LEE L. JOHNSON
TREASURER
GLACIER PEAK HEALTHCARE, INC.

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

December 29, 2021

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

CN22-23

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

RE: Hospice Certificate of Need Application for Glacier Peak Healthcare, Inc., d/b/a Alpha Hospice

Dear Mr. Eric Hernandez,

Please accept the attached as Glacier Peak Healthcare, Inc. d/b/a Alpha Hospice's Certificate of Need application proposing to start providing hospice services to Medicare and Medicaid eligible patients in Skagit County.

Please note that payment was made by check (# 0089089) mailed via USPS Priority Mail Express for 1-Day Delivery. Tracking number 9481 7036 9930 0041 2543 66.

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 tracSkagit 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

CN22-23

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. _____Skagit County _____	

GLACIER PEAK HEALTHCARE INC.,
d/b/a Alpha Hospice
Certificate of Need Application
Establish a Medicare/Medicaid Certified Hospice Agency
in
Skagit County

January 2022

Contents

Introduction

With this application, Glacier Peak Healthcare, Inc., d/b/a Alpha Home Health and Hospice, is seeking a service area expansion in Skagit County. The service area expansion is from our state licensed Snohomish County hospice, namely Alpha Hospice, which is Medicare certified and Medicaid eligible as well as ACHC accredited. In addition, Glacier Peak[1] operates a home health agency, Alpha Home Health that has serviced Skagit and Snohomish County for many years.

Alpha Hospice will operate under the philosophy and model of all affiliates of its ultimate parent company, the Pennant Group ("Pennant"), and its home health and hospice subsidiary, Cornerstone Healthcare ("Cornerstone").[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 Alpha Hospice's unique operating structure sets it apart as the applicant best situated to meet the hospice care needs of the residents of Skagit 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 Alpha Hospice 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, knowing and meeting the specific needs of their community is an expectation.

Second, all Pennant affiliates, such as Alpha Hospice, enjoy the support of a world class service center that includes experts in the field of hospice. The Pennant Service Center has contracted with Alpha Hospice, already providing 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 Alpha Hospice have a team of hospice experts who view themselves as partners and peers, dedicating their professional lives to the agency's success.

[1] Throughout this application, "Glacier Peak" will refer to the corporate entity that owns and operates both Alpha Hospice and Alpha Home Health. References to "Alpha Hospice" will refer to only Glacier Peak's hospice operations, and may also be referred to as "Agency."

[2] As referenced below, Cornerstone Healthcare, Inc. is a subsidiary of the Pennant Group, Inc., and wholly owns Glacier Peak Healthcare, Inc., along with all of Pennant's home health and hospice agencies.

Lastly, as a long-standing home health provider within Snohomish County, Glacier Peak has become a trusted community partner that has provided diverse and unique care for thousands of patients that has resulted in clinical outcomes ranking among the best in the country. Our locally led care team know the home health needs of Skagit County and continue to make uncompromising strides to provide not only comprehensive patient care, but exceptional clinical quality outcomes. With a home health agency that has an average rating of 4.0 stars or above for patient outcomes and 4.0 stars for patient survey ratings, our patients receive some of the best hands on care in the state.[3] This rating is among the highest in Washington, as the state average home health star rating for patient outcomes is 3.5 stars.[4]

With the addition of providing hospice care in Skagit County, Glacier Peak will be able to provide additional care along the spectrum of post-acute care. Glacier Peak's Alpha Home Health has a history of partnering with upstream healthcare providers throughout Skagit County including hospital networks, specifically Skagit Regional Health, PeaceHealth Medical Group and Island Hospital. In addition, Alpha is a member of Senior Care Network, whose purpose is to connect healthcare agencies to the community and provide an open exchange of resources and ideas to positively impact the lives of those living in Skagit County. Glacier Peak will bring this approach to healthcare and community partnership to the community in Skagit County. In doing this, Glacier Peak will be better able to provide patients with the right care, in the right place, at the right time. Glacier Peak's proposal set out in this application will demonstrate that Alpha Hospice is uniquely situated to provide timely and exceptional hospice care in Skagit County.

These three facets, along with the others set out in this application, uniquely position Alpha Hospice to provide a level of care that its competitor in Skagit 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, the basis for our proposal as we have set out illustrates why Alpha Hospice is the best choice to meet the hospice care needs of the residents of Skagit County.

[3] https://www.medicare.gov/care-compare/results?searchType=HomeHealth&page=1&city=Tacoma&state=WA&sort=alpha
[4] 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, Glacier Peak Healthcare, Inc.'s (the licensee) UBI number is 604 158 700 .

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

   Lee Johnson, Treasurer of Glacier Peak 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.

Alpha Hospice
10530 19th Avenue SE Suite 201
Everett Wa. 98208

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 application is proposing to expand an existing hospice agency, namely Alpha Hospice, which is currently serving patients in Snohomish County as a Medicare and Medicaid hospice. If awarded the Skagit certificate of need, we will expand our services into Skagit County. This means that if this project is approved, Alpha Hospice will be able to easily integrate serving patients in Skagit County into its existing operations. Numerous Pennant home health and hospice agencies have expanded their respective service areas successfully due to the experience and support of peer-agencies and Resources. Because of this, Pennant is confident Alpha Hospice will be able to successfully expand its service area into Skagit County.

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.

Alpha Hospice
10530 19th Avenue SE Suite 201
Everett Wa. 98208

4. Provide a detailed description of the proposed project.

Alpha Hospice will be a state licensed and Medicare/Medicaid certified hospice agency in Skagit 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. Many individuals leaving an acute setting or who have experienced traumatic health issues elect hospice services rather curative treatment, and is very often the case, others elect home health services then eventually end up bridging over to hospice services. With this project we'll be able to facilitate both. Particularly with patients that bridge to

hospice services, those patients build a significant relationship with their care team and don't want to change organizations. By having both lines of care, Alpha Hospice will be able to transition patients from home health to hospice care seamless, without patients having the burden of starting over, so to speak, with a new provider. In other words, we are positioned to best support the residents of Skagit County and their long term healthcare needs.

As with all Cornerstone-affiliated hospice agencies, Alpha Hospice will provide exceptional patient-specific care in any setting the patient may be in, whether it's 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.

Apha Hospice'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, Alpha Hospice 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 Pennant-affiliated hospice agencies, Alpha Hospice approaches hospice care with the foundational belief that to produce the best patient outcomes, healthcare must be tailored to the specific needs of its community. All Pennant-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 Skagit 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.

Alpha Hospice will be available and accessible to the entire geography of Skagit County. Alpha Home Health has served Skagit County for 3 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	Alpha Hospice is already ACHC accredited
Agency Providing Medicare and Medicaid hospice services in the proposed county.	January 2023

* 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).

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 proposing to expand the service area of an existing hospice agency, namely Alpha Hospice, which serves patients in Snohomish County as a Medicare and Medicaid certified hospice. We expect to begin serving patients in January of 2023 in Skagit County.

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.

The proposed services identified above are consistent with the existing services provided by the agency in other planning areas.

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).

Alpha Hospice 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, Alpha Hospice'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 Skagit County (excluding accidents) are cancer, heart disease, and stroke.[5] According to a recent prospective cohort study on cancer and non-cancer deaths, hospice is significantly underutilized, particularly in those with a non-cancer diagnosis (e.g., heart disease, stroke and dementia).[6] With heart disease and stroke being the second and third leading causes of death in Skagit County, it is likely that residents of Skagit County are underutilizing necessary hospice care. With our proposed project, Skagit County residents will have access to timely and high-quality hospice services. It is crucial that patients receive the most timely and appropriate level of care so they can receive the full benefits of that care at their most vulnerable time of life. For instance, research has shown that patients with congestive heart failure (CHF) who chose hospice care lived for an average 29 days longer [7] and may be associated with a modest cost savings.[8]

The intent of hospice is to provide timely, 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 Skagit County Residents.

[5]Community Health Assessment Skagit County 2019.
[6] 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.
[7] 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.
[8] Pyenson B, Connor S, et al. 2004 Medicare cost in matched hospice and non-hospice cohorts. *J Pain Symptom Manage,* 28:200-10. 2.
[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.

Top 10 Causes of Death, Skagit County, 2019

Cause of Death	Rate*
Cancer	149.1
Diseases of Heart	128.1
Accidents	44.9
Cerebrovascular diseases	43.7
Alzheimer's disease	38.0
Chronic lower respiratory diseases	33.0
Diabetes mellitus	18.2
Intentional self-harm (suicide)	15.8
Chronic liver disease and cirrhosis	14.5
Influenza and pneumonia	8.7

*Age adjusted death rate per 100,000 people
Source: WA State Department of Health Mortality Dashboard, 2019 (Leading Causes of Death by Gender and County).

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.

Alpha Hospice will be certified by Medicare and Medicaid eligible as it is a service area expansion from Alpha Hospice, which is Medicare certified and Medicaid eligible.

IHS.FS.61032013

Medicare #:501546

Medicaid #:2174879

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.

COUNTY: Snohomish	2019	2020	2021
Total number of admissions	NA	33	107
Total number of patient days	NA	726	3,517
Average daily census	NA	7	19

**Note: First 2020 patients admitted mid-year.

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: Snohomish +Skagit	2020 Snoho	2021 Snoho	2022 Snoho	2023 Skagit	2024 Skagit	2025 Skagit	2026 Skagit
Total number of admissions	33	107	107	39	61	87	117
Total number of patient days	726	3,517	3,517	2,409	3,816	5,435	7,266
Projected average daily census	7	19	19	7	10	15	20

.

To remain consistent with utilization of the Washington Department of Health's (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 financial projections for year 2023 through 2026. Because we identified an underserved population, we have assumed a modest 33% increase for the DOH determined ADC of 1 in 2021, 6 in 2022, and 10 in 2023. Our assumed ADC numbers per year are 2 in 2021, 8 in 2022, and 13 in 2023. 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 18. This information, data and assumptions are also shown in the *Assumptions and Calculations* and pro forma at **Exhibit 10.**

Additionally, we anticipate a reasonable amount of our home health patients choosing to bridge to our hospice services if they elect the hospice benefit. Alpha Home Health of Skagit County's average daily census is approximately 70 and based on historical averages, we expect 5-10% of these patients will bridge to hospice. Our bridging program will provide a natural transition of treatment focus from curative to comfort care, providing

the best quality of life for our patients. Considering the percentage of home health patients we anticipate bridging to our hospice line, our utilization estimates are conservative, as these patients will be in addition to patients who choose Alpha Hospice from other referral sources in the community (e.g., skilled nursing facility partners, physicians, etc.).

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 Pennant 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 affecting the ability to provide hands-on care to patients, we were able to adjust our care according to the needs of the patients, 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, in spite of the global pandemic.

Pennant operates across 14 states and in each of those states we have consistently seen access to hospice care being restricted due to healthcare providers and patients having a general misunderstanding about what hospice services entail and when they are most appropriate for patients. It is no wonder that in each of these states there is inadequate education in the community about hospice care. As discussed above, hospice is underutilized in Skagit County and we believe by using our extensive experience, knowledge, and resources to provide education to community partners, health care providers, and patients, we will be able to remove a significant barrier to hospice services, which will lead to more residents of Skagit County receiving 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 Group skilled nursing facility has already welcomed 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 Skagit County based on our findings that there are underserved populations within the county. We utilized the Department's 8 step need methodology to help us arrive at a reasonable ADC for 2023 through 2026.

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 **1** in 2021, **6** in 2022 and **10** in 2023. This unmet ADC translates into unmet patient days of **435** in 2021, **2,029** in 2022, and **3,623** in 2023.

The need for additional hospice agencies is determined by the same methodology referenced above. As applied to Skagit County, it identifies the need for **0** additional hospice providers. Please see the Step 8 table below for a summary of the unmet ADC per year and the numeric need of **0** new hospice agencies.

While the DOH has determined there is not a need for a new hospice based on the ADC being below 35 through 2023, we have identified an underserved population that we propose requires a new hospice provider in Skagit County. For reference, the DOH need methodology for Skagit County is shown below:

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
Skagit	231	229	269	243	Skagit	1,001	1,018	1,068	1,029

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
Skagit	243	62	Skagit	1,029	619

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
Skagit	62	100,807	101,887	102,236	102,586	63	63	63

						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
Skagit	619	27,881	30,314	31,460	32,607	673	698	724

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*
Skagit	736	762	787	729	7	33	58

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*
Skagit	7	33	58	62.12	435	2,029	3,623

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*
Skagit	435	2,029	3,623	1	6	10

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
Skagit	1	6	10	FALSE	0

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. Because we identified an underserved population, we have assumed a modest 33% increase for the DOH determined ADC of 1 in 2021, 6 in 2022, and 10 in 2023. Our assumed ADC numbers per year are **2** in 2021, **8** in 2022, and **13** in 2023. Our assumed 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-SKAGIT	2023	2024	2025	2026
unmet patient days	4818	6938	9058	11178
unmet patient days % per year	50%	55%	60%	65%
Patient Days	2409	3816	5435	7266
Annual admissions - Unduplicated Patients with ALOS of 62.12	39	61	87	117
Monthly Unduplicated Patient admissions	3	5	7	10
Average Daily Census (ADC)	7	10	15	20

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

Alpha Hospice plans to support Skagit County in its entirety.

6. Identify how this project will be available and accessible to underserved groups.

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

Hispanic and Latino populations make up nearly 1 in 5 residents (18.6%) which is nearly 6% higher than the state average of 13% and over 1% higher than the national average of 17.4%[10]. There have been extensive studies showing these populations are at greater risk for death and disease, due to several key factors such as culture, citizenship status and language barriers, which limit healthcare options and accessibility in their communities. This issue is supported by a recent Community Health Assessment completed in Skagit County by the Population Health Trust/DOH, and further found these issues to be exacerbated during the ongoing global COVID-19 pandemic.[11] This issue will persist as the pandemic continues and we see further strain on the healthcare system until new supportive systems are put in place to reinforce the community health needs of all residents in Skagit County. Alpha Hospice will be able to provide increased access to hospice care to this underserved population as its non-discrimination policies do not take into account citizenship status. Further, we view each patient's culture as extremely important to the patient, and our chaplain and spiritual counseling services are tailored to each individual's beliefs and needs, which are often a vital part of their culture and background. Additionally, we provide translation services to any patient in need of them, thereby removing that barrier to care.

We believe a collaborative approach with the lone hospice provider in Skagit County would better meet the needs of patients in Skagit County. This would be accomplished through cooperative education and palliative bridging for patients transitioning from home health services. Alpha Home Health has partnered with Hospice of the NW for several years and they are receptive to additional support from a locally known healthcare provider in Skagit county.

The collaboration implemented by Alpha Hospice would materialize following the opening of our hospice agency. The purpose of the collaboration is to increase access to special populations such as the rural and underserved residents in Skagit County.

7. Provide a copy of the following policies:
    - 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)

[10] United States Census Bureau – Quick Facts, Skagit County WA 2019. https://www.census.gov/quickfacts/fact/table/skagitcountywashington/PST045219

[11] https://www.skagitcounty.net/Departments/PHTAC

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, we show that although the numeric need is not identified by the Department, we have identified an underserved population that justifies the need for Alpha Hospice.

The need for an additional Medicare and Medicaid certified hospice agency in the planning area of Skagit County exists. According to WAC 246-310-290 (12), an additional hospice agency may be granted a certificate of need absent of a calculated numeric need if there is a specific underserved population within the planning area. We have found there to be an underserved population in Skagit County and we have outlined concerning trends and demographic tendencies based on Community Health Assessment data, interviews, health surveys and letters of support from stakeholders in the planning area. Documentation of this will be referenced in and included with our application.

The underserved population:

The overwhelming barrier to accessible hospice care identified in Skagit County is due to the ratio of Skagit County residents to hospice providers. Skagit is the only county in Washington state with a population greater than 100,000 (129,205 as of 2019) that has only one hospice provider.[12] We've received both unsolicited and solicited feedback on hospice accessibility from a wide variety of community stakeholders, specifically case managers and providers from our local skilled nursing facilities, assisted living facilities, hospitals, and memory care facilities, with whom we partner. Based on this feedback it is abundantly clear that critical issues related to hospice accessibility exist in Skagit County that are correlated with a lack of hospice services. There are frequently re-occurring delays in patients' being able to elect and start hospice care due to the one hospice agency's capacity and staffing constraints. Please see our community survey results at **Exhibit 13**, the answers reflect the long wait times for hospice admission and the need for a new hospice agency.

[12] Community Health Needs Assessment Report Skagit County Public Hospital District No. 2. 2016

Karen Schanno, one of our Home Health nurses who serves patients in Skagit County, has often experienced admission times for patients transitioning from home health to hospice taking a week or more. See her email, also at **Exhibit 13.** This is extremely alarming because many patient's need for hospice care is urgent, with many passing away in a matter of days. With long delays on the initiation of hospice care, those patients pass away having had care inadequate to palliate their symptoms. On average, Alpha Hospice admits patients within 24 to 36 hours. With the addition of Alpha Hospice in Skagit County we will be able to timely meet the urgent and significant needs of patients in need of hospice care.

Another critical issue with hospice care in Skagit County that providers reported to us is poor quality care and decreased visit hours per patient day. With no competition, the one existing hospice sees no real competitive impact of low quality of care, delayed initiation of care, or decreased visit hour per patient day. This translates into sustained low utilization of hospice care despite the need for such care. We believe these issues will only worsen as the demand for hospice services steadily grows. As the population ages and health care treatments advance to extend the lives of those with chronic conditions, we can expect continued strains on the single, limited hospice agency that cannot expand rapidly enough to meet the need of a burgeoning community. The benefit of adding another hospice at this time would be to give Alpha Hospice the opportunity to establish itself, control costs, and develop with the growing need as opposed to waiting until the need is too great in the county to truly be effective.

According to the Community Health Needs Assessment Report of 2016, Skagit County's most recent health factor rating between 2013 and 2016 decreased from 18th to 23rd out of 39 counties.[13] The report concludes that the decline indicates that the residents are "currently suffering from unhealthy historic behaviors, insufficient medical care, social factors and environmental factors [and there is a fear that residents] are likely to continue this pattern in the future" until significant changes to their health needs are made.[14]

Alpha Home Health & Hopice will be in a unique position to specifically address the access to healthcare for those in our rural community. Our clinicians and social work teams are treating and educating our patients and their families, connecting them with community resources while creating care plans that result in high quality care. Additionally, our outreach and marketing teams work to increased access to healthcare for the community through in-service and public education, liaison connections and marketing events. Our home health and hospice team will meet the challenge of identifying patients that are appropriate for hospice care through our in-home clinical care and outreach teams. Data from the US Census and American Community Survey indicates that 41% of the Skagit County population live in unincorporated areas, which includes four tribal communities: Upper Skagit Tribe, Swinomish Indian Tribal Community, Samish Indian Nation and Sauk-Suiattle Indian Tribe.[15] We believe that

[13] Community Health Needs Assessment Report Skagit County Public Hospital District No. 2. 2016
[14] Community Health Needs Assessment Report Skagit County Public Hospital District No. 2. 2016
[15] Skagit County Population Summary: Source: All data from US Census and American Community Survey

with historical trends of poor health outcomes within a rural population layered with above average size groups of historically underrepresented Hispanic and Native American groups, there is a greater unrealized need than what is projected by the DOH methodology.

