costs and longevity. Because the prognosis is typically poor for these conditions, the first appearance of the diagnosis is an effective starting point for which costs and longevity could be tabulated. For cancer of the esophagus and stomach, we excluded beneficiaries who

appeared to be receiving curative therapy as defined by particular surgical interventions, because certain types of esophagus and stomach cancer are considered curable through surgery.

For the remainder of the diagnoses, an "indicative event" that signaled the terminal phase of an incurable, advanced disease was chosen as the marker. The indicative event consisted of specific treatments (chemotherapy, radiation therapy and surgery as detailed in Table 1) or a hospitalization with specific interventions or diagnoses. The treatments identified for the cancer diagnoses suggested either failure of curative therapy or evidence for palliative therapy. The hospital treatments used to define indicative events for the non-cancer diagnoses suggested a serious decline in health status.

The vast majority of dying patients would not meet the criteria of the indicative diagnoses – whether or not they elected to receive the Medicare Hospice Benefit. The challenge of using the available data to identify a patient at the cusp of being faced with a decision about choosing hospice care severely limited the possible number of cohorts. Hospice physicians, including those who advised us, do not identify patients through medical claims coding, and rarely if ever treat patients before they decide to obtain hospice benefits. Because of these constraints, the authors feel that there was no deliberate bias in our methodology.

Data Source

Our analysis used Medicare health insurance claims and enrollment data from the 5% Sample Beneficiary Standard Analytic Files[23] for the years 1998, 1999, and 2000. The 5% sample, which is created by and available from the Centers for Medicare and Medicaid Services (CMS), was created from the 100% Medicare Standard Analytical Files. The 5% sample is created by CMS as a statistically representative, longitudinal dataset.

The 5% Medicare Sample contains claims for about two million enrollees. Members have unique identifiers that allow patient tracking from year to year. The claims sample comprises seven distinct databases, each containing claims from a particular provider type: Physician Supplier Part B, Outpatient Hospital, Inpatient Hospital, Home Health Agency (HHA), Hospice, Skilled Nursing Facility (SNF), and Durable Medical Equipment (DME). We extracted data from all patients who met our criteria.

Sample Selection

Our data selection criteria were chosen primarily to avoid biasing time until death or cost according to whether an individual chose hospice. Consequently, we caution the reader that the costs and time until death time shown should not be used as a guide for individual patient time until death or cost.

In our algorithm, assignment into one of the 16 diagnostic categories required two physician claims or one inpatient hospital claim with the relevant ICD-9-CM code. We used a disease hierarchy to set the category for a beneficiary who could fall into more than one category. Before applying narrowing criteria, these diagnoses accounted for approximately 55% of all Medicare beneficiaries' deaths in the 5% Medicare sample. Beneficiaries were designated as hospice users if they had one or more hospice claims.

The final sample size did not change significantly from the base sample for beneficiaries diagnosed with esophageal, stomach, liver, gallbladder and pancreatic cancer, as the date of the first appearance of the diagnostic ICD-9-CM code itself was used as the marker for each affected individual. For other diagnoses, the final sample was significantly smaller than the base sample, as specific treatments, "indicative events," were required. The percentage of individuals utilizing hospice services was similar for patients with or without the indicative event.

Because cost comparison analysis was the primary focus of this study, and because the last few days of life can be very expensive, especially if the patient is hospitalized, we included only patients whose death could be observed in the data. Costs (Medicare payments) were tabulated starting with the time of the "indicative diagnosis" or "indicative event" to the time of death. For years prior to 2000, Medicare Part B claims indicate a date of service, which was used as the marker date for cost and longevity comparison. Medicare Part A claims show only the quarter and year of service; Part A claims were attributed to the patient if the claim fell in the quarter of the indicative event or later. Medicare payments are the amounts that

Medicare pays—net of beneficiary coinsurance and deductibles.

We removed certain patients and their claims from the analysis as required by inherent data limitations or in order to avoid bias in favor of patients who chose or did not choose hospice care. In particular, we removed patients who incurred less than $4,000 in claims (approximating the low end cost of one Medicare-paid hospitalization) or greater than $115,000 in claims from the indicative event through death. This reduced the population by about 5% and total cost by about 20%. The removal of these patients reduces the possibility that the results reflect the influence of very large or very small claims. We also removed patients who died within 15 days after the indicative event. This removes from the analysis people who die very quickly, and, as a result, may incur very low costs, and may not have a chance to consider entering hospice. For congestive heart failure, COPD and stroke, the short-stay trim removed a significantly higher portion of patients. This is not surprising, because the indicative marker for each of these cohorts is an acute hospital stay with significant intervention, and those patients who die within 15 days of admission might not have the opportunity to consider hospice care. We note that hospice data show many patients enter hospice with only a few days to live, and hospice executives complain about the quality and cost impact this has.[24] We note that hospice practitioners inform us that many patients do choose hospice care under such circumstances.

We followed individuals identified in 1999 with indicative events through the year 2000. For esophageal, stomach, liver, gallbladder and pancreatic cancers, where we used the first appearance of the ICD-9-CM code in the data as the indicative marker, we examined 1998 data for earlier appearances of these diagnoses among the claims. For the other diseases, we identified each individual's first indicative event in 1999. Individuals with a first indicative event in 2000 were eliminated from our study, to avoid biasing the sample toward short survivors. It is possible, but for most conditions clinically unlikely, that some individuals may have had a first indicative event in 1998 and a second in 1999. We did not examine the data from 1998 to identify any such patients. As a result of this approach, we considered only patients who were age 66 and older if the indicative event occurred in 1999.

We eliminated any individuals who were not observed to die. While the data from such individuals would be useful for a survival study, costs are generally believed to be higher toward the end of life. Because of our focus on cost, we wanted to capture only people with observed deaths. As mentioned above, because the primary purpose of this study was to evaluate cost, we analyzed only patients who died. This limits the usefulness of the data for survival analysis purposes. Nonetheless, we report the mean and median time until death for the cohorts.

Statistical Analysis

We used the *t*-test to evaluate differences in means, which is the goal of this study, to measure the Type I comparison wise error rate. We did not attempt to develop predictive parameters for time until death or cost. We tested for the significance of the following variables: age, sex, Medicaid-eligibility, and use or nonuse of hospice cost. The significance of these variables was tested through a generalized linear model. The *P* values shown in Table 2 are based on unadjusted means tests using cost as the only independent variable. The significance of other variables was determined using multiple regression on hospice use, age, sex and dual eligibility for Medicare and Medicaid. Table 3 shows that the hospice group is slightly more female and slightly younger than the nonhospice group.

We did not perform any analysis to attempt to identify the impact of co-morbidities on cost or time until death. The patient cohorts were very narrowly chosen from approximately 200,000 Medicare deaths, and the hierarchy we used in assigning indicative markers does provide some control over co-morbidities. More fundamentally, the predictive models in commercial use have weak predictive power and all were designed to forecast future costs for general populations, not those with short-term terminal illness.[22] Similarly, the Charlson approach also seems inappropriate given the terminally ill characteristic of the population and the narrow population definitions.[25] The geographic distribution by state of the hospice and non-hospice groups was very similar, with a 93% correlation coefficient, 94% for dual-eligibles and 92% for non-dual-eligibles. Of the cancer cohorts, 53%

Table 2
Medicare Cost Per Patient for Studied Diseases

Disease Cohort	Choice[a]/Patient Count	Mean Cost/SD per Patient (US$)	Median Cost per Patient (US$)	Mean Time Until Death in Days/SD	Median Time Until Death in Days
Alzheimer's disease	H/29	29,828/16,986	29,309	221/177	166
	NH/122	30,925/21,268	24,034	175/155	117
Brain cancer	H/284	35,768/20,743	32,706	203/146	170
	NH/166	38,300/24,729	31,260	159/139	108
Breast cancer	H/144	37,968/22,426	34,428	353/172	362
	NH/111	41,269/24,641	38,349	306/184	293
Congestive heart failure[b]	H/174	46,793/24,469	41,136	185/163	136
	NH/1141	53,528/26,705	50,015	135/145	65
Colon cancer	H/327	31,819/20,727	41,136	310/168	292
	NH/199	33,979/22,283	50,015	266/182	226
Chronic obstructive pulmonary disease	H/33	43,744/22,830	37,495	136/143	96
	NH/292	51,831/26,991	45,458	132/151	57
Esophageal cancer	H/232	33,489/22,749	28,289	252/168	210
	NH/300	36,133/22,833	31,816	209/173	149
Gallbladder cancer	H/70	30,454/17,895	25,725	211/163	159
	NH/58	33,026/22,676	27,596	186/163	139
Liver cancer[b]	H/496	27,364/19,544	22,909	183/158	133
	NH/388	30,402/23,331	21,974	170/167	100
Ovarian cancer	H/24	45,296/22,272	35,946	296/141	303
	NH/17	54,231/30,387	43,197	248/133	246
Pancreatic cancer[b]	H/663	29,621/20,786	23,617	198/160	151
	NH/459	34,784/24,232	27,834	183/164	128
Prostate cancer	H/270	30,573/19,761	25,763	404/180	392
	NH/459	30,382/21,257	25,182	366/177	370
Rectal cancer	H/191	34,478/21,698	31,168	289/174	263
	NH/193	37,917/25,152	32,283	233/179	200
Stomach cancer	H/252	32,004/22,687	25,314	228/175	190
	NH/264	35,658/25,151	29,951	194/171	133
Stroke[b]	H/22	46,910/30,767	40,900	177/127	156
	NH/125	34,579/24,148	28,230	165/168	101
Trachea, bronchial & lung cancer	H/648	36,209/20,136	32,886	262/157	229
	NH/547	37,845/20,808	34,855	225/152	201