As mentioned above, we have a robust non-discrimination policy and demographic characteristics are not considered when making the decision to admit a patient. Our home health agency, Alpha Home Health, addressed the issue of inadequate provider coverage by entering into commercial and Medicaid payer contracts that other providers will not participate in. This allows Alpha Home Health to serve and provide care to underserved patients in Skagit County. Alpha Hospice will be able to increase access to hospice care to these underserved populations by partnering with Alpha Home Health to appropriately bridge those home health patients to provide them timely hospice care precisely when they need it. Similarly, we will continue partnerships with community providers like Sea Mar clinics and Northwest Regional Council (NWRC) to meet the need of those underserved in Skagit County.

Another contributing factor to Skagit County be underservedthat the type of hospice program that Hospice of NW provides is inadequately addressing hospice patients' needs. Hospice of the NW is a cooperative program between United General Hospital and Skagit Valley Hospital. A hospital-based hospice program can limit community collaboration and may drive complacency in care outcomes. Interviews with local care facilities in Skagit pointed to this fact as they mentioned long delays in hospice admissions (often greater than 5 days) and a trending decrease in overall quality and collaboration as hospice of the NW census has grown in recent years. A regional administrator at a memory care facility in Skagit disclosed to Alpha that Hospice of the NW too often takes a week or more to initiate patient care and fails to collaborate in care planning with patients that were on service in the memory care facility. These delays are supported by the Medicare Compare Hospice website, showing a timeliness rating below the national average, at 78%.[16] Adding another hospice provider in Skagit County will eliminate delays and allow for an increase in quality care in two ways:

1. Competition drives quality, especially in a state with a certificate of need program. See note at **Exhibit 13** from Voluntary Stopping Eating and Drinking (VSED) Resources NW Co-founder Nancy Simmers. She supported a similar hospice expansion in Whatcom County in 2020 (involving a hospital-based Hospice) and supports the same opportunity in Skagit County.
2. Additional education and resources in the community will reach more lives and provide those in underserved communities, specifically Hispanic and Latino populations, a better opportunity to use the benefits offered. This can be done collaboratively through health fairs and resource events (something that Alpha has already been working on with Hospice of NW) and through healthy competition and specialization strategies.

[16] Medicare.gov. Care Compare Hospice

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 operating agreement is 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 executed 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 Pennant'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 Pennant'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 Pennant'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 Pennant 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.

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

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[17]

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.**

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.

[17] All costs include sales tax.

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 on the next page shows all FTE's by category for the county.

Table 4

SKAGIT CO

Clinical Staff by FTE	2023	2024	2025	2026
Registered Nurse	1.0	1.6	2.2	3.0
Certified Nursing Assistant	0.7	1.0	1.5	2.0
Licensed Clinical Social Worker	0.2	0.3	0.5	0.7
Spiritual Care Coordinator	0.2	0.3	0.5	0.7
Director of Clinical Services	0.2	0.3	0.4	0.5
Total	**2.3**	**3.6**	**5.1**	**6.8**
Compensation and Benefits				
Registered Nurse	79,200	125,454	178,678	238,872
Certified Nursing Assistant	20,592	32,618	46,456	62,107
Licensed Clinical Social Worker	15,620	24,742	35,239	47,111
Spiritual Care Coordinator	12,320	19,515	27,794	37,158
Director of Clinical Services	18,150	28,750	40,947	54,742
Payroll Taxes & Benefits	43,765	69,324	98,735	131,997
Total	**189,647**	**300,404**	**427,850**	**571,986**
Administrative Staff by FTE				
Administrator	0.1	0.1	0.1	0.1
Business Office Manager, Medical Records,	0.2	0.3	0.5	0.7
Intake	0.2	0.3	0.5	0.7
Community Liaison	0.2	0.3	0.5	0.7
Total	**0.8**	**1.1**	**1.6**	**2.1**
Administrative Compensation and Benefits				
Administrator	10,000	10,000	10,000	10,000
Business Office Manager, Medical Records,	11,000	17,424	24,816	33,177
Intake	11,440	18,121	25,809	34,504
Community Liaison	14,300	22,651	32,261	43,130
Payroll Taxes & Benefits	14,022	20,459	27,866	36,243
Total	**60,762**	**88,656**	**120,753**	**157,053**

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.

The table below shows all FTE's by category for the county for Alpha Hospice + Skagit County.

ALPHA HOSPICE + SKAGIT				COMBINED			
Clinical Staff by FTE	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Registered Nurse	0.75	2.5	2.5	3.5	4.1	4.7	5.5
Certified Nursing Assistant	0.25	0.5	0.5	1.2	1.5	2.0	2.5
Licensed Clinical Social Worker	1	1	1	1.2	1.3	1.5	1.7
Spiritual Care Coordinator	0.5	1.2	1.2	1.4	1.5	1.7	1.9
Director of Clinical Services	1	1	1	1.0	1.0	1.0	1.0
Total	**3.5**	**6.2**	**6.2**	**8.3**	**9.5**	**10.9**	**12.5**
Compensation and Benefits							
Registered Nurse	$74,100	$204,000	$204,000	$283,200	$329,454	$382,678	$442,872
Certified Nursing Assistant	$4,850	$21,300	$21,300	$41,892	$53,918	$67,756	$83,407
Licensed Clinical Social Worker	$31,500	$71,200	$71,200	$86,820	$95,942	$106,439	$118,311
Spiritual Care Coordinator	$15,000	$27,300	$27,300	$39,620	$46,815	$55,094	$64,458
Director of Clinical Services	$62,800	$116,200	$116,200	$134,350	$144,950	$157,147	$170,942
Payroll Taxes & Benefits	$13,450	$57,270	$57,270	$101,035	$126,594	$156,005	$189,267
Total	**$201,700**	**$497,270**	**$497,270**	**$686,917**	**$797,674**	**$925,120**	**$1,069,256**
Administrative Staff by FTE							
Administrator	0.1	0.25	0.25	0.4	0.4	0.4	0.4
Business Office Manager, Medical Records, Scheduling	0.25	0.5	0.5	0.7	0.8	1.0	1.2
Intake	0.25	1	1	1.2	1.3	1.5	1.7
Community Liaison	0.25	0.5	0.5	0.7	0.8	1.0	1.2
Total	**0.85**	**2.3**	**2.3**	**3.0**	**3.4**	**3.8**	**4.3**
Administrative Compensation and Benefits							
Administrator	$20,000	$30,000	$30,000	$ 40,000	$40,000	$ 40,000	$40,000
Business Office Manager, Medical Records, Scheduling	$12,300	$35,675	$35,675	$ 46,675	$53,099	$ 60,491	$68,852
Intake	$4,750	$15,325	$15,325	$ 26,765	$33,446	$ 41,134	$49,829
Community Liaison	$27,000	$40,000	$40,000	$ 54,300	$62,651	$ 72,261	$83,130
Payroll Taxes & Benefits	$12,810	$24,200	$24,200	$ 38,222	$44,659	$ 52,066	$60,443
Total	**$76,860**	**$145,200**	**$145,200**	**$205,962**	**$233,856**	**$265,953**	**$302,253**

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 Pennant-owned hospice agencies, which includes 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.

Alpha Hospice is confident that our proposed staff to patient ratio is appropriate for several reasons. First, Pennant-owned hospice agencies have found that operating at these ratios is optimal to produce quality outcomes. Additionally, these ratios were in two separate Pennant-owned 2018 hospice CN applications for Snohomish and Snohomish Counties, respectively, which the CN Department found to be appropriate.[18] 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

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. Nhi Ngyuyen is our contracted medical director, her professional license number is MD#**60784507**.

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

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

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

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.)

Chris Boetthcher 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.

Rebecca O'Donnel is the DCS, her professional license number is **RN00140403.**

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 Glacier Peak Healthcare Inc. operating a home health agency in Snohomish and Skagit 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, Pennant owns Washington-based hospice agencies that service Snohomish, Aston, Garfield, Thurston, Grays Harbor, and Mason counties. In the experience of Pennant- owned health care agencies, health care employees are drawn to the Pacific Northwest Region for its outdoor experiences, culture and vitality, making recruiting to locations like Skagit County generally easier than other parts of the country. Additionally, if Pennant-owned health care agencies have qualified and experienced staff in good standing that want to move to Skagit 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 Glacier Peak Healthcare Inc. 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.

Pennant 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 Alpha Hospice's approach to recruiting and retention.

<u>Recruiting</u>
Alpha Hospice 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 Pennant's multistate organizations.

Alpha Hospice's Administrator and DCS will continually identify open positions. They will create open positions based on staffing needs driven by 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.

Alpha Hospice'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. Alpha Hospice 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, Alpha Hospice'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.

All Pennant 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.

Strategic Healthcare Programs (SHP)[19]
Home Care Home Base (HCHB)
DME Vendor
Pharmacy Vendor
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

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

None of these contracts are expected to change as a result of this project

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

This is not applicable as this is not a new agency.

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

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

Since being awarded the CN for Snohomish County, Alpha Hospice has been laying the groundwork and building relationships with local hospice referral sources, medical leaders, and local skilled nursing facilities in the surrounding areas. Alpha Hospice has been in conversations with its partner on the skilled nursing side, the Ensign Group, specifically Ensign-affiliated skilled nursing facilities surrounding Snohomish County such as Mountain View Rehabilitation in Marysville, Lynwood Post-Acute and Mira Vista Care center in Mount Vernon to help support and provide hospice needs to those who may seek medical care outside of Skagit County who intend to return to Snohomish county for hospice services. These providers have expressed a desire to partner with us to meet the needs of those needing hospice services. This will include providing education to other community healthcare providers in a joint effort to improve patients' outcomes and care coordination.

Alpha Hospice's medical director, Dr. Nhi Nguyen, has practiced medicine for over 30 years, with most of his professional career being right here in Washington. Dr. Elledge, our associate MD, has detailed knowledge of the local healthcare systems and those medical providers who support hospice service within Thurston and Mason counties.

We are confident that the groundwork we've laid in our working relationships will prove effective in our future care coordination and meeting the hospice needs of the residents of Skagit County.

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

We anticipate our working relationships would only grow stronger as a result of approval of this project.

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

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

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

Sound Physicians Group	Island Hospital
PeaceHealth Medical Group – UGH and St. Joes Hospital	Life Care Centers – Mt Vernon and Skagit Valley
NOVARI Primary Care	Soundview Rehab
Mira Vista Care Center	Veterans Affairs – Mt Vernon Clinic
Kaiser Healthcare	Hospice of Northwest
Skagit Regional Clinics – Oncology	Skagit Regional Clinics - Neurology
Birchview Memory Care ALF	Lighthouse Memory Care ALF

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 Glacier Peak Healthcare Inc., 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 Community Health Assessment group, we are committed to collaboration through community engagement and data observation. Alpha Home Health has established continuity in local health care by aligning with hospitals, health systems, and the post-acute care community to improve access to care for Skagit County residents. Relationships and partnerships have been established with our home health agency in Snohomish, Skagit, Whatcom and San Juan counties. Examples include Skagit Regional Health, Peace Health Medical Group and Island Hospital health networks. Additionally, Alpha Home Health has strong relationships with assisted living facilities,

adult family homes and their in-house providers to help provide and advocate for the continuity of services. Novari Primary has been a leading proponent of Alpha Home Health and Hospice in these environments.

The Ensign Group, Pennant'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 skilled nursing facility within Skagit County that we will partner with to address the needs of those transitioning to end-of-life care.

With these relationships, we believe we can improve the continuity of care and prevent unwarranted fragmentation of services through quick, thoughtful bridging of referrals to our 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 an established provider in Skagit County, Alpha Home Health has strong, established relationships with existing healthcare systems in Skagit County and surrounding counties. Alpha Home Health works closely with community partners, local hospital systems, private duty providers, physicians, and in home care physician groups. In fact, Pennant's operational model is for each agency to engage in and seek market-specific care within each county we service. This is accomplished through building partnerships with health care providers. This partnership takes many forms, including sharing of coordination of care, assisting and coordinating appropriate admissions, mutually driven quality outcomes, preventing hospital readmissions, and overall patient satisfaction.

Alpha Home Health has been involved in the community's ongoing efforts in Skagit County and other counties to battle the COVID-19 pandemic. With the most recent COVID-19 pandemic surges, Alpha Home Health was able to support Peace Health, Island Hospital, and Skagit Regional Health by providing overflow for their increased number of referrals and COVID-19 positive patients. We were able to care for patients in their home setting which reduced the burden on local inpatient providers. In addition, Alpha Home Health's director of rehab is a local fire chief to a large rural area and has spearheaded our emergency response program which has been implemented twice this past year due to environmental emergencies.

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 Pennant'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 Skagit 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 Skagit 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 Skagit County. There are no disadvantages.
Cost and Operating Efficiency	Alpha Hospice 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 Skagit 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 Glacier Peak Healthcare Inc. have a proven track record of hiring and retaining quality staff.
Legal Considerations	The advantage: Alpha Hospice staff will be able to provide hospice services to Skagit 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 Skagit County when compared to alternative A and alternative B. Also, at present, we do not know of a hospice agency for sale in Skagit Co.
Quality of Care	The advantage: This option could enhance quality and continuation of care in Skagit 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 Skagit 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 Skagit 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 tracSkagit tools for more accurate documentation between multiple caregivers, order tracSkagit, 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
- Alpha Home Health and Hospice + Alpha Hospice-Skagit pro forma income statement
- Alpha Home Health and Hospice + Alpha Hospice-Skagit pro forma balance sheet
- Cornerstone HC inc. + Alpha Hospice-Skagit pro forma income statement
- Cornerstone HC inc. + Alpha Hospice-Skagit pro forma balance sheet
- Cornerstone HC inc. + Pierce + King + Spokane + Skagit pro forma income statement
- Cornerstone HC inc. + Pierce + King + Spokane + Skagit 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

EXHIBIT 1

Organizational Chart

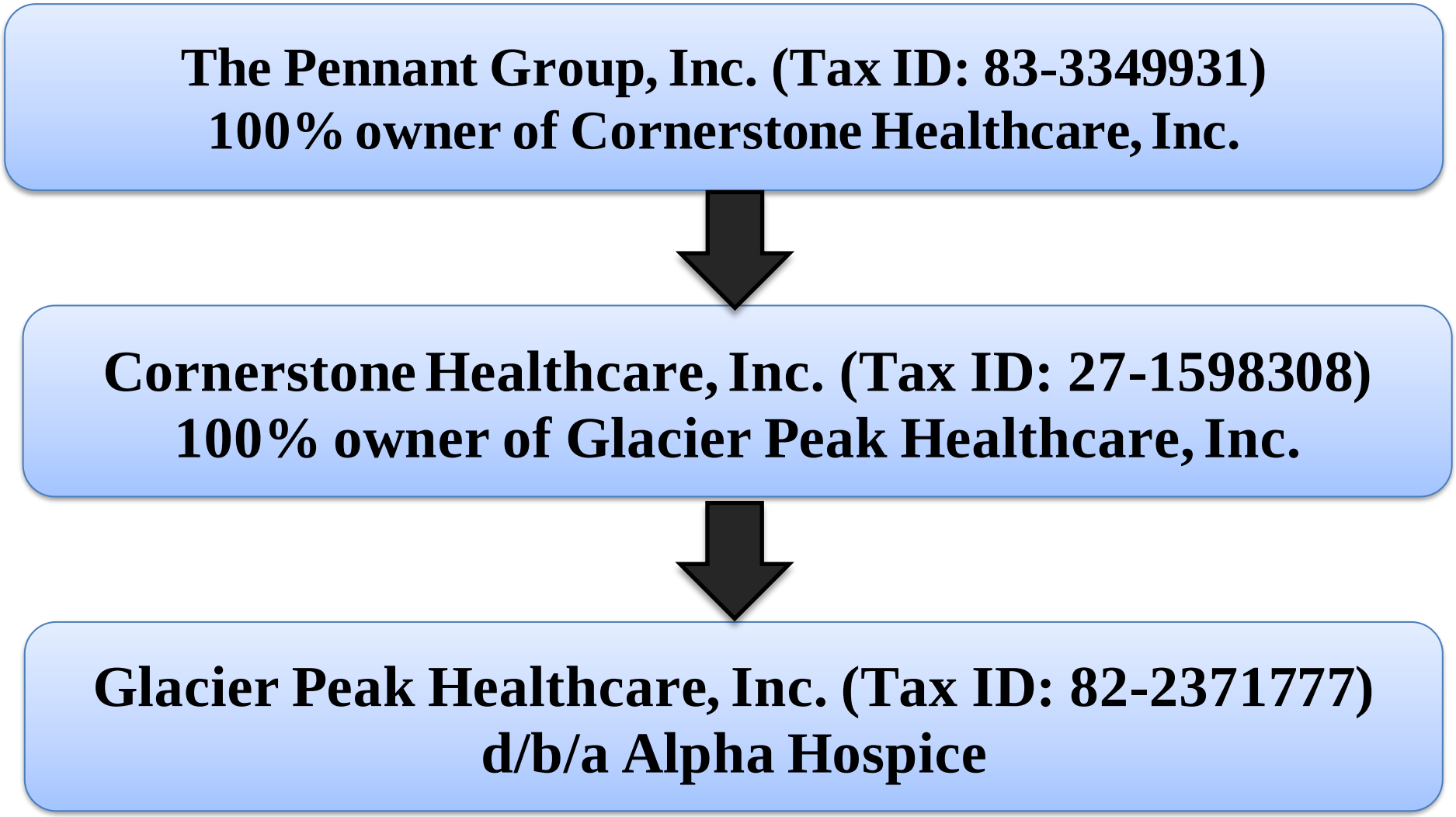


EXHIBIT 2

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 PHYSICIAN SERVICE AGREEMENT

AGREEMENT EFFECTIVE DATE:	8/27/20, 2020
AGENCY:	**GLACIER PEAK HEALTHCARE, INC., dba ALPHA HOME HEALTH AND HOSPICE** **Address:** 10530 19th Avenue S.E., Suite 201, Everett, WA 98208
PHYSICIAN:	**NHI NGUYEN, M.D.** **Address:** 16259 Sylvester Rd Suite 401 Burien WA 98166

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

RECITALS

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, Physician 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 Physician to support 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:

TERMS AND CONDITIONS

Section 1. Physician's Duties

The Physician agrees to serve as the Physician 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 Physician'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 Physician with such supplies and materials as might ordinarily be expected for the preparation of reports, remarks and consultations.

2.5 Indemnify and hold harmless Physician 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 Physician 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 Physician as follows:

3.1 Agency shall pay Physician an all-inclusive hourly rate of **One Hundred Ninety Dollars ($190)**, 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 Physician's required duties ("Administrative Services").

3.2 For each month during the Term of this Agreement, Physician 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. Physician 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 Physician.

3.3 *Direct Patient Care Services.* In the event Physician renders direct patient care services ("Direct Patient Care Services") in his or her capacity as an Agency Patient's attending physician, Physician 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 Physician 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. Physician 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 Physician.

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 Physician's receipt of written notice documenting the breach and decision. For purposes of this Section, "for cause" shall include the following: (i) Physician's breach of any material term or condition of this Agreement; (ii) limitation, suspension or revocation of Physician's license to practice medicine or to prescribe controlled substances; (iii) Physician'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, Physician 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 Physician's ability to practice medicine.

5.4 The Physician 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 Physician 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 Physician 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 Physician and any employee of Physician 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 Physician 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 Physician 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, Physician shall provide documentation that Physician 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. Physician represents and warrants that neither Physician nor any individual or entity with a direct or indirect ownership or control interest of five percent (5%) or more in Physician, 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 Physician 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. Physician 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, Physician, its parent, or any officer, director or owner receives such a sanction, or notice of proposed sanction, Physician 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 Physician has been sanctioned under fraud and abuse statutes and/or any other federal, state or local regulation.

7.5 Physician 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 Physician shall participate in PennantU/compliance training and activities as required by Agency or Agency's compliance partners.

Section 8. Physician's Schedule and Availability

8.1 Nothing in this Agreement shall be construed as limiting or restricting in any manner Physician'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 Physician 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 Physician is entitled to be reasonably absent for annual vacations, sick leave, continuing education, and personal reasons; provided that in the event of any absence Physician 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 Physician of the Agency during the period of absence.

Section 9. Contractual Relationship

9.1 *Independent Contractor.* It is expressly acknowledged by both parties that Physician is an independent contractor. Nothing herein is intended to be construed to create an employer-employee, partnership, joint-venture or other relationship between Physician 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 Physician performs its duties, renders services or practices medicine in the Agency as the Physician 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 Physician hereunder, or be in any way responsible for, any sums for income tax, employment insurance, Social Security, or any other agency, and Physician agrees that the payment of all such amounts as may be required by law are and shall be the sole responsibility of Physician.

9.2 *Fair Market Value*. The amounts to be paid to Physician 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 Physician to Agency, or by Agency to Physician, 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, Physician 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 Physician's acts and omissions, Agency agrees to defend, indemnify, and hold Physician, 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 Physician 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 Physician.

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 Physician 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 Physician 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. Physician acknowledges that in the course of performing Physician's services, duties and obligations herein, Physician may receive, create or obtain access to PHI. Physician 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.* Physician 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, Physician 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 Physician.

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.* Physician shall preserve the confidentiality of all private, confidential and/or proprietary information disclosed to or discovered by Physician 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. Physician 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. Physician 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, demands, and communications called for in this Agreement will be given by registered or certified United States mail or available express mail carrier (Federal Express, UPS, Airbourne, etc.) return receipt requested, to the following address or to such other address as Agency or Physician may designate by written notice to the other pursuant to this Section. Such notice or other communication will be deemed given when received by the addressee, or on the date that the addressee refused delivery. For a notice from Physician to Agency to be effective, a true and complete copy of such notice shall be simultaneously delivered by Physician to: Pennant Service Center, Attn: General Counsel, 1675 E. Riverside Dr., Ste. 200, Eagle, ID 83616, as well as the respective addresses for the Parties listed above.

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 Physician 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 Physician 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"). Physician 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 Law by Physician 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, Physician acknowledges that a material and substantial consideration in Agency's execution of this Agreement is the identity and reputation of Physician, and Agency's subjective perception of Physician'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 Physician hereunder are personal to Physician and may not be assigned or subcontracted to, nor shall the duties and responsibilities of Physician 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 Physician. Agency and Physician 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.

PHYSICIAN SIGNATURE	**AGENCY SIGNATURE**
Name: Nguyen Nhi	By: _____
	Administrator/Authorized Agent
Date: 8/27/20	Date: 8/27/20

EXHIBIT A

Physician Duties

1. Performs all services under the supervision of Agency's Medical Director.
2. Performs Hospice Face-to-Face Encounters as directed by Administrator and in compliance with the hospice conditions of participation and other applicable state and Federal requirements.
3. Participates in hospice interdisciplinary group meetings as directed by Agency's Executive Director, Administrator, or Medical Director, and offers consulting and resource services to address Agency's clinical needs, and assists the Agency's care staff as needed in addressing medical emergencies within the Agency.
4. Performs on-call services as directed by Medical Director.
5. As designated by Executive Director, Administrator or Medical Director, acts as Agency's Physician Designee and assumes all responsibilities (outlined below) of the Medical Director when the Medical Director is unavailable.

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 Hospice Physician 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 Hospice Physician Service Agreement.

Alan Nguyen

Physician Signature

8/27/20

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 Hospice Physician Service Agreement.

Administrator Signature

8/27/20

Date

THIRD ADDENDUM TO LEASE AGREEMENT

AMENDMENT EFFECTIVE DATE:	DECEMBER 10, 2021
TENANT:	**GLACIER PEAK HEALTHCARE, INC., DBA ALPHA HOME HEALTH** **Address**: 10530 19th Avenue S.E., Suite 201, Everett, WA 98208
LANDLORD:	**CASCADE PLAZA, LLC** **Address:** 3719 108th Street S.E., Everett, WA 98208

THIS THIRD ADDENDUM TO LEASE AGREEMENT ("First Addendum") is made and entered into as of the Effective Date above ("Effective Date") by and between Glacier Peak Healthcare, Inc., dba Alpha Home Health ("Tenant"), and Cascade Plaza, LLC ("Landlord"), each a ("Party") and collectively the ("Parties").

RECITALS

A. Tenant and Landlord previously entered into a Lease Agreement, entitled Commercial Lease on February 11, 2020, (referred to herein as the "Lease") in regard to the Leased Premises located at 10530 19th Avenue S.E., Suite 201, Everett, WA;

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

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

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 2. Term**. Section 2 of the Lease shall be amended by deleting the first full paragraph in Section 2 and replacing said paragraph with the following:

   "The Term of this Lease shall be SIX (6) YEARS AND TEN (10) MONTHS from the date of commencement THROUGH DECEMBER 31, 2026. The date of commencement is MARCH 31, 2020."

2. **Section 3.1. Base Rent.** Section 3 of the Lease shall be amended by adding the following at the end of the current Section 3.1:

"The Base Rent for the months of January 2026 through December 2026 shall be the same as the Base Rent for December 2025. There shall be no increase in Base Rent for the yar of 2026."

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

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

Signature:	Signature: Roderick Z. Keppler
	Signature: Marilou D. Keppler
GLACIER ALPHA H[illegible]	**CARE, INC., D/B/A**
	CASCADE PLAZA, LLC
	Roderick Keppler
Name: Chris Boettcher	Name: Marilou Keppler
Title: Executive Director	Title: Managing Partners
Date: 12/10/2021	Date: 12-16-2021

Cascade Plaza, LLC

3719 108TH St. S.E. * Everett, WA 98208 * 425.337.0325

December 1, 2021

Chris Boettcher
Alpha Nursing & Services, Inc/Glacier Peak Healthcare, Inc.
Alpha Home Health
10530 19th Ave SE, Suite 201
Everett, WA 98208

Re: Lease Agreement dated February 11, 2020 and Addendum dated January 28, 2021
Addendum dated March 1, 2021

Chris,

Per the above Lease Agreement and Addendum, following is the rent increase effective January 1, 2022.

	January, 2022
Rent	$ 8,240.00
NNN	$ 3,148.50
Total Monthly	$ 11,388.50

Triple Net Expense will be recapped after the first of the year and any change we will notify you at that time.

If you have any questions, please let us know.

Sincerely,
Cascade Plaza, LLC

Debbie Shewfelt
Office Manager

ADDENDUM TO LEASE AGREEMENT

AMENDMENT EFFECTIVE DATE:	MARCH 1, 2021
TENANT:	GLACIER PEAK HEALTHCARE, INC. dba ALPHA HOME HEALTH Address: 10530 19th Ave SE, Suite 201, Everett, WA 98208
LANDLORD:	CASCADE PLAZA, LLC Address: 3719 108th St SE Everett, WA 98208
Date of Lease Agreement:	February 11, 2020

This agreement is made and entered on the 28th day of January, 2021, between CASCADE PLAZA, LLC, hereafter referred to as "Landlord" and GLACIER PEAK HEALTHCARE, INC., dba ALPHA HOME HEALTH, hereinafter referred to as "Tenant" regarding the premises of 10530 19th Ave SE, Suite #201, Everett, Washington 98208.

Tenant and Landlord previously entered into a Commercial Lease for Five Years and Ten Months from date of Commencement through December 31, 2025. The Date of Commencement is March 1, 2020.

The Parties desire to add additional 2094 square feet of rentable square feet for a total of 4600 square feet to begin March 1, 2021.

All terms, provisions and covenants of the above-described lease shall include the additional square footage of 2094 and will remain in full force for the duration of the original Lease Terms except as noted:

BASE RENT: Beginning March 1, 2021, Tenant shall pay to Landlord on or before the first (1st) day of each month, without offset or deduction the following amounts as rent for the total 4600 square feet of rental space:

03.01.2021 – 12.31.2021	$ 8,000.00
01.01.2022 – 12.31.2022	$ 8,240.00
01.01.2023 – 12.31.2023	$ 8,487.20
01.01.2024 – 12.31.2024	$ 8,741.82
01.01.2025 – 12.31.2025	$ 9,004.07

TENANT COSTS: Tenant Cost for the additional leased space will begin March 1, 2020 and will follow same rate schedule and dates as stated in Section 7.2. Total Tenant Cost Square Footage will be based on 4600 SF, effective March 1, 2021

IN WITNESS WHEREOF, the parties have affixed their signature hereto as of the dates ser forth below:

Signature

GLACIER PEAK HEALTHCARE, INC. d/b/a/
ALPHA HOME HEALTH

Name: Chris Boettcher

Title: Executive Director

Date: 01/28/2021

Signature

CASCADE PLAZA, LLC

CASCADE PLAZA, LLC

Name: Roderick Keppler

Name: Marilou Keppler

Title: Managing Partners

Date: 1-28-21

Johnson, Lee

From:	Johnson, Lee
Sent:	Monday, November 29, 2021 5:23 PM
To:	DOH HSQA CHS CON
Cc:	Ricketts, Isaac
Subject:	Skagit County Hospice Letter of Intent
Attachments:	2021-11-29 Skagit County CN Letter of Intent - Glacier Peak Healthcare, Inc.pdf

Dear Washington Certificate of Need Department,

Consistent with the requirements of WAC 246-310-290 (12),please accept the attached letter of intent for Cycle 1 (Skagit 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
GLACIER PEAK HEALTHCARE, INC.

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

November 29, 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, Glacier Peak Healthcare, Inc., hereby submits a letter of intent proposing to establish a Medicare certified/Medicaid eligible hospice agency based on the special needs of Skagit County. In conformance with the requirements of WAC, the following information is provided:

1. A Description of the Extent of Services Proposed:
Glacier Peak 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 Skagit 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 Skagit County.

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

Sincerely,

Glacier Peak 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

Information you may also include:
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

Alpha 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).

Alpha 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 Alpha 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 Alpha 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 Alpha 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, Alpha 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, Alpha 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, Alpha 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, Alpha 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 Alpha Hospice to comply with the regulations will be the Executive Director/Administrator. Contact the Executive Director/Administrator at _____ (insert telephone number.)

2. Alpha 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 Alpha 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: *"Alpha Hospice complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Alpha 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). Alpha 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 Alpha 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 Alpha 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. Alpha 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 Alpha 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. Alpha 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

---

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 Alpha 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 Alpha 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 Alpha 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 Alpha Hospice policies, procedures, and information presented during orientation. That individual will be responsible for orienting other contract personnel from that organization to Alpha 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

Alpha 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 Alpha 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. Alpha 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

Alpha 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. Alpha 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.

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:	**Glacier Peak Healthcare, Inc. d/b/a Alpha Home Health**
Address:	10530 19th Ave SE, Ste 201, Everett, WA 98208
Phone:	360-299-1302
Fax:	360-299-1373
FEIN:	82-2371777

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.

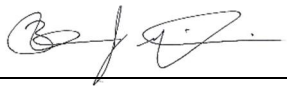
16. Arbitration.

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:

GLACIER PEAK 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:	**GLACIER PEAK HEALTHCARE, INC.** ADDRESS: 10530 19TH AVE SE, STE 201, EVERETT, WA 98208
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.

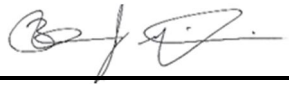
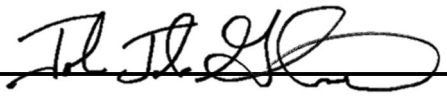
COVERED ENTITY: Glacier Peak Healthcare, Inc.	**BUSINESS ASSOCIATE: PENNANT SERVICES, INC.**
Sign: 	**Sign:** 
Name: Brent Guerisoli	Name: John J. Gochnour
Title: Authorized Agent	Title: Authorized Agent
Date: September 28, 2019	Date: September 28, 2019

Exhibit 1

Notification to Glacier Peak Healthcare, Inc. of
Unauthorized Use or Disclosure of PHI/Breach of Unsecured PHI

Attn: Privacy Officer
Glacier Peak Healthcare, Inc.
10530 19th Ave SE, Ste 201, Everett, WA 98208
Phone: 360-299-1302
Fax: 360-299-1373
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
(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:	**Glacier Peak Healthcare, Inc. d/b/a Alpha Home Health**
Address:	10530 19th Ave SE, Ste 201, Everett, WA 98208
Phone:	360-299-1302
Fax:	360-299-1373
FEIN:	82-2371777

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:

CORNERSTONE SERVICE CENTER, INC.
a Nevada corporation

BY:_____
Brent Guerisoli
Authorized Agent
Date: September 28, 2019

AGENCY:

GLACIER PEAK 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:	**GLACIER PEAK HEALTHCARE, INC.** ADDRESS: 10530 19TH AVE SE, STE 201, EVERETT, WA 98208
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.

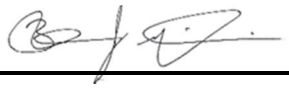
COVERED ENTITY: Glacier Peak Healthcare, Inc.	**BUSINESS ASSOCIATE: PENNANT SERVICES, INC.**
Sign: 	**Sign:** 
Name: Lee Johnson	Name: Brent Guerisoli
Title: Authorized Agent	Title: Authorized Agent
Date: September 28, 2019	Date: September 28, 2019

Exhibit 1

Notification to Glacier Peak Healthcare, Inc. of
Unauthorized Use or Disclosure of PHI/Breach of Unsecured PHI

Attn: Privacy Officer
Glacier Peak Healthcare, Inc.
10530 19th Ave SE, Ste 201, Everett, WA 98208
Phone: 360-299-1302
Fax: 360-299-1373
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.

GLACIER PEAK HEALTHCARE, INC. 2021-2022

EXHIBIT 10

Hospice assumptions and calculations	We assume a modest 33% increase of the DOH estimated ADC (1, 6, 10) for 2021-2023 based on 2021	2022	2023	Estimated 2024	Estimated 2025	Estimated 2026	
SKAGIT COUNTY UNMET NEED ADC	**2**	**8**	**13**				WA DOH Numeric Need Methodology 11/10/21
NUMERIC NEED OF 1	**1**	**1**	**1**				WA DOH Numeric Need Methodology 11/10/21
TOTAL ADC PER AGENCY	2	8	13	18	23	28	WA DOH Numeric Need Methodology 11/10/21

SKAGIT COUNTY UNMET NEED PATIENT DAYS	**578**	**2698**	**4818**				WA DOH Numeric Need Methodology 11/10/21
Numeric need	1	1	1				WA DOH Numeric Need Methodology 11/10/21
unmet patient days	578	2698	4818	6938	9058	11178	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

SKAGIT County unduplicated admissions calculation

Unmet annual admits	9.30	43.43	77.56	111.69	145.81	179.94	
Monthly admits	0.78	3.62	6.46	9.31	12.15	15.00	*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**	50%	55%	60%	65%
Patient Days	**2409**	**3816**	**5435**	**7266**	Projected service for 50% in 2023, 55% in 2024, 60% in 2025, 65% in 2026			
Annual admissions - Unduplicated Patients with ALOS of 62.12	**39**	**61**	**87**	**117**				
Monthly Unduplicated Patient admissions	**3**	**5**	**7**	**10**				
Average Daily Census (ADC)	**7**	**10**	**15**	**20**				

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
SKAGIT County- Days of Care (DOC)

	2023	2024	2025	2026	
Routine Home Care (RHC)	2,361	3,740	5,326	7,120	Level of Care Percentage x Projected service of unmet days
Inpatient Respite Care (IRC)	36	57	82	109	Level of Care Percentage x Projected service of unmet days
Continuous Home Care (CHC)	5	8	11	15	Level of Care Percentage x Projected service of unmet days
General InPatient Care (GIP)	7	11	16	22	Level of Care Percentage x Projected service of unmet days
Total Days of Care	2,409	3,816	5,435	7,266	

Referral resources based on Cornerstone averages

	# of Referrals by Source				Avg referral %
Physician Referral	1.1	1.7	2.4	3.2	32.9%
Clinic Referral	1.2	1.9	2.7	3.6	36.5%
Transfer from Hospital	0.4	0.6	0.9	1.2	12.2%
Transfer from SNF	0.5	0.9	1.2	1.6	16.7%
All other	0.1	0.1	0.1	0.2	1.7%
Subtotal Referrals	3.2	5.1	7.3	9.7	

Per Diem Rates - 2022

SKAGIT County	Days 1-60	Days > 60		
Routine Home Care	**$ 201.73**	**$ 159.42**	**$ 168.67**	Blended rate of 30% Tier 1 and 70% Tier 2 based on
Inpatient Respite	**$ 469.87**		Per Day	Cornerstone averages, includes 2% sequestration
Continuous Home Care	**$ 57.67**		Per Hour	Per Hour, minimum 8 hours required
General InPatient	**$ 1,059.52**		Per Day	

REVENUE

Gross revenue by type of care

SKAGIT County	2023	2024	2025	2026	
Routine Home Care	398,206	630,765	898,368	1,201,015	Days of Care x Per Diem Rates
Inpatient Respite	16,979	26,894	38,304	51,208	Days of Care x Per Diem Rates
Continuous Home Care	2,223	3,521	5,015	6,705	Days of Care x Per Diem Rates: Assumes one 8 hour shift per each unmet day
General InPatient	7,657	12,129	17,275	23,094	Days of Care x Per Diem Rates
Gross revenue subtotal	425,065	673,310	958,963	1,282,022	

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

SKAGIT County	2023	2024	2025	2026	
Medicare	402,111	636,951	907,179	1,212,793	Gross revenue by Type of Care x Payor Mix
Medicaid	17,003	26,932	38,359	51,281	Gross revenue by Type of Care x Payor Mix
Commercial	5,101	8,080	11,508	15,384	Gross revenue by Type of Care x Payor Mix
self pay	850	1,347	1,918	2,564	Gross revenue by Type of Care x Payor Mix
Gross revenue subtotal	**425,065**	**673,310**	**958,963**	**1,282,022**	