[a]H = patients choosing hospice; NH = patients not choosing hospice.
[b]$P < 0.05$ for mean cost differences.

of the patients were in the hospice cohorts, compared to 60% of all Medicare decedents in 2000, while for cancer plus non-cancer cohorts, 44% of patients were in the hospice cohorts compared to 23% for all Medicare decedents in 2000.[24]

SAS™ (SAS Institute Inc, Cary, NC) and Excel™ were used for all analyses. We conducted statistical tests on each disease separately and did not attempt cross-disease analysis to determine whether hospice use, age, sex or dual eligible status had significant impacts.

Results

For the diseases studied, we compared Medicare patients enrolled in the Medicare hospice benefit with those not enrolled in the Medicare hospice benefit for Medicare cost. Table 2

Table 3
Age–Sex Demographics of Cohorts

Age	Female	Male	Total
Patients Receiving Hospice Care			
64–69	412	476	888
70–74	462	578	1,040
75–79	449	481	930
80–84	299	297	596
>85	221	184	405
Total	1,843	2,016	3,859
Patients Not Receiving Hospice Care			
64–69	437	532	969
70–74	497	643	1,140
75–79	464	648	1,112
80–84	400	458	858
>85	401	361	762
Total	2,199	2,642	4,841
Grand Total	4,042	4,658	8,700

shows summaries of these measures for the narrowly defined patient populations shown in Table 1.

For all diseases except prostate cancer and stroke, mean cost was lower for patients who chose hospice but was significant ($P < 0.05$) only for CHF, liver cancer and pancreatic cancer. Patients choosing hospice had higher cost at this significance for stroke (Table 2). Median costs generally followed the same pattern. Mean and median costs for untrimmed data followed the same pattern as for trimmed data with few exceptions.

Because cost was the focus of this study, we included only patients who died during the study period. Consequently, the data are of limited value for a survival study. Nevertheless, the pattern of lower costs for patients who choose hospice does not appear to be associated with shorter survival. Patients who choose hospice showed longer mean and median time until death than their matched non-hospice cohorts—by days to months for all of the diagnoses studied.

We caution the reader that the time until death times shown in Table 2 are means for the cohorts studied. Because the criteria use administrative, not clinical data, clinicians may find it hard to know whether an individual patient meets the detailed criteria we used to select patients, and the results should not be used to predict time until death times for individual patients.

A multiple regression was used to evaluate the effect of the available variables (i.e., hospice/non-hospice, age, sex, and Medicaid dual eligibility status) on time until death, cost, and cost/day by disease category. For each condition, we show whether hospice status, age, sex or Medicaid dual eligibility were significant for cost. Table 3 presents age and sex demographics of the hospice and non-hospice cohorts. Overall, the hospice group had slightly more females than the non-hospice group (48% vs. 45%) and patients in the hospice group were slightly younger than patients in the non-hospice group (74% and 67% of patients were ≤79 years of age, respectively).

Discussion

This study provides evidence that, for certain well-defined terminally ill populations, costs are lower for patients who choose hospice care than for those who do not. Furthermore, for certain well-defined terminally ill populations, among the patients who died, patients who choose hospice care live longer on average than similar patients who do not choose hospice care. This pattern persisted across most of the disease states studied. Hospice care is widely used by patients with cancer, which was reflected in the high proportion of patients choosing hospice care in our cancer diagnoses groups. Notable among the findings, however, is that the CHF-related group, where relatively few patients receive hospice care, shows lower cost and higher time until death for the patients who choose hospice care.