Adjustments to revenue	2023	2024	2025	2026	
Contractual adjustments Medicare Managed Care, Medicaid Managed Care, Private Pay, Third Party Ins	(8,501)	(13,466)	(19,179)	(25,640)	Assumed 2%
Charity Care	(21,253)	(33,666)	(47,948)	(64,101)	Assumed 5%
Provisions for Bad Debt	(4,251)	(6,733)	(9,590)	(12,820)	Assumed 1%
Total Adjustments to Revenue	(34,005)	(53,865)	(76,717)	(102,562)	

Total Net Revenue	**391,059**	**619,445**	**882,246**	**1,179,460**

EXPENSES

PATIENT CARE COSTS

Clinical Staff by FTE	2023	2024	2025	2026	Annual Comp/FTE	Note
Registered Nurse	1.0	1.6	2.2	3.0	80,000	1 RN/12 ADC and .8 RN/12 ADC for weekend/night/call rotation
Certified Nursing Assistant	0.7	1.0	1.5	2.0	31,200	1 CNA/10 ADC
Licensed Clinical Social Worker	0.2	0.3	0.5	0.7	71,000	1 LCSW/30 ADC; Also covers Volunteer Coordinator until ADC of 60
Spiritual Care Coordinator	0.2	0.3	0.5	0.7	56,000	1 SCC/30 ADC; Also covers Bereavement Coordinator until ADC of 60
Director of Clinical Services	0.2	0.3	0.4	0.5	110,000	1/DPS/40 ADC includes QAPI
Total	**2.3**	**3.6**	**5.1**	**6.8**		

Clinical Staffing	2023	2024	2025	2026	Note
Compensation and Benefits					
Registered Nurse	79,200	125,454	178,678	238,872	FTE x Annual Compensation
Certified Nursing Assistant	20,592	32,618	46,456	62,107	FTE x Annual Compensation
Licensed Clinical Social Worker	15,620	24,742	35,239	47,111	FTE x Annual Compensation
Spiritual Care Coordinator	12,320	19,515	27,794	37,158	FTE x Annual Compensation
Director of Clinical Services	18,150	28,750	40,947	54,742	FTE x Annual Compensation
Payroll Taxes & Benefits	43,765	69,324	98,735	131,997	30% of Base Compensation
Total	**189,647**	**300,404**	**427,850**	**571,986**	

Contracted Patient Care	2023	2024	2025	2026	Note	
Medical Director	11,286	17,877	25,462	34,039	MD rate of $190/hr. per contract. Assumption of .75hrs/ADC	
Physical Therapist	252	399	568	759	$42.38/hr	1.5 hours/20 ADC/Month
Occupational Therapist	233	369	526	703	$39.26/hr	1.5 hours/20 ADC/Month
Speech Therapist	211	334	476	637	$35.55/hr	1.5 hours/20 ADC/Month
Dietitian	198	313	446	596	$33.29/hr	1.5 hours/20 ADC/Month

Total	**12,180**	**19,293**	**27,478**	**36,735**	

Direct Patient Care Costs	**2023**	**2024**	**2025**	**2026**	**Note**
DME	14,550	23,048	32,826	43,885	$6.04/PPD based on Cornerstone averages
Pharmacy	17,080	27,055	38,533	51,514	$7.09/PPD based on Cornerstone averages
General Inpatient Costs	7,657	12,129	17,275	23,094	$1180.67 per General Inpatient DOC
Medical Supplies	6,239	9,883	14,076	18,818	$2.59/PPD based on Cornerstone averages
Inpatient Respite	16,979	26,894	38,304	51,208	$520.36 per Inpatient Respite DOC
Room and Board	1,084	1,717	2,446	3,270	$.45/PPD based on Cornerstone averages
Mileage	8,672	13,737	19,565	26,157	Estimate 8 miles/DOC reimbursed at $.45/mile based on existing local agency
Subtotal	**72,262**	**114,464**	**163,025**	**217,946**	

Total Direct Patient Care Costs	**274,088**	**434,161**	**618,354**	**826,668**	

ADMINISTRATIVE COSTS

Administrative Staff by FTE	**2023**	**2024**	**2025**	**2026**	**Annual Comp/FTE**	**Note**
Administrator	0.1	0.1	0.1	0.1	100,000	10% of comp
Business Office Manager, Medical Records, Scheduling	0.2	0.3	0.5	0.7	50,000	1 BOM/30 ADC
Intake	0.2	0.3	0.5	0.7	52,000	1 per/30 ADC
Community Liaison	0.2	0.3	0.5	0.7	65,000	1 CL/30 ADC
Total	**0.8**	**1.1**	**1.6**	**2.1**		

Administrative Compensation and Benefits	**2023**	**2024**	**2025**	**2026**	**Note**
Administrator	10,000	10,000	10,000	10,000	FTE x Annual Compensation, represents 10% of HH&H Administrator
Business Office Manager, Medical Records, Scheduling	11,000	17,424	24,816	33,177	FTE x Annual Compensation
Intake	11,440	18,121	25,809	34,504	FTE x Annual Compensation
Community Liaison	14,300	22,651	32,261	43,130	FTE x Annual Compensation
Payroll Taxes & Benefits	14,022	20,459	27,866	36,243	30% of Base Compensation
Total	**60,762**	**88,656**	**120,753**	**157,053**	

Administration Costs	**2023**	**2024**	**2025**	**2026**	**Note**
Advertising	7,911	6,194	8,822	11,795	$4,000 launch plus 1% of revenue
Allocated Costs	21,253	33,666	47,948	64,101	5% Allocation to Cornerstone Service Center for support; Legal, HR, Accounting, IT, and Clinical
B & O Taxes	6,376	10,100	14,384	19,230	1.5% of Gross Revenue
Dues & Subscriptions	450	450	450	450	10% of $375/month, primarily Medbridge
Education and trainings	1,000	1,000	1,000	1,000	10% of $10,000/year, Continuing education including Clinical education and compliance
Information Technology/Computer/Software Maintenance	1,500	1,500	1,500	1,500	10% of $1250/month
Insurance	120	120	120	120	10% of Liability and property content
Legal and professional	-	-	-	-	Included in Allocated Costs to Cornerstone Service Center
Licenses and Fees	-	-	-	-	0% of bi-annual license
Postage	600	600	600	600	10% of $500/month
Purchased services	1,200	1,200	1,200	1,200	10% of $1000/month; bank fees, system access: HCHB, SHP, Workday
Repairs and Maintenance	180	180	180	180	10% of $150/month
Cleaning	252	252	252	252	10% of $210/month
Office supplies	300	300	300	300	10% of $250/month

Equipment lease & maintenance	600	600	600	600	10% of $500/month, copier and postage machines
Building rent or lease	-	-	-	-	Lease is 0% of Alpha 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	4,990	6,113	7,406	8,869	$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	**58,232**	**70,275**	**92,763**	**118,197**	
Total Administrative Expense	**118,994**	**158,931**	**213,516**	**275,250**	
TOTAL COSTS	**393,082**	**593,092**	**831,870**	**1,101,917**	
EBITDA	(2,022)	26,354	50,375	77,543	
EBITDA Margin %	-0.5%	4.3%	5.7%	6.6%	
Depreciation	1,333	1,333	1,334	-	
Amortization	-	-	-	-	
EBIT	(3,355)	25,021	49,041	77,543	
Interest Expense	-	-	-		
Earnings before Taxes	(3,355)	25,021	49,041	77,543	

YEAR	MO LEASE		LEASE PER YR
2023	$ -	$ -	-
2024	$ -	$ -	-
2025	$ -	$ -	-
2026	$ -	$ -	-

GLACIER PEAK HEALTHCARE, INC. 2021-2022 BALANCE SHEET-HOSPICE ONLY SKAGIT CO	2023	2024	2025	2026
Assets				
Current Assets				
Cash	(42,776)	(30,397)	4,616	64,786
Accounts Receivable	44,351	70,252	100,057	133,764
Allowance for Bad Debt	(1,774)	(2,810)	(4,002)	(5,351)
Prepaid Assets	-	-	-	-
Total Current Assets	(199)	37,045	100,671	193,199
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	-	-	-	-
Start Up Costs	15,500	15,500	15,500	15,500
Other Assets	-	-	-	-
Total Other Assets	15,500	15,500	15,500	15,500
Total Assets	**18,968**	**54,879**	**117,171**	**209,699**
Liabilities				
Current Liabilities				
Accounts Payable/Credit Card Payable	11,889	17,003	23,606	31,073
Payroll Liabilities	10,434	16,211	22,858	30,377
Total Current Liabilities	22,323	33,213	46,464	61,450
Long Term Liabilities				
Other Liabilities	-	-	-	
Hospice CAP				
Total Long Term Liabilities	-	-	-	
Total Liabilities	**22,323**	**33,213**	**46,464**	**61,450**
Equity				
Retained Earnings	-	(3,355)	21,665	70,707
Net Income	(3,355)	25,021	49,041	77,543
Total Equity	(3,355)	21,665	70,707	148,250
Total Liabilities and Equity	**18,968**	**54,879**	**117,171**	**209,699**
	-	-	-	-

GLACIER PEAK HEALTHCARE, INC.
2021-2022
PRO FORMA-HOSPICE ONLY
SKAGIT CO
REVENUE

Gross revenue by type of care

SKAGIT County	**2023**	**2024**	**2025**	**2026**	
Routine Home Care	398,206	630,765	898,368	1,201,015	Days of Care x Per Diem Rates
Inpatient Respite	16,979	26,894	38,304	51,208	Days of Care x Per Diem Rates
Continuous Home Care	2,223	3,521	5,015	6,705	Days of Care x Per Diem Rates: Assumes one 8 hour shift per each unmet day
General InPatient	7,657	12,129	17,275	23,094	Days of Care x Per Diem Rates
Gross revenue subtotal	425,065	673,310	958,963	1,282,022	

Adjustments to revenue	**2023**	**2024**	**2025**	**2026**	
Contractual adjustments Medicare Managed Care, Medicaid Managed Care, Private Pay, Third Party Ins	(8,501)	(13,466)	(19,179)	(25,640)	Assumed 2%
Charity Care	(21,253)	(33,666)	(47,948)	(64,101)	Assumed 5%
Provisions for Bad Debt	(4,251)	(6,733)	(9,590)	(12,820)	Assumed 1%
Total Adjustments to Revenue	(34,005)	(53,865)	(76,717)	(102,562)	
Total Net Revenue	**391,059**	**619,445**	**882,246**	**1,179,460**	

EXPENSES

Clinical Staffing	**2023**	**2024**	**2025**	**2026**	**Note**
Compensation and Benefits					
Registered Nurse	79,200	125,454	178,678	238,872	FTE x Annual Compensation
Certified Nursing Assistant	20,592	32,618	46,456	62,107	FTE x Annual Compensation
Licensed Clinical Social Worker	15,620	24,742	35,239	47,111	FTE x Annual Compensation
Spiritual Care Coordinator	12,320	19,515	27,794	37,158	FTE x Annual Compensation
Director of Clinical Services	18,150	28,750	40,947	54,742	FTE x Annual Compensation
Payroll Taxes & Benefits	43,765	69,324	98,735	131,997	30% of Base Compensation
Total	**189,647**	**300,404**	**427,850**	**571,986**	

Contracted Patient Care	**2023**	**2024**	**2025**	**2026**	**Note**	
						-
Medical Director	11,286	17,877	25,462	34,039	MD rate of $190/hr. p	-
Physical Therapist	252	399	568	759	$42.38/hr	1.5 hours/20 ADC/Month
Occupational Therapist	233	369	526	703	$39.26/hr	1.5 hours/20 ADC/Month
Speech Therapist	211	334	476	637	$35.55/hr	1.5 hours/20 ADC/Month
Dietitian	198	313	446	596	$33.29/hr	1.5 hours/20 ADC/Month
Total	**12,180**	**19,293**	**27,478**	**36,735**		

Direct Patient Care Costs	**2023**	**2024**	**2025**	**2026**	**Note**

DME	14,550	23,048	32,826	43,885	$6.04/PPD based on Cornerstone averages
Pharmacy	17,080	27,055	38,533	51,514	$7.09/PPD based on Cornerstone averages
General Inpatient Costs	7,657	12,129	17,275	23,094	$1180.67 per General Inpatient DOC
Medical Supplies	6,239	9,883	14,076	18,818	$2.59/PPD based on Cornerstone averages
Inpatient Respite	16,979	26,894	38,304	51,208	$520.36 per Inpatient Respite DOC
Room and Board	1,084	1,717	2,446	3,270	$.45/PPD based on Cornerstone averages
Mileage	8,672	13,737	19,565	26,157	Estimate 8 miles/DOC reimbursed at $.45/mile based on existing local agency
Subtotal	**72,262**	**114,464**	**163,025**	**217,946**	
Total Direct Patient Care Costs	**274,088**	**434,161**	**618,354**	**826,668**	

ADMINISTRATIVE COSTS

Administrative Compensation and Benefits	**2023**	**2024**	**2025**	**2026**	**Note**
Administrator	10,000	10,000	10,000	10,000	FTE x Annual Compensation, represents 10% of HH&H Administrator
Business Office Manager, Medical Records, Scheduling	11,000	17,424	24,816	33,177	FTE x Annual Compensation
Intake	11,440	18,121	25,809	34,504	FTE x Annual Compensation
Community Liaison	14,300	22,651	32,261	43,130	FTE x Annual Compensation
Payroll Taxes & Benefits	14,022	20,459	27,866	36,243	30% of Base Compensation
Total	**60,762**	**88,656**	**120,753**	**157,053**	

Administration Costs	**2023**	**2024**	**2025**	**2026**	**Note**
Advertising	7,911	6,194	8,822	11,795	$4,000 launch plus 1% of revenue
Allocated Costs	21,253	33,666	47,948	64,101	5% Allocation to Cornerstone Service Center for support; Legal, HR, Accounting, IT, and Clinical
B & O Taxes	6,376	10,100	14,384	19,230	1.5% of Gross Revenue
Dues & Subscriptions	450	450	450	450	10% of $375/month, primarily Medbridge
Education and trainings	1,000	1,000	1,000	1,000	10% of $10,000/year, Continuing education including Clinical education and compliance
Information Technology/Computer/Software Maintenance	1,500	1,500	1,500	1,500	10% of $1250/month
Insurance	120	120	120	120	10% of Liability and property content
Legal and professional	-	-	-	-	Included in Allocated Costs to Cornerstone Service Center
Licenses and Fees	-	-	-		0% of bi-annual license
Postage	600	600	600	600	10% of $500/month
Purchased services	1,200	1,200	1,200	1,200	10% of $1000/month; bank fees, system access: HCHB, SHP, Workday
Repairs and Maintenance	180	180	180	180	10% of $150/month
Cleaning	252	252	252	252	10% of $210/month
Office supplies	300	300	300	300	10% of $250/month
Equipment lease & maintenance	600	600	600	600	10% of $500/month, copier and postage machines
Building rent or lease	-	-	-	-	Lease is 0% of Alpha 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	4,990	6,113	7,406	8,869	$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	**58,232**	**70,275**	**92,763**	**118,197**
Total Administrative Expense	**118,994**	**158,931**	**213,516**	**275,250**
TOTAL COSTS	**393,082**	**593,092**	**831,870**	**1,101,917**
EBITDA	(2,022)	26,354	50,375	77,543
EBITDA Margin %	-0.5%	4.3%	5.7%	6.6%
Depreciation	1,333	1,333	1,334	-
Amortization	-	-	-	
EBIT	(3,355)	25,021	49,041	77,543
Interest Expense	-	-	-	
Earnings before Taxes	(3,355)	25,021	49,041	77,543

INCOME STATEMENT ALPHA HH&H + SKAGIT

For the Ten Months Ending Sunday, October 31, 2021

	YTD	2022	2023	2024	2025	2026
Home Health Services - Medicare	$3,155,786.47	$3,155,787.47	$3,155,788.47	$3,155,789.47	$3,155,790.47	$3,155,791.47
Home Health Services- HMO	1,083,161.38	1,083,161.38	1,083,161.38	1,083,161.38	1,083,161.38	1,083,161.38
Home Health Services - Commercial	1,078,914.30	1,078,914.30	1,078,914.30	1,078,914.30	1,078,914.30	1,078,914.30
Home Health Services - Medicaid	49,767.30	49,767.30	49,767.30	49,767.30	49,767.30	49,767.30
Home Health Services - Private	7,922.76	7,922.76	7,922.76	7,922.76	7,922.76	7,922.76
Total Home Health	5,375,552.21	5,375,553.21	5,375,554.21	5,375,555.21	5,375,556.21	5,375,557.21
Hospice Services - Medicare	1,083,753.93	1,083,753.93	1,083,753.93	1,083,753.93	1,083,753.93	1,083,753.93
Hospice Services - Commercial						
Hospice Services - Medicaid	261,472.28	261,472.28	261,472.28	261,472.28	261,472.28	261,472.28
Hospice Services - Private						
TOTAL NET SKAGIT HOSPICE CN REVENUE			**391059.38**	**619445.20**	**882245.55**	**1179460.42**
Total Hospice	1,345,226.21	1,345,226.21	1,736,285.59	1,964,671.41	2,227,471.76	2,524,686.63
Other Rev - Misc Rev	0.01	1.01	2.01	3.01	4.01	5.01
Total Other Revenue	0.01	1.01	2.01	3.01	4.01	5.01
TOTAL NET REVENUE	6,720,778.43	6,720,780.43	7,111,841.81	7,340,229.63	7,603,031.98	7,900,248.85
DIRECT COSTS						
HH- Therapy Wages	828,735.76	828,735.76	828,735.76	828,735.76	828,735.76	828,735.76
HH- Therapy Benefits	131,319.07	131,319.07	131,319.07	131,319.07	131,319.07	131,319.07
HH- Therapy Mileage	97,054.11	97,054.11	97,054.11	97,054.11	97,054.11	97,054.11
HH - Therapy Other	448,212.30	448,212.30	448,212.30	448,212.30	448,212.30	448,212.30
Total Home Health Therapy	1,505,321.24	1,505,321.24	1,505,321.24	1,505,321.24	1,505,321.24	1,505,321.24
HH- CNA Wages	31,200.57	31,200.57	31,200.57	31,200.57	31,200.57	31,200.57
HH- CNA Benefits	8,192.63	8,192.63	8,192.63	8,192.63	8,192.63	8,192.63
HH- CNA Mileage	6,168.15	6,168.15	6,168.15	6,168.15	6,168.15	6,168.15
HH - CNA Other	279.80	279.80	279.80	279.80	279.80	279.80
Total Home Health CNA	45,841.15	45,841.15	45,841.15	45,841.15	45,841.15	45,841.15
HH- Nursing Wages	699,319.64	699,319.64	699,319.64	699,319.64	699,319.64	699,319.64
HH- Nursing Benefits	133,467.19	133,467.19	133,467.19	133,467.19	133,467.19	133,467.19
HH- Nursing Mileage	43,950.19	43,950.19	43,950.19	43,950.19	43,950.19	43,950.19
HH - Nursing Other	6,991.28	6,991.28	6,991.28	6,991.28	6,991.28	6,991.28
Total Home Health Skilled Nursing	883,728.30	883,728.30	883,728.30	883,728.30	883,728.30	883,728.30