Although the data suggest some longevity benefit to hospice, the causality for reduced cost seems stronger than for greater time until death, because patients who happen to live longer after their indicative event may have greater opportunity to choose hospice. Alternatively, these patients will also have greater opportunity to enter a track of aggressive, non-hospice treatment. While the study's design does not provide comprehensive results for longevity, the hypothesis that longer surviving patients may more likely choose hospice seems counterintuitive to the finding of lower costs for patients choosing hospice. This is an important area for further research.

A critical question is whether the selection criteria—either for the defined cohorts or for the individuals who choose hospice care—biased the results. The administrative data used

do not capture significant clinical measures or psycho-socio-economic data such as education or income. Hospice enrollment was not randomly assigned, and the individuals who choose hospice may have tended to avoid expensive care even if they had no access to the hospice benefit. One approach to identifying such bias is to assume that high spending (or low spending) before hospice enrollment is a predictor of an individual's probability of obtaining (or avoiding) aggressive medical treatment. However, certain of the indicative diagnosis definitions (for example, breast and ovarian cancers) required a history of obtaining aggressive medical treatment, so such look-back methods may have limited value for these cohorts. In addition, the attempt to use pre-hospice treatment to adjust for "propensity to treat" bias would discount the possibility that changes in their medical condition could cause some people to dramatically change their choices about the desired kind of medical care.

Although the Medicare 5% sample contains information about race, we did not include that factor in our analysis. African-American patients have been shown to be less likely to choose hospice services than non-minority patients.[26] Racial disparities deserve further investigation, although the authors do not have a strong intuitive sense of the cost bias that might have been introduced by failure to consider race.

We believe that our "indicative event" definitions identified individuals with similar health status, although the more complicated indicative events, which require a combination of circumstances, probably produced more homogenous cohorts than the simpler indicative events (for example, the first appearance of a pancreatic cancer diagnosis). For most indicative events, the individuals were well enough to have passed medical clearance to receive aggressive treatment. They were all sick enough to die within two years of the event. The limited success of predictive modeling[21] argues against using existing models (or simpler look-back approaches) to create matched cohorts and we did not attempt to do so. The analysis does exclude all individuals who die within 15 days of the indicative event, so that the non-hospice group would not include individuals who die immediately after the intervention, so have no opportunity to choose hospice.

Our trimming rules had almost no impact on which cohort had higher mean or median costs and no impact on which cohort had longer time until death. One of the few exceptions is cost for CHF, where a large number of non-hospice patients died within a few days after the indicative hospitalization event. For CHF, including these very short times until death patients would shift mean and median costs for the non-hospice cohort to be lower than for the hospice cohort. This exception does not weaken our view about the relative costs of hospice patients, as hospice would have had little opportunity to reduce costs for these patients.

The study does raise temporal bias issues. Patients who choose hospice care may incur lower expenses, with or without hospice care, because they may desire to avoid aggressive treatment. This may explain some of the cost findings for cancer of the esophagus, stomach, liver, gallbladder and pancreas, where the indicative event was defined by the appearance of a diagnosis, rather than a more aggressive medical intervention. However, for the other conditions studied, the indicative event screen required that all patients in both the hospice and non-hospice cohorts have a history of choosing aggressive treatment—and access to such aggressive treatment. For example, a diagnosis of brain cancer followed by a surgical intervention and radiation treatment does not suggest a patient who avoids aggressive treatment or one who has little access to aggressive care.

The question "How is it possible that hospice can prolong life?" is critically important to answer. Hospice care promotes itself as providing compassionate care, emphasizing pain management, comfort and quality of life. These kinds of support may tend to prolong life, although the evidence base for much of what hospice achieves has yet to be assembled. Terminally ill patients who choose hospice avoid the hazards of aggressive medical treatment, which may contribute to the longer time until death observed in these patients. We suggest, however, that the longer time until death may be due to significantly longer time until death by a relatively small number of patients, rather than short increases by a large number of patients. This hypothesis may find support through further data analysis or clinical research to identify whether some hospice patients survive

one or more crisis periods better than do non-hospice patients. We hope this study may prompt additional investigation into the appropriate length of hospice enrollment needed to achieve the goals of end-of-life care. The appropriate length continues to be debated, especially as the mean length of hospice enrollment has declined from a high of 74 days in 1992 to 59 days in 1998,[27] although the decline appears to have stopped in more recent years.[28]

Another important question to answer, which our study did not address, is "Do the differences in time until death matter to patients and families?" In our study sample, the average time until death from the indicative event ranged from about 6 months to about 1 year. The hospice patients had an increase in time until death compared with the non-hospice patients that ranged from days to months. This increase in time until death may be particularly important to family members if pain management, comfort and quality of life can be maintained.