HH - SS Wages	37,447.01	37,447.01	37,447.01	37,447.01	37,447.01	37,447.01
HH - SS Benefits	4,813.89	4,813.89	4,813.89	4,813.89	4,813.89	4,813.89
HH - SS Mileage	4,465.75	4,465.75	4,465.75	4,465.75	4,465.75	4,465.75
HH - SS Other	385.16	385.16	385.16	385.16	385.16	385.16
Total Home Health Social Services	47,111.81	47,111.81	47,111.81	47,111.81	47,111.81	47,111.81
HH - Supplies	164,438.70	164,439.70	164,440.70	164,441.70	164,442.70	164,443.70
TOTAL DIRECT COSTS - HOME HEALTH	2,646,441.20	2,646,442.20	2,646,443.20	2,646,444.20	2,646,445.20	2,646,446.20
Hospice- CNA Wages	18,564.85	18,564.85	18,564.85	18,564.85	18,564.85	18,564.85
Hospice- CNA Benefits	2,309.82	2,309.82	2,309.82	2,309.82	2,309.82	2,309.82
Hospice- CNA Mileage	2,785.74	2,785.74	2,785.74	2,785.74	2,785.74	2,785.74
Total Hospice CNA	23,660.41	23,660.41	23,660.41	23,660.41	23,660.41	23,660.41
Hospice- Nursing Wages	168,554.87	168,554.87	168,554.87	168,554.87	168,554.87	168,554.87
Hospice- Nursing Benefits	37,380.71	37,380.71	37,380.71	37,380.71	37,380.71	37,380.71
Hospice- Nursing Mileage	6,681.80	6,681.80	6,681.80	6,681.80	6,681.80	6,681.80
Hospice - Nursing Other	41,106.84	41,106.84	41,106.84	41,106.84	41,106.84	41,106.84
Total Hospice Skilled Nursing	253,724.22	253,724.22	253,724.22	253,724.22	253,724.22	253,724.22
Hospice - SS Wages	59,603.27	59,603.27	59,603.27	59,603.27	59,603.27	59,603.27
Hospice - SS Benefits	12,241.59	12,241.59	12,241.59	12,241.59	12,241.59	12,241.59
Hospice - SS Mileage	631.00	631.00	631.00	631.00	631.00	631.00
Total Hospice Social Services	72,475.86	72,475.86	72,475.86	72,475.86	72,475.86	72,475.86
Hospice - Chaplain Wages	19,389.72	19,389.72	19,389.72	19,389.72	19,389.72	19,389.72
Hospice - Chaplain Benefits	2,553.53	2,553.53	2,553.53	2,553.53	2,553.53	2,553.53
Hospice - Chaplain Mileage	606.60	606.60	606.60	606.60	606.60	606.60
Total Hospice Chaplain	22,549.85	22,549.85	22,549.85	22,549.85	22,549.85	22,549.85
Hospice - Volunteer Wages	5,951.04	5,951.04	5,951.04	5,951.04	5,951.04	5,951.04
Hospice - Volunteer Benefits	2,265.88	2,265.88	2,265.88	2,265.88	2,265.88	2,265.88
Total Hospice Volunteer	8,216.92	8,216.92	8,216.92	8,216.92	8,216.92	8,216.92
Hospice - Pharmacy	19,668.51	19,668.51	19,668.51	19,668.51	19,668.51	19,668.51
Hospice - Supplies	12,273.71	12,273.71	12,273.71	12,273.71	12,273.71	12,273.71
Hospice - DME	64,310.50	64,310.50	64,310.50	64,310.50	64,310.50	64,310.50
Hospice- Room and Board	209,264.42	209,264.42	209,264.42	209,264.42	209,264.42	209,264.42
TOTAL DIRECT COSTS - HOSPICE	686,144.40	686,144.40	686,144.40	686,144.40	686,144.40	686,144.40

SKAGIT HOSPICE CN						
Registered Nurse			79,200.00	125,454.25	178,678.36	238,872.33
Certified Nursing Assistant			20,592.00	32,618.10	46,456.37	62,106.81
Licensed Clinical Social Worker			15,620.00	24,742.37	35,239.34	47,110.93
Spiritual Care Coordinator			12,320.00	19,515.11	27,794.41	37,157.92
Director of Clinical Services			18,150.00	28,749.93	40,947.12	54,741.58
Payroll Taxes & Benefits			43,764.60	69,323.93	98,734.68	131,996.87
Total			**189,646.60**	**300,403.68**	**427,850.29**	**571,986.43**
Medical Director			11,286.00	17,877.23	25,461.67	34,039.31
Physical Therapist			251.74	398.76	567.93	759.26
Occupational Therapist			233.20	369.40	526.12	703.36
Speech Therapist			211.17	334.49	476.40	636.89
Dietitian			197.74	313.23	446.12	596.40
Total			**12,179.85**	**19,293.11**	**27,478.23**	**36,735.22**
DME			14,550.36	23,048.04	32,826.19	43,884.83
Pharmacy			17,079.81	27,054.73	38,532.73	51,513.81
General Inpatient Costs			7,657.15	12,129.07	17,274.84	23,094.47
Medical Supplies			6,239.31	9,883.18	14,076.13	18,818.16
Inpatient Respite			16,978.58	26,894.38	38,304.35	51,208.50
Room and Board			1,084.05	1,717.16	2,445.66	3,269.57
Mileage			8,672.40	13,737.24	19,565.28	26,156.52
Subtotal			**72,261.66**	**114,463.79**	**163,025.19**	**217,945.85**
TOTAL DIRECT COSTS			**274,088.11**	**434,160.58**	**618,353.71**	**826,667.50**
TOTAL DIRECT COSTS	3,332,585.60	3,332,586.60	3,606,675.71	3,766,749.18	3,950,943.31	4,159,258.10
INDIRECT COSTS						
HCHB	77,300.66	77,300.66	77,300.66	77,300.66	77,300.66	77,300.66
Administration-Wages	639,066.34	639,066.34	639,066.34	639,066.34	639,066.34	639,066.34
Administration-Benefits	106,220.58	106,220.58	106,220.58	106,220.58	106,220.58	106,220.58
Administration-Purchased Services	289,140.42	289,140.42	289,140.42	289,140.42	289,140.42	289,140.42
Administration-Insurance	22,162.69	22,162.69	22,162.69	22,162.69	22,162.69	22,162.69
Administration-Other	389,458.30	389,458.30	389,458.30	389,458.30	389,458.30	389,458.30
Total Administration	1,446,048.33	1,446,048.33	1,446,048.33	1,446,048.33	1,446,048.33	1,446,048.33
Marketing - Wages	179,293.15	179,293.15	179,293.15	179,293.15	179,293.15	179,293.15
Marketing - Benefits	27,717.09	27,717.09	27,717.09	27,717.09	27,717.09	27,717.09
Marketing - Other	9,275.79	9,275.79	9,275.79	9,275.79	9,275.79	9,275.79

Total Marketing	216,286.03	216,286.03	216,286.03	216,286.03	216,286.03	216,286.03
Occupancy - Utilities	3,452.87	3,453.87	3,454.87	3,455.87	3,456.87	3,457.87
Occupancy - Other						
Total Occupancy	3,452.87	3,453.87	3,454.87	3,455.87	3,456.87	3,457.87
SKAGIT HOSPICE CN						
Administrator			10,000.00	10,000.00	10,000.00	10,000.00
Business Office Manager, Medical Records, Scheduling			11,000.00	17,424.20	24,816.44	33,176.71
Intake			11,440.00	18,121.17	25,809.10	34,503.78
Community Liaison			14,300.00	22,651.46	32,261.37	43,129.73
Payroll Taxes & Benefits			14,022.00	20,459.05	27,866.07	36,243.07
Total			60,762.00	88,655.88	120,752.98	157,053.28
Advertising			7,911	6,194	8,822	11,795
Allocated Costs			21,253	33,666	47,948	64,101
B & O Taxes			6,376	10,100	14,384	19,230
Dues & Subscriptions			450	450	450	450
Education and trainings			1,000	1,000	1,000	1,000
Information Technology/Computer/Software Maintenance			1,500	1,500	1,500	1,500
Insurance			120	120	120	120
Legal and professional			-	-	-	-
Licenses and Fees			-	-	-	
Postage			600	600	600	600
Purchased services			1,200	1,200	1,200	1,200
Repairs and Maintenance			180	180	180	180
Cleaning			252	252	252	252
Office supplies			300	300	300	300
Equipment lease & maintenance			600	600	600	600
Building rent or lease			-	-	-	-
Lease NNN or Common Area Maintenance charges			-	-	-	-
Recruitment			5,000	3,000	3,000	3,000
Telephones			4,990	6,113	7,406	8,869
Travel			6,500	5,000	5,000	5,000
Subtotal			**58,232**	**70,275**	**92,763**	**118,197**
TOTAL INDIRECT COSTS			**118,994**	**158,931**	**213,516**	**275,250**

TOTAL COSTS			**393,082**	**593,092**	**831,870**	**1,101,917**
TOTAL INDIRECT COSTS	1,743,087.89	1,743,088.89	1,862,083.58	1,902,021.87	1,956,608.28	2,018,342.83
TOTAL COSTS	5,075,673.49	5,075,675.49	5,468,759.29	5,668,771.04	5,907,551.59	6,177,600.93
Bad Debt	422,727.83	422,728.83	422,729.83	422,730.83	422,731.83	422,732.83
TOTAL OPERATING EXPENSES	5,498,401.32	5,498,404.32	5,891,489.12	6,091,501.87	6,330,283.42	6,600,333.76
Service Center Allocation	325,681.91	325,682.91	325,683.91	325,684.91	325,685.91	325,686.91
EBITDAR	896,695.20	896,693.20	894,668.78	923,042.85	947,062.65	974,228.18
EBITDAR Margin	13.34%	13.34%	12.58%	12.58%	12.46%	12.33%
Occupancy- Rent	111,924.29	111,925.29	111,926.29	111,927.29	111,928.29	111,929.29
Total Property Expenses	111,924.29	111,925.29	111,926.29	111,927.29	111,928.29	111,929.29
EBITDA	784,770.91	784,767.91	782,742.49	811,115.56	835,134.36	862,298.89
EBITDA MARGIN	11.68%	11.68%	11.01%	11.05%	10.98%	10.91%
Depreciation and Amortization	2,878.72	2,879.72	4,213.72	4,214.72	4,216.72	2,883.72
Earnings Before Interest & Tax	781,892.19	781,888.19	778,528.77	806,900.84	830,917.64	859,415.17
Interest	164,233.40	164,234.40	164,235.40	164,236.40	164,237.40	164,238.40
Earnings Before Income Taxes	617,658.79	617,653.79	614,293.37	642,664.44	666,680.24	695,176.77
NET INCOME	617,658.79	617,653.79	614,293.37	642,664.44	666,680.24	695,176.77
Net Income Attributable to Consolidated	617,658.79	617,653.79	614,293.37	642,664.44	666,680.24	695,176.77

BALANCE SHEET- ALPHA HH&H + SKAGIT

For the Ten Months Ending Sunday, October 31, 2021

	October	12/31/2022	12/31/2023	12/31/2024	12/31/2025	12/31/2026
ASSETS						
CURRENT ASSETS						
CASH						
ACCOUNTS RECEIVABLE						
Medicare A	$1,317,282.54	$1,317,283.54	$1,317,284.54	$1,317,285.54	$1,317,286.54	$1,317,287.54
Medicaid	284,686.59	284,686.59	284,686.59	284,686.59	284,686.59	284,686.59
Private	3,434.46	3,434.46	3,434.46	3,434.46	3,434.46	3,434.46
Managed Care	825,828.94	825,828.94	825,828.94	825,828.94	825,828.94	825,828.94
Miscellaneous	2,035.84	2,035.84	2,035.84	2,035.84	2,035.84	2,035.84
Prebilled A/R	60,953.00	60,953.00	60,953.00	60,953.00	60,953.00	60,953.00
Clearing - Adjustments - Cornerstone	(102,180.99)	(102,180.99)	(102,180.99)	(102,180.99)	(102,180.99)	(102,180.99)
TOTAL ACCOUNTS RECEIVABLE	2,392,040.38	2,392,041.38	2,392,042.38	2,392,043.38	2,392,044.38	2,392,045.38
ALLOWANCE FOR DOUBTFUL ACCOUNTS						
Medicaid	(574,078.00)	(574,077.00)	(574,076.00)	(574,075.00)	(574,074.00)	(574,073.00)
TOTAL ALLOWANCE FOR DOUBTFUL ACCOUNTS	(574,078.00)	(574,077.00)	(574,076.00)	(574,075.00)	(574,074.00)	(574,073.00)
ACCOUNTS RECEIVABLE NET OF ALLOWANCE	1,817,962.38	1,817,962.38	1,817,962.38	1,817,962.38	1,817,962.38	1,817,962.38
PREPAID EXPENSES						
Prepaid Other	4,199.63	4,199.63	4,199.63	4,199.63	4,199.63	4,199.63
Prepaid Rent	3,148.50	3,148.50	3,148.50	3,148.50	3,148.50	3,148.50
TOTAL PREPAID EXPENSES	7,348.13	7,348.13	7,348.13	7,348.13	7,348.13	7,348.13
OTHER CURRENT ASSETS						
SUPPLIES						
INTERCOMPANY BALANCES						
Inter Company - SC due from Facility	37,497.70	37,498.70	37,499.70	37,500.70	37,501.70	37,502.70
NET INTERCOMPANY BALANCES	37,497.70	37,498.70	37,499.70	37,500.70	37,501.70	37,502.70
PREPAID EXPENSES AND OTHER CURRENT ASSETS	44,845.83	44,845.83	44,845.83	44,845.83	44,845.83	44,845.83
TOTAL CURRENT ASSETS	1,862,808.21	1,862,808.21	1,862,808.21	1,862,808.21	1,862,808.21	1,862,808.21
FIXED ASSETS						
Leasehold improvements	13,598.73	13,598.73	13,598.73	13,598.73	13,598.73	13,598.73
Computer Equipment	10,294.07	10,294.07	10,294.07	10,294.07	10,294.07	10,294.07

	23,892.80	23,892.80	23,892.80	23,892.80	23,892.80	23,892.80
ACCUMLATED DEPRECIATION						
Leasehold Improvements	(2,030.33)	(2,030.33)	(2,030.33)	(2,030.33)	(2,030.33)	(2,030.33)
Computer Equipment	(7,906.03)	(7,906.03)	(7,906.03)	(7,906.03)	(7,906.03)	(7,906.03)
TOTAL ACCUMLATED DEPRECIATION	(9,936.36)	(9,936.36)	(9,936.36)	(9,936.36)	(9,936.36)	(9,936.36)
FIXED ASSETS NET	13,956.44	13,956.44	13,956.44	13,956.44	13,956.44	13,956.44
ROU Asset-Op Lease (R/E)	514,853.51	514,853.51	514,853.51	514,853.51	514,853.51	514,853.51
ROU Asset A/D-Op Lease (R/E)	(124,921.84)	(124,921.84)	(124,921.84)	(124,921.84)	(124,921.84)	(124,921.84)
Op Lease Clearing	8,749.00	8,749.00	8,749.00	8,749.00	8,749.00	8,749.00
TOTAL ROU ASSETS	398,680.67	398,680.67	398,680.67	398,680.67	398,680.67	398,680.67
Goodwill	1,363,500.00	1,363,500.00	1,363,500.00	1,363,500.00	1,363,500.00	1,363,500.00
Tradename	36,600.00	36,600.00	36,600.00	36,600.00	36,600.00	36,600.00
MCare License	1,249,900.00	1,249,900.00	1,249,900.00	1,249,900.00	1,249,900.00	1,249,900.00
INTANGIBLE AND OTHER ASSETS, NET	2,650,000.00	2,650,000.00	2,650,000.00	2,650,000.00	2,650,000.00	2,650,000.00
Deposits Rent	727.00	727.00	727.00	727.00	727.00	727.00
Restricted & Other Assets	727.00	727.00	727.00	727.00	727.00	727.00
TOTAL OTHER LONG TERM ASSETS	2,650,727.00	2,650,727.00	2,650,727.00	2,650,727.00	2,650,727.00	2,650,727.00
SKAGIT CN TOTAL ASSETS			**18,968**	**54,879**	**117,171**	**209,699**
TOTAL ASSETS	4,926,172.32	4,926,172.32	4,945,140.02	4,981,051.03	5,043,343.03	5,135,871.77
LIABILITIES AND STOCKHOLDERS' EQUITY						
CURRENT LIABILITIES						
TRADE ACCOUNTS PAYABLE						
Accounts payable - trade	51,631.95	51,631.95	51,631.95	51,631.95	51,631.95	51,631.95
Accrued AP	98,264.51	98,264.51	98,264.51	98,264.51	98,264.51	98,264.51
TOTAL TRADE PAYABLES	149,896.46	149,896.46	149,896.46	149,896.46	149,896.46	149,896.46
ACCRUED WAGES AND RELATED LIABILITIES						
Accrued Payroll	218,508.91	218,508.91	218,508.91	218,508.91	218,508.91	218,508.91
Payroll Clearing	55.91	55.91	55.91	55.91	55.91	55.91
Federal Payroll Taxes Payable	104,587.63	104,587.63	104,587.63	104,587.63	104,587.63	104,587.63
Deferred Payroll FICA Emergency	42,543.08	42,543.08	42,543.08	42,543.08	42,543.08	42,543.08
Accrued Vacation	58,768.11	58,768.11	58,768.11	58,768.11	58,768.11	58,768.11
TOTAL ACCRUED WAGES AND RELATED LIABILITIES	424,463.64	424,463.64	424,463.64	424,463.64	424,463.64	424,463.64
Op Lease Liability ST						
TOTAL CURRENT OP LEASE LIABILITIES	0.00	0.00	0.00	0.00	0.00	0.00