Finally, the question "Do these results apply to other kinds of patients?" must be asked. In performing this study, we chose very narrowly defined patient cohorts and removed patients with short or long survival periods. These cohorts were unusual in that administrative data, by itself, was used to identify a precise point in the patient's treatment and course of disease. The diagnoses from which we chose patients account for a majority of Medicare deaths, but the criteria used to choose cohorts generally produce many fewer deaths. Further research should be undertaken to determine whether other kinds of patients follow disease courses similar to those reported in this study. Future research in this area will elucidate the applicability of these findings.

Although the use of administrative data presents some limitations, it also has strengths. Well-known weaknesses include incomplete or inaccurate coding by healthcare providers during the course of billing. However, we believe these weaknesses do not bias the results of our study. One important strength of using the Medicare 5% sample is that this administrative data is taken from actual Medicare payments for actual patients rather than modeled patients or expenses. These data were produced by the Medicare payment adjudication system, so, unlike using data from a small controlled study or charges generated by hospital charge masters, the findings require little translation to make them applicable to likely aggregate results for Medicare as a payer.

Most analyses of the cost of end-of-life care, including this study, have not considered the substantial out of pocket costs to families.[29] Medicare hospice services require minimal cost sharing, and, unlike the regular Medicare program, drugs are covered. Medicare cost sharing practically guarantees that, if our findings are true, the cost to patients will be less for hospice care, although this is a fertile topic for further investigation. Had we considered the value of the Medicare Part A deductible, the Medicare Part B coinsurance and deductible and the cost of prescription drugs, the total cost savings for hospice care would have been more dramatic than shown.

We caution that while the choice of hospice or non-hospice appears to have an important influence on average time until death time, the variance in time until death is very large for both cohorts. In other words, for an individual, the choice of hospice or non-hospice has very low predictive value for individuals. We hope that this study will generate hypotheses that can be tested in a clinical environment to produce evidence-based recommendations.

Predicting the date of an individual's death has been a challenge for the Medicare program's definition of hospice eligibility and the costs of care for Medicare beneficiaries at the end of their life is an immense cost issue for the financially-beleaguered program.[30] This study provides important information that may guide physician recommendations that are both compassionate and cost effective.

References

1. Wennberg JE, Cooper MM, eds. The quality of care in the last six months of life. In: the quality of medical care in the United States: A report on the Medicare program. The Dartmouth atlas of health care. Chicago: American Health Association Press, 1999.

2. National Hospice and Palliative Care Organization. NHPCO facts and figures. Accessed 4/24/04 at: http://www.nhpco.org/files/public/Facts%20 Figures %20Feb%2004.pdf

3. Mor V, Greer D, Kastenbaum R. The hospice experiment. Baltimore: Johns Hopkins University Press, 1988.

4. National Hospice and Palliative Care Organization. An analysis of the cost savings of the Medicare Hospice Benefit. (Item No. 712901). Alexandria, VA: 1995.

5. Birenbaum HG, Kidder D. What does hospice cost? Am J Public Health. 1992;74:689–697.

6. Emanuel EJ, Ash A, Wu W, et al. Managed care, hospice use, site of death, and medical expenditures in the last year of life. Arch Intern Med 2002;162: 1622–1628.

7. Lo JC. The impact of hospices on health care expenditures—The case of Taiwan. Soc Sci Med 2002; 64:981–991.

8. Campbell DE, Lynn J, Louis TA, Shugarman LR. Medicare program expenditures associated with hospice use. Ann Intern Med 2004;140:269–277.