OTHER ACCRUED LIABILITIES						
Deferred Revenue	69,122.92	69,122.92	69,122.92	69,122.92	69,122.92	69,122.92
Accrued Insurance Premiums	5,161.15	5,161.15	5,161.15	5,161.15	5,161.15	5,161.15
Sales/Excise/B&O TAXES PAYABLE	30,735.90	30,735.90	30,735.90	30,735.90	30,735.90	30,735.90
Unprocessed Patient Refunds	60,157.00	60,157.00	60,157.00	60,157.00	60,157.00	60,157.00
Deferred Income Taxes						
Facility Fund	200.00	200.00	200.00	200.00	200.00	200.00
TOTAL OTHER ACCRUED LIABILITIES	165,376.97	165,376.97	165,376.97	165,376.97	165,376.97	165,376.97
TOTAL CURRENT LIABILITIES	739,737.07	739,737.07	739,737.07	739,737.07	739,737.07	739,737.07
LONG TERM DEBT						
Op Lease Liability LT	531,680.70	531,680.70	531,680.70	531,680.70	531,680.70	531,680.70
Op Lease Liability A/D	(133,465.01)	(133,465.01)	(133,465.01)	(133,465.01)	(133,465.01)	(133,465.01)
Total Long Term Op Lease Liabilities	398,215.69	398,215.69	398,215.69	398,215.69	398,215.69	398,215.69
TOTAL LONG TERM LIABILITIES	398,215.69	398,215.69	398,215.69	398,215.69	398,215.69	398,215.69
TOTAL LIABILITIES	1,137,952.76	1,137,952.76	1,137,952.76	1,137,952.76	1,137,952.76	1,137,952.76
STOCKHOLDERS' EQUITY						
Spin RE Adjust - Adj	3,133,641.21	3,133,641.21	3,133,641.21	3,133,641.21	3,133,641.21	3,133,641.21
	3,133,641.21	3,133,641.21	3,133,641.21	3,133,641.21	3,133,641.21	3,133,641.21
Retained Earnings, Prior Year	36,919.56	36,919.56	36,919.56	36,919.56	36,919.56	36,919.56
Current Year Income	781,892.19	781,892.19	781,892.19	781,892.19	781,892.19	781,892.19
Current Year Income	617,658.79	617,658.79	617,658.79	617,658.79	617,658.79	617,658.79
Total Stockholders' Equity	3,788,219.56	3,788,219.56	3,788,219.56	3,788,219.56	3,788,219.56	3,788,219.56
TOTAL SKAGIT LIABILITIES AND EQUITY			18,967.70	54,878.71	117,170.71	209,699.45
TOTAL LIABILITIES AND STOCKHOLDERS' EQUITY	4,926,172.32	4,926,172.32	4,945,140.02	4,981,051.03	5,043,343.03	5,135,871.77
	0.00	0.00	0.00	0.00	0.00	0.00

CORNERSTONE HEALTHCARE INC +
SKAGIT 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				**391,059.38**	**619,445.20**	**882,245.55**	**1,179,460.42**
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	312,029,685.74	312,258,071.56	312,520,871.91	312,818,086.78
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				79,200.00	125,454.25	178,678.36	238,872.33
Certified Nursing Assistant				20,592.00	32,618.10	46,456.37	62,106.81
Licensed Clinical Social Worker				15,620.00	24,742.37	35,239.34	47,110.93
Spiritual Care Coordinator				12,320.00	19,515.11	27,794.41	37,157.92
Director of Clinical Services				18,150.00	28,749.93	40,947.12	54,741.58
Payroll Taxes & Benefits				43,764.60	69,323.93	98,734.68	131,996.87
Medical Director				11,286.00	17,877.23	25,461.67	34,039.31
Physical Therapist				251.74	398.76	567.93	759.26
Occupational Therapist				233.20	369.40	526.12	703.36

Speech Therapist				211.17	334.49	476.40	636.89
Dietitian				197.74	313.23	446.12	596.40
DME				14,550.36	23,048.04	32,826.19	43,884.83
Pharmacy				17,079.81	27,054.73	38,532.73	51,513.81
General Inpatient Costs				7,657.15	12,129.07	17,274.84	23,094.47
Medical Supplies				6,239.31	9,883.18	14,076.13	18,818.16
Inpatient Respite				16,978.58	26,894.38	38,304.35	51,208.50
Room and Board				1,084.05	1,717.16	2,445.66	3,269.57
Mileage				8,672.40	13,737.24	19,565.28	26,156.52
TOTAL DIRECT COSTS-CN HOSPICE				**274,088.11**	**434,160.58**	**618,353.71**	**826,667.50**
TOTAL DIRECT COSTS	131,978,121.51	165,655,008.16	165,655,008.16	165,929,096.27	166,089,168.73	166,273,361.86	166,481,675.66
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				10,000.00	10,000.00	10,000.00	10,000.00
Business Office Manager, Medical Records, Scheduling				11,000.00	17,424.20	24,816.44	33,176.71
Intake				11,440.00	18,121.17	25,809.10	34,503.78
Community Liaison				14,300.00	22,651.46	32,261.37	43,129.73
Payroll Taxes & Benefits				14,022.00	20,459.05	27,866.07	36,243.07

Advertising				7,910.59	6,194.45	8,822.46	11,794.60
Allocated Costs				21,253.23	33,665.50	47,948.13	64,101.11
B & O Taxes				6,375.97	10,099.65	14,384.44	19,230.33
Dues & Subscriptions				450.00	450.00	450.00	450.00
Education and trainings				1,000.00	1,000.00	1,000.00	1,000.00
Information Technology/Computer/Software Maintenance				1,500.00	1,500.00	1,500.00	1,500.00
Insurance				120.00	120.00	120.00	120.00
Legal and professional				0.00	0.00	0.00	0.00
Licenses and Fees				0.00	0.00	0.00	0.00
Postage				600.00	600.00	600.00	600.00
Purchased services				1,200.00	1,200.00	1,200.00	1,200.00
Repairs and Maintenance				180.00	180.00	180.00	180.00
Cleaning				252.00	252.00	252.00	252.00
Office supplies				300.00	300.00	300.00	300.00
Equipment lease & maintenance				600.00	600.00	600.00	600.00
Building rent or lease				0.00	0.00	0.00	0.00
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				4,989.90	6,113.49	7,406.40	8,868.61
Travel				6,500.00	5,000.00	5,000.00	5,000.00
TOTAL INDIRECT COST-CN HOSPICE				**118,993.69**	**158,930.98**	**213,516.39**	**275,249.94**
TOTAL INDIRECT COSTS	73,477,101.29	89,716,217.62	89,716,217.62	89,835,211.31	89,875,148.60	89,929,734.01	89,991,467.56
TOTAL COSTS	205,455,222.79	255,371,225.78	255,371,225.78	255,764,307.58	255,964,317.33	256,203,095.88	256,473,143.22
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	255,776,060.71	255,976,070.46	256,214,849.01	256,484,896.35
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	39,758,775.33	39,787,151.40	39,811,173.20	39,838,340.73
EBITDAR Margin	14.18%	12.76%	12.76%	12.74%	12.74%	12.74%	12.74%
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	34,768,583.86	34,796,959.93	34,820,981.73	34,848,149.26
EBITDA MARGIN	12.70%	11.16%	11.16%	11.14%	11.14%	11.14%	11.14%
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	33,324,953.36	33,353,329.43	33,377,350.23	33,404,518.76
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	25,339,891.37	25,368,267.44	25,392,288.24	25,419,456.77
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	25,338,291.37	25,366,667.44	25,390,688.24	25,417,856.77

CORNERSTONE HEALTHCARE INC +
SKAGIT 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				**(42,776)**	**(30,397)**	**4,616**	**64,786**
Petty Cash	2,762	2,762	2,762	2,762	2,762	2,762	2,762
TOTAL CASH	2,762	2,762	2,762	(40,014)	(27,635)	7,378	67,548
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				**44,351**	**70,252**	**100,057**	**133,764**
TOTAL ACCOUNTS RECEIVABLE	43,197,174	49,791,505	49,791,505	49,835,855	49,861,757	49,891,562	49,925,269

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				**(1,774)**	**(2,810)**	**(4,002)**	**(5,351)**
TOTAL ALLOWANCE FOR DOUBTFUL ACCOUNTS	116,325	(340,535)	(340,535)	(342,309)	(343,345)	(344,537)	(345,885)
ACCOUNTS RECEIVABLE NET OF ALLOWANCE	43,313,499	49,450,970	49,450,970	49,493,547	49,518,412	49,547,025	49,579,384
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				-	-	-	-
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	544,432	544,432	544,432	544,432
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)	(6,809,730)	(6,809,730)	(6,809,730)	(6,809,730)
TOTAL CURRENT ASSETS	67,327,761	42,644,002	42,644,002	42,643,803	42,681,047	42,744,673	42,837,202
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				-	-	-	-
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	7,312,775	7,312,775	7,312,775	7,312,775
TOTAL OTHER LONG TERM ASSETS	131,035,729	144,838,714	144,838,714	144,857,881	144,856,548	144,855,214	144,855,214
TOTAL ASSETS	198,363,491	187,482,716	187,482,716	187,501,684	187,537,595	187,599,887	187,692,415.7
LIABILITIES AND STOCKHOLDERS' EQUITY							
CURRENT LIABILITIES							
TRADE ACCOUNTS PAYABLE							
Accounts payable - trade **(INCLUDES CN)**	452,260	643,623.48	643,623.48	**655,513**	**660,626**	**667,229**	**674,697**
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)	(10,756,915)	(10,751,802)	(10,745,199)	(10,737,731)
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				**10,434**	**16,211**	**22,858**	**30,377**
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	17,853,054	17,858,831	17,865,479	17,872,997
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	21,443,136	21,454,027	21,467,277	21,482,263
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	31,890,169	31,901,059	31,914,310	31,929,296

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**	**30,612,433**	**30,637,454**	**30,686,496**
Total Stockholders' Equity	26,231,712	21,141,624	21,141,624	**21,138,268**	**21,166,644**	**21,190,665**	**21,219,167**
TOTAL LIABILITIES AND STOCKHOLDERS' EQUITY	134,470,157	155,614,870	155,614,870	155,611,515	155,636,535	155,685,577	155,763,120
	198,363,491	187,482,716	187,482,716	187,501,684	187,537,595	187,599,887	187,692,415.7
	-	-	-	-	-	-	-

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

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
	-	-	-	-	-	-	-

NHPCO *Original Article*

Comparing Hospice and Nonhospice Patient Survival Among Patients Who Die Within a Three-Year Window

Stephen R. Connor, PhD, Bruce Pyenson, FSA, MAAA,
Kathryn Fitch, RN, MA, MEd, Carol Spence, RN, MS,
and Kosuke Iwasaki, FIAJ, MAAA
National Hospice and Palliative Care Organization (S.R.C., C.S.), Alexandria, Virginia; and Milliman, Inc. (B.P., K.F., K.I.), New York, New York, USA

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

This study was sponsored by the National Hospice and Palliative Care Organization.

Address reprint requests to: Stephen R. Connor, PhD, National Hospice and Palliative Care Organization, 1700 Diagonal Road, Suite 625, Alexandria, VA 22314, USA. E-mail: sconnor@nhpco.org

Accepted for publication: October 13, 2006.

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

0885-3924/07/$–see front matter
doi:10.1016/j.jpainsymman.2006.10.010

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

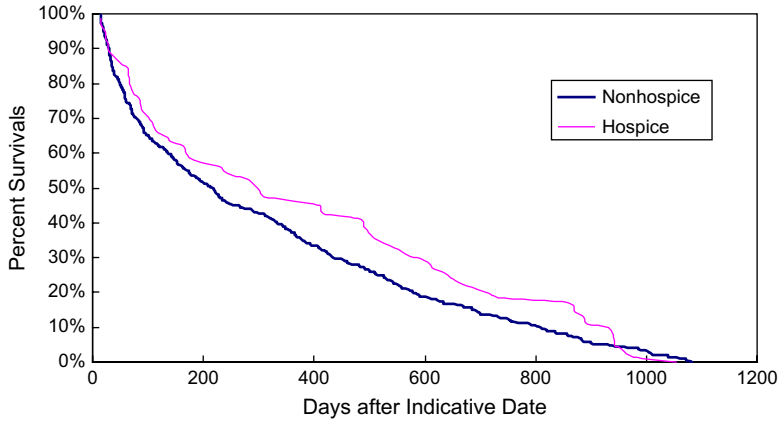


Fig. 1. Survival curve for patients with CHF.

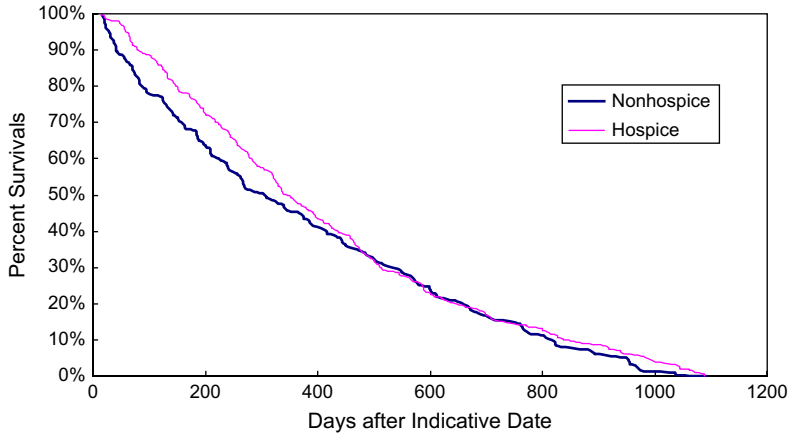


Fig. 2. Survival curve for patients with colon cancer.

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.

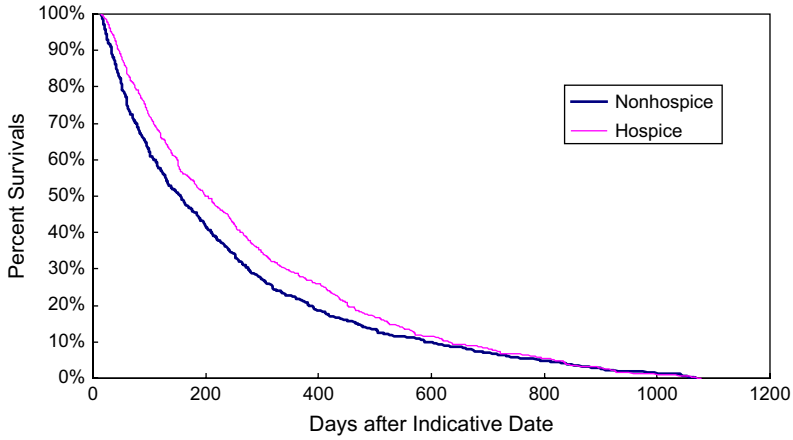


Fig. 3. Survival curve for patients with lung cancer.

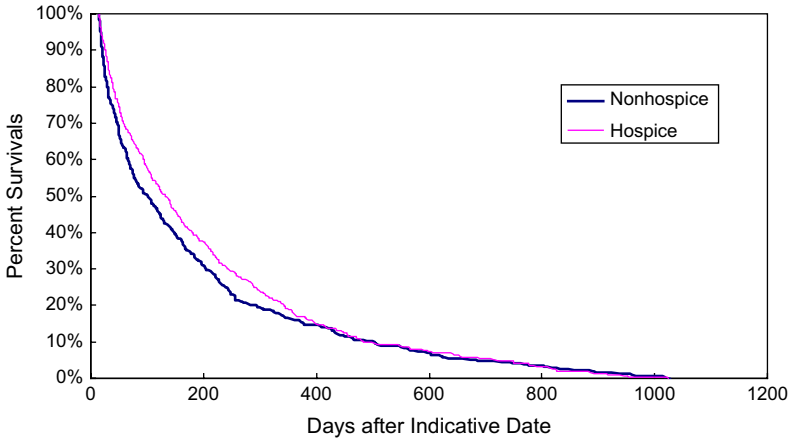


Fig. 4. Survival curve for patients with pancreatic cancer.

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

The authors gratefully acknowledge the support of the National Hospice and Palliative Care Organization in funding this project.

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.

Death and dying in the US: the barriers to the benefits of palliative and hospice care

Albert J Finestone
Gail Inderwies

School of Medicine, Temple University, Philadephia, PA, USA

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

Correspondence: Albert J Finestone
Director, Institute on Aging, Geriatric Education Center, Temple University, Philadephia PA, USA
Tel +1 215 707 4741
Fax +1 215 707 3675

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.

Hospice Utilization in the United States: A Prospective Cohort Study Comparing Cancer and Noncancer Deaths

John G. Cagle, PhD, MSW, Joonyup Lee, MSW,* Katherine A. Ornstein, PhD,† and Jack M. Guralnik, MD, PhD‡*

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.

From the *University of Maryland, School of Social Work, Baltimore, Maryland; †Icahn School of Medicine at Mount Sinai, New York, New York; and the ‡University of Maryland, School of Medicine, Baltimore, Maryland.

Address correspondence to John G. Cagle, PhD, MSW, School of Social Work, University of Maryland, Baltimore, 525 West Redwood Street, 3W13, Baltimore, MD 21201. E-mail: jcagle@ssw.umaryland.edu

DOI: 10.1111/jgs.16294

0002-8614/20/$15.00

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

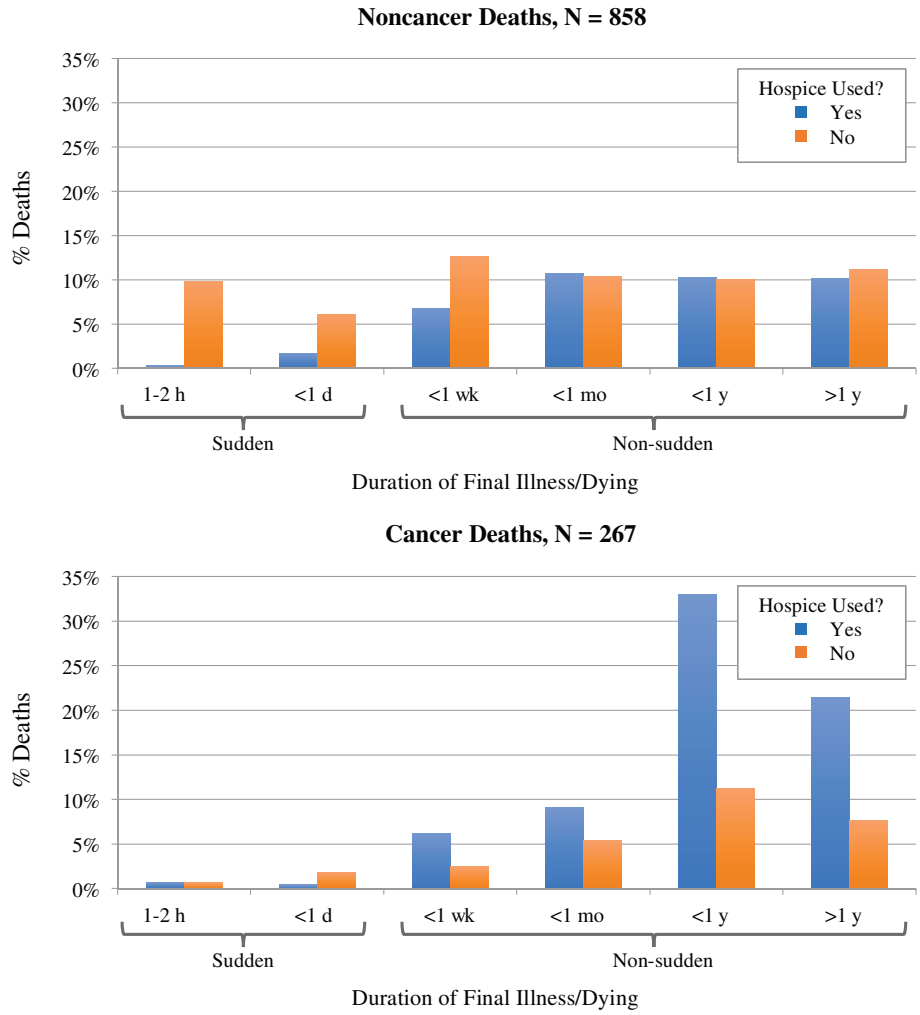


Figure 1. Distribution of deaths according to duration of final illness and hospice use.