9. Emanuel LL, von Gunten CF, Ferris FD. Gaps in end-of-life care. Arch Intern Med 2000;9:1166–1180.

10. Iwashyna TJ, Christakis NA. Signs of death. J Palliat Med 2001;4:451–452.

11. Connor S. Hospice: Practice, pitfalls, and promise. Philadelphia: Taylor and Francis, 1998:118–119.

12. Christakis NA. Predicting patient survival before and after hospice enrollment. Hosp J 1998;13:71–87.

13. Christakis NA, Iwashyna TJ, Zhang JX. Care after the onset of serious illness: a novel claims-based dataset exploiting substantial cross-set linkages to study end-of-life care. J Palliat Med 2002;5:515–529.

14. Forster LE, Lynn J. The use of physiologic measures and demographic variables to predict longevity among inpatient hospice applicants. Am J Hosp Care 1989;6:31–34.

15. Spiegel D. Mind matters – group therapy and survival in breast cancer. N Engl J Med 2001;345: 1667–1668.

16. Goodwin PJ, Leszcz M, Ennis M, et al. The effect of group psychosocial support on survival in metastatic breast cancer. N Eng J Med 2001;345:1619–1626.

17. Kane RL, Wales J, Bernstein L, Leibowitz A, Kaplan S. A randomised controlled trial of hospice care. Lancet 1984;1(8382):890–894.

18. Fox E, Landrum-McNiff K, Zhong Z, et al. Evaluation of prognostic criteria for determining hospice eligibility in patients with advanced lung, heart, or liver disease. J Am Med Assoc 1999;282:1638–1645.

19. SUPPORT Principal Investigators. A controlled trial to improve care for seriously ill hospitalized patients: The study to understand prognoses and preferences for outcomes and risks of treatment. JAMA 1995;274:1591–1598.

20. National Hospice and Palliative Care Organization. Medical guidelines for determining prognosis in selected non-cancer diseases, 2nd ed. (Item No. 713008). Alexandria, VA: 1996.

21. Schonwetter RS, Soendker S, Perron V, et al. Review of Medicare's proposed hospice eligibility criteria for select non-cancer patients. Am J Hosp and Palliative Care 1998;15:155–158.

22. Cummings R, Knutson D, Cameron B, Derrick B. A comparative analysis of claims-based methods of health risk assessment for commercial populations. Chicago: Society of Actuaries, 2002.

23. 5% Standard Analytical File: data provided by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore MD, 21244–1850. Final action claims of approx. 2 million Medicare beneficiaries; includes all services except Rx drug. Years used: 1998–2000.

24. Medicare Payment Advisory Commission, Report to Congress, May 2002: Medicare Beneficiaries' Access to Hospice.

25. Field TS, Gurwitz JH, Avorn J, et al. Risk factors for adverse drug events among nursing home residents. Arch Intern Med 2001;161:1629–1634.

26. Greiner KA, Perera S, Ahluwalia JS. Hospice usage by minorities in the last year of life: results from the National Mortality Followback Survey. J Am Geriatr Soc 2003;51:970–978.

27. GAO. Medicare: More beneficiaries use hospice but for fewer days of care. Report GAO/HEHS-00-182. September 2000, Retrieved Oct 8, 2002, from http://www.gao.gov/archive/2000/he00182.pdf.

28. National Hospice and Palliative Care Organization. NHPCO facts and figures on hospice and palliative care. Accessed 10/27/03 at http://www.nhpco.org/files/public/facts_and_figures_0703.pdf

29. Chochinov HM, Janson LK. Dying to pay: the cost of end-of-life care. J Palliat Care 1998;4:5–15.

30. Skinner J, Wennberg JE. How much is enough? Efficiency and Medicare spending in the last six months of life. In: Cutler DM, ed. The changing hospital industry: comparing not-for-profit and for-profit institutions. Chicago: The University of Chicago, 2000:169–193.

EXHIBIT 12

PENNANT

December 9, 2021

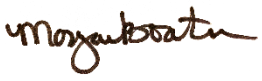
Eric Hernandez, Program
Manager Certificate of Need
Program
Department of Health
P.O. Box 47852
Olympia, WA 98504-7852

Dear Mr. Hernandez,

As the Corporate Controller for The Pennant Group, Inc., the ultimate parent company of Symbol Healthcare, Inc., I am writing to affirm a commitment to fully finance the establishment of Puget Sound Hospice of King County, in King County, Washington. As the ultimate parent of Symbol Healthcare, Inc., we have provided a copy of Pennant's 10-Q in conjunction with this filing that demonstrates the necessary capital reserves to meet the funding requirements.

Please do not hesitate to contact me if you have any questions or require additional information.

Sincerely,



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