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.

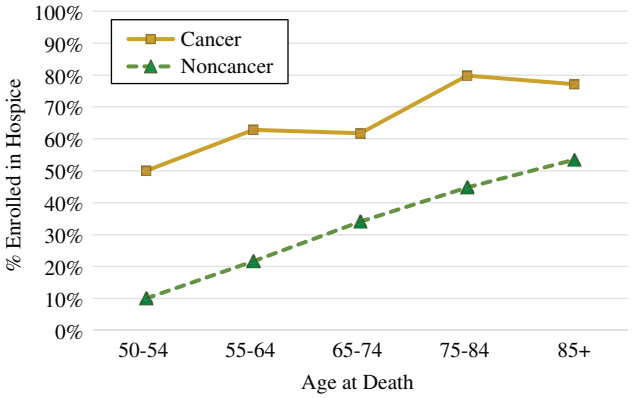


Figure 2. Hospice utilization rate across age groups: cancer vs noncancer deaths. [Color figure can be viewed at wileyonlinelibrary.com]

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]

ACKNOWLEDGMENTS

We would like to thank John T. Lemm, MD, and Karthik Raghunathan, MD, who read and provided helpful feedback on an early draft of this article.

Financial Disclosure: U.S. Department of Health and Human Services National Institutes of Health National Institute on Aging NIA U01AG009740.

Conflict of Interest: The authors have declared no conflicts of interest for this article.

Author Contributions: All authors contributed to the study design, analysis, interpretation of data, and development of the manuscript. John G. Cagle takes full responsibility for the accuracy of the information reported in this report.

Sponsor's Role: Funders had no role in study development, execution, or dissemination of results. Health and Retirement Study data are publicly available. The protocol and data are produced and distributed by the University of Michigan with funding from the National Institute on Aging (NIA U01AG009740), http://hrsonline.isr.umich.edu.

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

Bruce Pyenson, FSA, MAAA, Stephen Connor, PhD, Kathryn Fitch, RN, MA, Med, and Barry Kinzbrunner, MD
Milliman, Inc. (B.P., K.F.), New York, New York; National Hospice and Palliative Care Organization (S.C.), Alexandria, Virginia; and VITAS Healthcare Corporation (B.K.), Miami, Florida, USA

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

Address reprint requests to: Bruce Pyenson, FSA, MAAA, Principal and Consulting Actuary, Milliman USA, Inc., One Pennsylvania Plaza, New York, NY 10119, USA.

Accepted for publication: May 28, 2004.

0885-3924/04/$–see front matter
doi:10.1016/j.jpainsymman.2004.05.003

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.

Community Health Needs Assessment Report
Skagit County Public Hospital District No. 2
DBA: Island Hospital
Anacortes, Washington

Published December 18, 2019

Introduction

Skagit County Public Hospital District No. 2 (DBA: Island Hospital) is the center for health and wellness in western Skagit County. Since 1962, our award-winning hospital has focused on providing the community with the latest in technological advances and medical innovations. With over 190 physicians and healthcare providers, we are proud to offer a wide range of comprehensive services that are sure to fit your needs.

Island Hospital is a public hospital district, comprising boundaries include Fidalgo, Cypress, Guemes and Sinclair Islands. We have five publicly elected Commissioners, who govern our hospital district to ensure best practices are fairly enforced, monitor facility upgrades and see to the enhancement of community services offered to residents of our district. Island Hospital employs more than 750 staff members and has five family care clinics, as well as six specialty clinics. We are designated as a Level III trauma facility with a Level II stroke center. We have 43 patient beds, including six intensive-care, six labor and delivery, and 31 medical/surgical beds.

Our Promise

Your best health care experience begins at Island Hospital. We always place your emotional and medical needs first and foremost.

Our Mission

We will deliver quality, compassionate and personalized health care to the communities we serve.

Our Vision

Through collaboration with our physicians, staff and community we will develop innovative programs and provide medical services that enhance patient experiences and outcomes.

Our history began in 1958, when Skagit Public Hospital District No. 2 was founded. The first patients were admitted to Island Hospital in 1962. The hospital underwent significant expansion and/or renovations in 1990 (Emergency Department), 1996 (surgery, birth center and health resource center), 1998 (Medical Office Building), 2008 (renovation and expansion), 2009 (Sleep Wellness Center) and 2012 (Medical Arts Pavilion housing Cancer Care, Physical Therapy and Wound Care).

Services

Island Hospital offers a full range of comprehensive medical services and support programs for your health care needs. Our medical staff is highly trained and specialized to provide the highest quality of care to our patients. In addition, as a commitment to the total well-being of each patient, Island Hospital offers a number of support programs to complement the medical services provided. Our Medical Services:

- Birth Center
- Cancer Care Center
  - Chemotherapy
  - Blood Product Transfusion
  - Non-Chemotherapy Medication
  - Personalized Genome Therapy
- Cardiac Rehabilitation for the following procedures:
  - Bypass Surgery
  - Valve Replacement/Repair
  - Angioplasty or Stent Procedures
  - Heart Transplant
- Diabetes Education
- Diagnostic Imaging
  - X-rays, MRIs, PET & Ultrasound
  - Interventional Radiology
  - Mammography
  - Nuclear Medicine
- Emergency Services
- Family Medicine
- Gynecology
- Headache Clinic
- Internal Medicine
- Laboratory
- Neurological Rehabilitation
- Obstetrics
- Occupational Therapy
- Pediatrics
- Physical Therapy
- Psychiatry & Behavioral Health
- Pulmonary Rehabilitation
- Respiratory Care
- Sleep Wellness Center
- Speech Therapy
- Sports & Spine
  - Interventional Spine Procedures
  - Ultrasound-Guided Diagnoses
  - Electro-Diagnostic Testing
  - Nerve-Root Blocks
  - Facet Medical Branch Rhizotomy
- Surgery (Inpatient & Outpatient)
- Wound Care & Hyperbaric Medicine

Honors

Our goal at Island Hospital is to achieve the highest possible quality of care and continue to improve our patient, staff and physician satisfaction. Island Hospital will always work toward our highest levels of performance quality and safety. Island Hospital has won a number of awards

over the years for our high-quality of service and patient satisfaction. The following are some of our highlights in recent years:

- In 2019, Island Hospital received a four-star rating by Medicare based on patient's survey.
- Island Hospital was No. 1 in Washington State for lowest readmission rates in 2015.
- According to an Article in the Seattle Post-Intelligencer (PI)[1], Island Hospital ranked 5th in Washington State for earning high scores for quality from Medicare patients who received care in 2015. In the survey, 78% of Island Hospital's patients scored their care as a 9 or 10.
- Island Hospital's Psychiatry & Behavioral Health program received national honors as one of ten programs to be awarded $10,000 by Jackson Healthcare for impacting underserved communities.
- The Psychiatry & Behavioral Health program was recognized for community impact and innovation by Intalere (formerly Amerinet).

Island Hospital is proud to be an accredited DNV hospital.

Other Facilities
Island Hospital is the primary facility of Skagit County Public Hospital District No. 2, a government-owned Public Hospital District. Island Hospital operates five family care clinics and six specialty clinics offering a wide range of services to the communities we serve.

Family Care Clinics:

- Anacortes Family Medicine
- Center for Maternal and Infant Care
- Fidalgo Medical Associates
- Teen Clinic
- The Walk-In Clinic

Specialty Clinics:

- Headache Clinic
- Island Surgeons
- Psychiatry & Behavioral Health
- Sleep Wellness Center
- Sports & Spine
- Wound Care & Hyperbaric Medicine

[1] "How Patients Rank Washington's Hospitals", Seattle Post-Intelligencer (PI), August 23, 201

Community Health Needs Assessment

Island Hospital is pleased to submit this Community Health Needs Assessment. We do so both as a matter of compliance with Section 501(r)(3) of the Internal Revenue Code, as mandated in the Patient Protection and Affordable Care Act, and as an obligation to those we serve. As an organization, we have taken this change in law as an opportunity to improve our community service and continuously focus on meeting the changing health care needs of our community.

Consistent with the requirements of Section 501(r)(3), the Community Health Needs Assessment Report is organized as follows:

- Our Community
- Review of Previous Community Health Needs Assessments
- Community Health Needs Assessment Methodology
- Prioritized Significant Community Health Needs
- Conclusion
- Appendix - Community Health Resources

Our Community

Island Hospital is located in the city of Anacortes in Skagit County, Washington. However, we have historically defined our "community" as a broader area, including west Skagit County, north Whidbey Island and the San Juan Islands. Based on inpatient and outpatient usage in recent years, our primary service area includes the following zip codes:

- 98221
- 98232
- 98233
- 98239
- 98245
- 98250
- 98257
- 98261
- 98273
- 98277
- 98279
- 98280

Approximately 90.1% of our outpatient usage and 86.1% of our inpatient usage is from individuals living within this primary service area. The remaining usage is from individuals living in the broader community as well as individuals vacationing near Anacortes. Throughout this document, all references to our community refer to these twelve zip codes.

One special aspect of our community is its location on Puget Sound. The San Juan Islands lie within a rain shadow cast by the nearby Cascade Mountains on the Olympic Peninsula. The result is that the islands receive approximately half of the annual rainfall of Seattle, which is only 80 miles south, and experience about 250 sunny days per year. Because of this, our coastal region and islands are a popular vacation destination and retirement area. In addition to the beautiful weather, the islands are relatively undeveloped and sparsely populated. The islands are primarily accessible by boat, although travel by plane or helicopter is also possible. For those who travel by ferry, the primary access location is Anacortes. The islands and coast are a sharp contrast to the inland community, including the relatively large city of Mount Vernon, whose economy is largely based on manufacturing and agriculture.

For demographic information, Skagit and San Juan Counties are a close approximation of our community. In 2010, the U.S. Census Bureau conducted the nation's most recent census and published that data by state, county and city. Similarly the Population Health Institute collects and reports health data and demographic data by county on an annual basis.

Demographic Comparison of Washington State, Skagit County and San Juan County

	Wash. State 2015	Wash. State 2018		Skagit County 2015	Skagit County 2018		San Juan County 2015	San Juan County 2018
Population	7,170,351	7,535,591		121,846	128,206		16,252	17,128
Age < 18	22.5%	22.1%		22.3%	21.8%		13.8%	13.0%
Age 65+	14.4%	15.4%		19.3%	20.7%		30.6%	34.1%
Female	50.0%	50.0%		50.4%	50.4%		51.6%	51.6%
Caucasian	80.3%	78.9%		90.7%	90.3%		94.3%	93.9%
African American	4.1%	4.3%		1.0%	1.1%		0.6%	0.8%
American Indian	1.9%	1.9%		2.8%	2.7%		0.9%	1.0%
Asian	8.4%	9.3%		2.3%	2.4%		1.5%	1.5%
Hispanic	12.4%	12.9%		17.9%	18.7%		6.1%	6.7%
Rural	16.0%	16.0%		29.0%	29.0%		100.0%	100.0%
Per Capita Income	$31,233	$34,869		$27,598	$30,069		$38,556	$40,784
Uninsured Adults	19.5%	9.0%		22.8%	12.0%		24.7%	11.0%
Children in Poverty	18.6%	14%		21.5%	16%		18.1%	15%
Unemployment Rate	7.0%	4.8%		8.3%	5.5%		5.9%	3.9%

San Juan County comprises the four largest of the San Juan Islands as well as many other smaller islands. As previously indicated, part of the islands' unique nature is their low population density and underdeveloped environment. Skagit County includes Anacortes on the western edge and extends approximately 95 miles inland into the Cascade Mountains. While Skagit County has a much larger population than San Juan County, approximately half of that population lives in and around Mount Vernon, on the edge of our community. Because Skagit County Hospital District No. 1 (DBA: Skagit Valley Hospital) is based in Mount Vernon, many of the individuals in that area tend to utilize Skagit Valley Hospital as their primary health care resource.

The residents of San Juan and Skagit Counties have very different economic situations. Per capita income in Skagit County ($30,069 in 2018) is consistently below the state average ($34,869 in 2018), while it is drastically higher than the state average in San Juan County ($40,784 in 2018). The income gap between Skagit County and the state worsened between 2015 and 2018. Skagit County's per capita income was 11.6% below the state average in 2015 while it was 13.8% below the state average in 2018. However, the income gap between the two counties slightly improved in the same period, from a 28.4% difference in 2015 to a 26.3% difference in 2018, although the size of the difference further emphasizes the economic difference between the counties. Additionally, Skagit County had a higher unemployment rate (5.5%) than the state (4.8%) in 2018 while San Juan County has a below-average unemployment rate (3.9%), although all of those rates decreased significantly between 2015 and 2018. Finally, Skagit County has higher rates of uninsured adults and children in poverty, although both counties and the state saw significant improvements in these rates between 2015 and 2018.

Change in Age Distributions

	Percentage Under Age 18				Percentage Age 65+		
	2015	**2018**	**Change**		**2015**	**2018**	**Change**
Washington State	22.5%	22.1%	-1.81%		14.4%	15.4%	6.49%
Skagit County	22.3%	21.8%	-2.29%		19.3%	20.7%	6.76%
San Juan County	13.8%	13.0%	-6.15%		30.6%	34.1%	10.26%

Compared to Washington State, Skagit County has approximately the same percentage of youth while San Juan County has a significantly lower percentage of youth. Additionally, while both counties have higher percentages of elderly adults than the state, the rate in San County (34.1% in 2018) was significantly higher than in Skagit County (20.7% in 2018). All three geographic areas experienced the same trend between 2015 – a decrease in the percentage of youth and an increase in the percentage of elderly adults – although both trends were more drastic in San Juan County. San Juan County's more extreme figures are likely due to the county's popularity as a retirement area as well as its extremely rural nature that limits social, cultural and educational opportunities for youth.

Both counties have less cultural diversity than Washington State, although diversity remained relatively similar for both counties between 2015 and 2018. Both counties have below-average rates for most ethnicities – Hispanics in Skagit County being the major exception, since that is higher than the state average – with less cultural diversity in San Juan County than in Skagit County. Between 2015 and 2018, the percentage of Caucasians decreased in each county with the percentages of most other races slightly increasing.

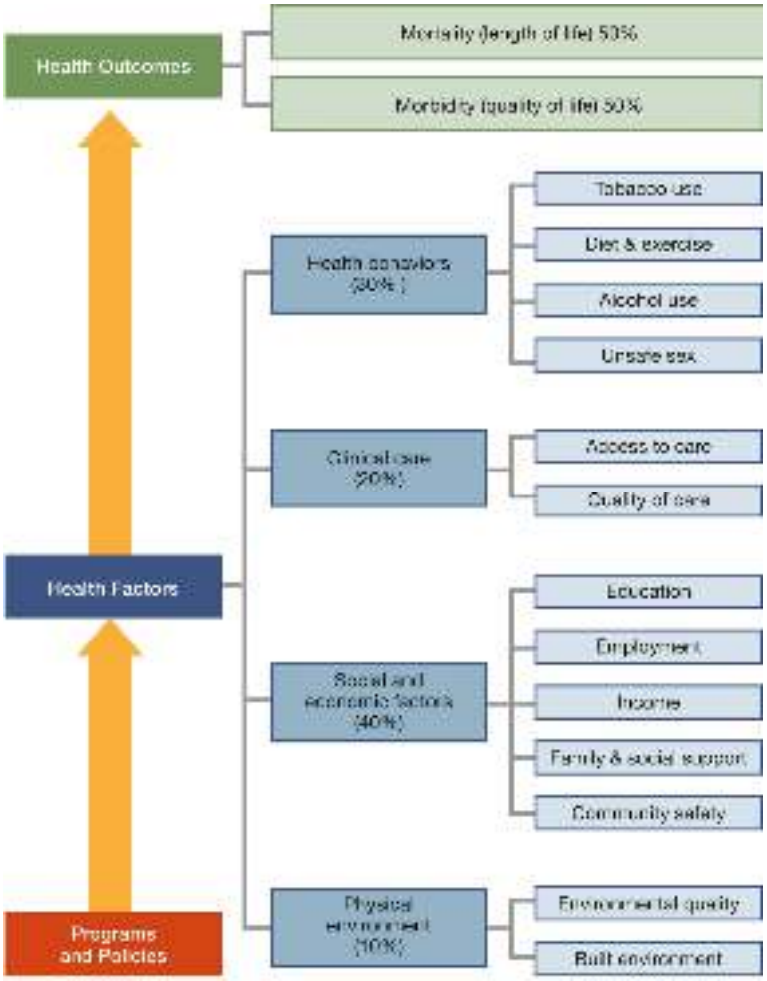
The Native American population in Skagit County is comprised primarily of three tribes—Samish, Swinomish and Upper Skagit—although the Upper Skagit Tribe is generally outside of our community. While the Swinomish and Upper Skagit Tribes each have a reservation that provides a geographic center for their communities, the Samish do not yet have a reservation and the related central population base. Samish covers the health needs of their membership across a ten-county service delivery area with an outreach model from Indian Health Service Purchased and Referred Care. Samish tribal members seek care through their own health providers with preauthorization from the Tribe and receive relevant health information via newsletters, health fairs, and other strategies to promote health and prevent chronic diseases.

Information about the tribes in our community is available online:

Samish Indian Nation: www.samishtribe.nsn.us
Swinomish Indian Tribal Community: www.swinomish-nsn.gov

The Hispanic population in our community tends to focus around Mount Vernon. This is likely related to the higher prevalence of agricultural work in that area as well. However, there is also a small Hispanic community on the San Juan Islands. The Hispanic community is comprised of both legal and illegal immigrants. The community also includes many individuals who speak fluent English and many individuals who speak little to no English. As indicated above, Skagit Valley Hospital tends to be the primary health care resource for the Hispanic individuals in that area.

The Population Health Institute ("PHI") publishes annual health data for every county in the United States. The data is aggregated into health outcomes and health factors. The PHI separates health outcomes into mortality (length of life) and morbidity (quality of life). Health factors are separated into four factors that largely influence the health outcomes: health behaviors, clinical care, social and economics, and physical environment.



County Health Rankings

	Skagit County			San Juan County	
	2016	**2019**		**2016**	**2019**
Health Behaviors	17	18		1	2
Clinical Care	16	16		4	9
Social & Economic Factors	22	22		11	1
Physical Environment	39	25		33	9
Overall Health Factors	**23**	**23**		**3**	**2**
Mortality (length of life)	19	19		5	4
Morbidity (quality of life)	10	13		1	1
Overall Health Outcomes	**13**	**19**		**1**	**1**

In 2016, San Juan County's health factors ranked 3rd and Skagit County's ranked 23rd out of 39 counties in Washington. In the same year, San Juan County's health outcomes ranked 1st while Skagit County's health outcomes ranked 13th. Between 2016 and 2019, San Juan County's health factor ranking increased from 3rd to 2nd in the state and Skagit County's health factor ranking remained the same at the 23rd. In the same period, San Juan County's health outcome ranking remained the same on 1st place and Skagit County's health outcome ranking worsened from 13th to 19th.

The extremely positive rankings for San Juan County reflect the local culture of a natural, outdoor lifestyle and generally healthy eating. The islands are well known for this environment, so they attract individuals with a similar mindset. Because health factors tend to lead to health outcomes, San Juan County's positive health factors today are likely to lead to positive future health outcomes.

Skagit County's rankings remained relatively similar between 2016 and 2019. Compared to the islands, our inland residents are currently suffering from unhealthy historic behaviors, and environmental factors. Skagit County's lower ranking in health factors indicates that those community members are likely to continue this pattern in the future unless we can make significant changes in their health factors.

Review of Previous Community Health Needs Assessments

Island Hospital conducted community health needs assessments in 2013 and 2016 and published the related reports in December 2013 and 2016, respectively. In those assessments, the following needs were identified:

2013 Assessment

- Behavioral Health
- Access to Health Care
- Obesity

2016 Assessment

- Behavioral Health
- Access to Health Care
- Chronic Diseases

A copy of the 2016 Community Health Needs Assessment Report is available on Island Hospital's website at https://www.islandhospital.org/publicdocuments.

In May 2017 the Implementation Strategy was published for the 2016 Assessment. Since then, Island Hospital has initiated the following programs/initiatives as an opportunity to improve our community services and continuously focus on meeting the changing health care needs of our community.

Behavioral Health

- Placed mental health counselors in Anacortes High School and Middle School to serve the students by providing confidential and free mental health services.
- Began Behavioral Health Integration Program, BHIP, which is the integration of mental health into the Family Practice Clinics.

- Recruited second Psychiatrist to the established practice which expanded access to specialty care and chronic care providers.
- Gathered data and evaluated needs related to behavioral health patients in the Emergency Department, leading to a grant request for a 7 day per week presence of a Medical Social Worker (MSW) in the ED. This grant through the IH Foundation was awarded for 5 years beginning in 2020, supporting this critical program for our community into the future.

Access to Health Care

- Realigned primary care providers by practice specialty to improve access, improve workflows and enhance the patient experience.
- Developed a dedicated call center to address high volume call clinics improving scheduling services and customer satisfaction.
- Recruited eighteen (18) new providers, both physicians and advance practice clinicians to Island Hospital Primary Care Clinics & Specialty Care Clinics in order to improve access and expand the provider offerings to meet the individual needs of our community members.
    - Family Practice-7 providers
    - General Surgeons-2 providers
    - Pediatrician-1 provider
    - OB/GYN-1 provider
    - Sleep Wellness-1 provider
    - Wound Care-1 provider
    - Interventional Pain-1 provider
    - Headache Medicine- 2 providers
    - Psychiatry-2 providers
- Assisted with recruitment efforts of three (3) new providers to our community.
    - Island Eye Surgeons
    - Island Internal Medicine
    - Island Family Physicians
- Refined and expanded the use of technology through the use of the Electronic Medical Record and the Patient Portal to support ease of access to medical information, care planning and appointments for the healthcare team and our patients.

Chronic Disease

- Established a Diabetes Education Program.
- Recruited a new Registered Dietician and expanded services.
- Improved Dietary options at hospital to encourage healthier eating for patients, staff and guests. Including the use of “Genuine Skagit” produce.
- Began a Summer Farmstand with local farms selling fresh produce.

- Established an Employee Wellness Program which focuses on healthy lifestyles, exercise and healthy eating.
- Utilization of a nurse navigator in Primary Care to connect with "at risk" patients regarding chronic disease management.
- Partnered with insurance companies on various initiatives to encourage patients to seek out preventative care options available to them at Island Hospital.

Community Health Needs Assessment Methodology

Island Hospital's executives led the planning, conduct and reporting of the community health needs assessment. We contracted with CliftonLarsonAllen LLP (CLA), one of the nation's top 10 certified public accounting and consulting firms, to assist with the community health needs assessment.

We began by identifying our community based on inpatient and outpatient services by zip code. We then gathered both quantitative and qualitative data about the health needs of our community. Qualitative data was collected through one-on-one interviews. Quantitative data included national, state and county health studies and our own records. All data was collected between August and October 2019.

Interviews
In August 2019, we gathered qualitative information and perspectives on community health needs through one-on-one interviews with key community stakeholders. The primary goal of these interviews was to ascertain a range of perspectives on the community's health needs. We gathered information from the following specified groups within our community:

- People with special knowledge or expertise in public health
- Government health departments and other government agencies
- Representatives of medically underserved populations
- Representatives of low-income populations
- Representatives of minority populations

The following agencies and organizations participated in Island Hospital's community health needs assessment by contributing their time, perspectives, opinions and observations. We thank them for their past and continued assistance.

- Island Hospital
- SeaMar
- Anacortes Police Department
- Skagit County Public Health Department
- Skagit County Sheriff Department
- Samish Indian Nation Health Department
- San Juan County Health & Community Services Department

We believe these organizations qualify as representative of our community's minority, low-income and medically underserved populations because the nature of their work brings them into contact with those groups on a regular basis.

Quantitative Data
The community health needs assessment included consideration and analysis of the following publicly available data.

- Centers for Disease Control and Prevention's Chronic Disease Overview
  - http://www.cdc.gov/chronicdisease/overview/
- Population Health Institute's County Health Rankings
  - http://www.countyhealthrankings.org/app/washington/2016/overview
- Skagit County 2016 Community Health Assessment Summary Report
  - http://www.skagitcounty.net/Departments/PHTAC/Reportsmain.htm
- United States Census Bureau QuickFacts
  - https://www.census.gov/quickfacts/table/PST045215/53055,53057,53
- Washington State Department of Health's Medically Underserved Areas & Medically Underserved Populations
  - ftp://ftp.doh.wa.gov/geodata/layers/maps/mua_p.pdf
- Washington State Department of Health's San Juan and Skagit County Chronic Disease Profiles
  - https://www.doh.wa.gov/portals/1/Documents/Pubs/345-271-ChronicDiseaseProfileSkagit.pdf
- Washington State Department of Health's Risk and Protection Profile for Substance Abuse Prevention in San Juan County
  - https://www.dshs.wa.gov/data/research/research-4.47-sanjuan.pdf
- Washington State Department of Health's Risk and Protection Profile for Substance Abuse Prevention in Skagit County
  - http://adai.uw.edu/wastate/RDA/skagit_rda.pdf
- Washington State Department of Transportation Ferry Passenger and Vehicle Fares
  - http://www.wsdot.wa.gov/ferries/pdf/CurrentFares.pdf
- Washington State Healthy Youth Survey, San Juan and Skagit Counties
  - http://www.askhys.net/Home/Press

Information Gaps
Although we are unable to identify any specific information gaps, we recognize members of the community representing different organizations, groups, etc., have differing opinions concerning community health needs and priorities and may have provided different input.

Analytical Methods Applied
We applied various analytical methods to the available data. During interviews, we asked participants to identify community health needs, prioritize those health needs, and identify possible solutions to those health needs. We analyzed the historic prevalence of various health issues in our community and compared those with county, state and national averages. Finally, we reviewed previously identified health priorities as identified by national, state and county health organizations.

Request for Feedback
Island Hospital was willing to consider written comments related to its last Community Health Needs Assessment Report, but received no such input. If any reader would like to provide input on this community health needs assessment, they can submit their comment(s), in writing, to the following address:

Attention: Executive Assistant to the CEO
RE: Community Health Needs Assessment
1211 24th Street
Anacortes, WA 98221

Determination of Significance
While many needs were identified during the community health needs assessment process, this report focuses on those needs that were deemed *significant* by Island Hospital. A health need's significance was evaluated based on many factors. The factor given the most weight was the relative importance placed on the health need by the community participants. Other factors included the number of people in our community impacted by the health need, the impact of that health need on quality of life and length of life, and the impact on low-income, minority, and other medically underserved populations. The decision was made by Island Hospital's executives, who were involved throughout the community health needs assessment process.

Process and Criteria for Prioritizing Identified Health Needs
Island Hospital's executives determined our prioritization based on the consistency of indications by participants and its agreement with historic quantitative data, our mission, and preventative impact.

Prioritized Significant Community Health Needs

Based on our interviews and small group meetings, as well as reviews of hospital, county, state and national health data, we identified the following significant community health needs, listed in order of priority:

- Behavioral Health
- Access to Health Care

Behavioral Health
Behavioral health is a term that encompasses mental health and substance abuse, both of which are significant issues in our community. Regarding mental health, community participants expressed concern regarding the rise in depression incidences and suicide and the increasing demand for mental health care to match the rise in incidences. See "Access to Health Care" below for a discussion of access to behavioral health care.

Mental health was consistently identified as a top priority by community participants. In 2015, San Juan County's average per capita mentally unhealthy days were slightly better than the

Washington State average while Skagit County's average was slightly worse. Between 2015 and 2018, mentally unhealthy days increased in Washington State and San Juan County and decreased slightly in Skagit County, so that all three areas are much more similar.

Change in Mentally Unhealthy Days per Month

	2015	2018	Change
Washington State	3.3	3.8	0.5
Skagit County	3.9	3.8	-0.1
San Juan County	2.7	3.6	0.9

The mental health disparity between Skagit and San Juan Counties has many causes and factors, but some of the difference can be attributable to economic stress. As discussed previously in the "Our Community" section, in both 2015 and 2018, Skagit County's unemployment rates and percentage of children in poverty were both above the state averages. Alternatively, while San Juan County's unemployment rate was below the state average in both 2015 and 2018, the percentage of San Juan County children in poverty continued to decrease from above the state average in 2015 to below the state average in 2018. The culture of the San Juan Islands encourages and somewhat necessitates a healthy lifestyle and routine. It may be that individuals with better mental and physical health tend to move to San Juan County while individuals with worse health issues tend to leave the area.

Change in Unemployment Rate

	2015	2018	Change
Washington State	7.0%	4.8%	-45.8%
Skagit County	8.3%	5.5%	-50.9%
San Juan County	5.9%	3.9%	-51.3%

Change in Children in Poverty

	2015	2018	Change
Washington State	18.6%	14.0%	-32.9%
Skagit County	21.5%	16.0%	-34.4%
San Juan County	18.1%	15.0%	-20.7%

In the last decade, worsening mental health conditions have been partially attributed to economic struggles of our community members. However, our community has seen significant improvements in its unemployment rates and the percentage of children living in poverty in recent years, while mental health has continued to be significant concern. Some possible explanations for this discrepancy are (a) that people are employed, but at a job that doesn't pay as well as they need, (b) that people are working multiple lower-paying jobs, which increases stress on other areas of life, or (c) that they aren't part of the official unemployment measure because they have given up hope and stopped searching for a job. Each of these possibilities were indicated by at least one community participant, with the idea of working multiple lower-paying jobs as the most common explanation for increasing stress and decreasing mental health in our community.

As adults work more jobs or longer hours, they have less time for relationships, exercise, rest and relaxation, each of which is important in achieving positive mental health. Alternatively, those

adults that would like to earn more money but can't find a means to that end face additional stress brought on by the lack of financial resources. Parents in these situations may unintentionally increase the stress level in their homes, negatively impacting the mental health of their spouse and/or children. Finally, there's a significant correlation between mental health and substance abuse, causing a spiraling decay in mental and physical health as each impacts the other (i.e. worsening mental health leads to increased substance abuse and/or increased substance abuse leads to worsening mental health).

Community participants expressed specific concern for the mental health of youth in our community. In the 2018 Washington State Healthy Youth Survey, children in grades 6, 8, 10 and 12 were asked a variety of questions regarding their health behaviors. The following discussion focuses on 10th graders as an example of the other grades, which were all similar. Approximately 35% of San Juan County 10th graders and 38% of Skagit County 10th graders felt so sad or hopeless almost every day for at least two weeks in a row that they stopped doing some usual activities. Those rates are a significant improvement for San Juan County, from 45% in 2015, and a slight worsening for Skagit County, from 36% in 2015.

Mental Health in Community 10th Graders

	San Juan County	Skagit County
High Anxiety	42%	32%
Sad or Hopeless	35%	38%
Experienced Bullying	31%	21%
Seriously Considered Suicide	16%	22%

San Juan County 10th graders reported experiencing worse anxiety and bullying in 2018 than Skagit County 10th graders, although Skagit County's 10th graders had a higher rate of seriously considering suicide. Regardless of any specific comparisons, the high rates of negative mental health conditions – all between 15% and 45% - in our community indicate a significant need for a lot of children.

Substance abuse covers a broad range of health issues, including tobacco, alcohol, prescription drugs and illicit drugs, as well as vaping and e-cigarettes as relatively new developments. Significant substance abuse in our community includes opiates (i.e., heroin, codeine, fentanyl, etc.), methamphetamine ("meth"), prescription drugs, vaping/e-cigarettes, and alcohol. Community participants indicated that alcohol, tobacco and marijuana are constant concerns among the adult population, but conversations tended to focus on more acute problems.

Community participants overwhelmingly identified opiates as the most significant substance abuse issue in our community, although for various reasons. First, participants were worried about the increase in crime – particularly burglary and theft – that comes with drug use. Second, home-made imitations of drugs like codeine and fentanyl may contain dangerous levels of drugs and other ingredients compared to legitimately produced medications from pharmaceutical companies. For example, a home fentanyl producer may not be as careful about the exact quantity if each ingredient, leading some pills to be relatively weak and others to be dangerously strong, which can lead to accidental overdoses.

Community members expressed concern regarding the use of marijuana and vaping among the youth. In its 2017 Community Health Assessment, Skagit County identified 10 priority areas to improve health and wellness for its residents. Skagit County identified marijuana use and vaping a common issue among the youth. The Population Health Trust reported 18% and 30% of marijuana use among 10th and 12th graders in 2018, compared to the state average of 18% and 26% among 10th and 12th graders, respectively. Skagit County 12th graders have a higher use of marijuana than at state level, while 10th graders in the County use marijuana at the same rate as at the state level.

Percentage of Youth Using Marijuana

	10th Grade	12th Grade
Washington State	18%	26%
Skagit County	18%	30%
San Juan County	N/A	N/A

Percentage of Youth Vaping

	10th Grade	12th Grade
Washington State	21%	N/A
Skagit County	18%	N/A
San Juan County	N/A	N/A

As for the use of vaping, 18% of 10th graders in Skagit County reported vaping in 2018, compared to 21% at the state level. Although the Skagit County vaping rate was slightly better than the state level, it will still approximately one in five 10th graders. Additionally, community participants indicated that they expected to see a large increase in youth vaping between that study in 2018 and today. In the summer of 2019, national reports began to appear about the dangers of vaping and e-cigarette use. The overall condition has been labeled "e-cigarette or vaping product use associated lung injury, or EVALI. When discussing the negative consequences of vaping and e-cigarettes, medical professionals and the county health departments generally indicated that we know their use is dangerous, but that they are so new to our country that the full extent of the negative impacts may not be known for years or decades. Recent research indicates that a youth who vapes is four times more likely to begin using traditional tobacco products such as cigarettes and chewing tobacco.

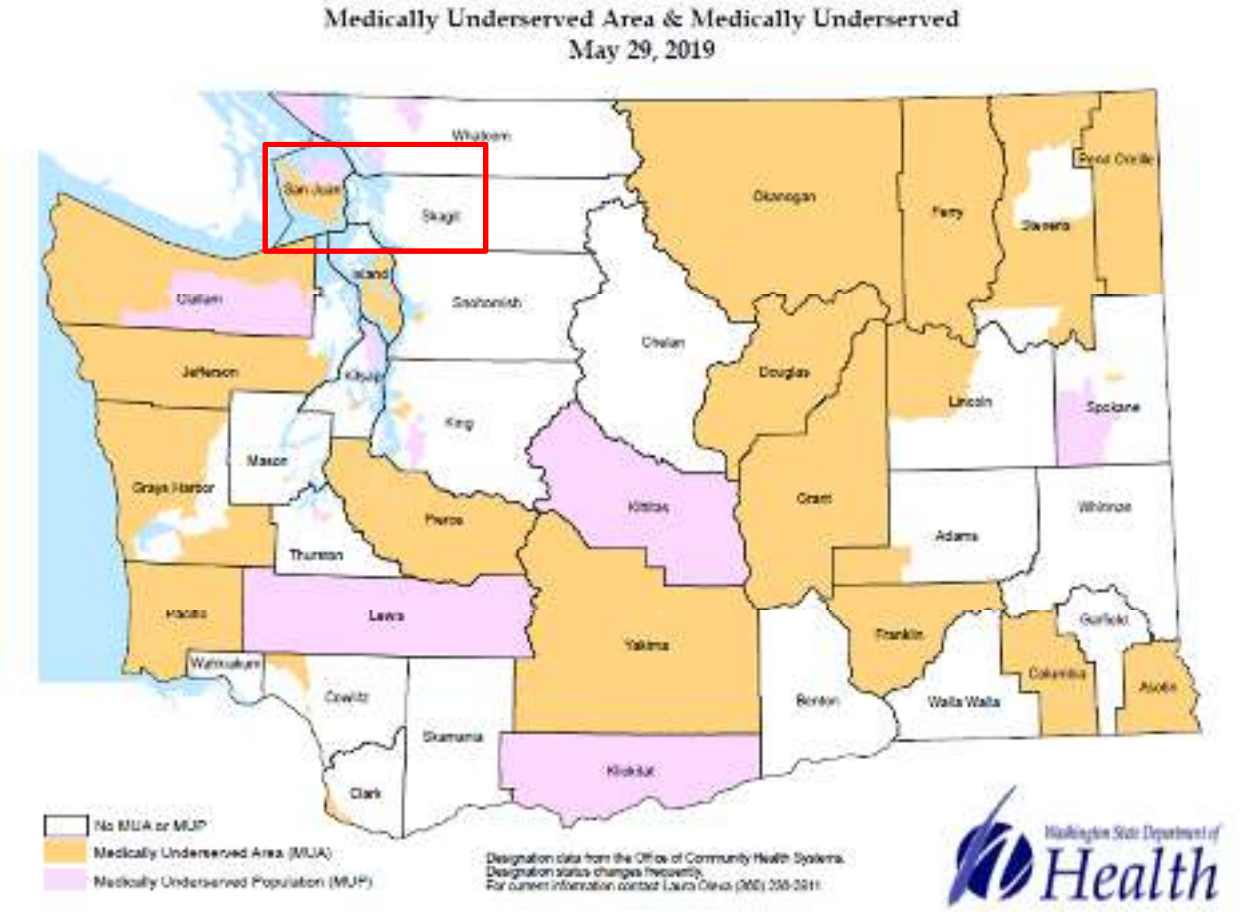
Community participants indicated concern about a rise in meth use, although this was secondary to the issues discussed above.

Access to Health Care

Our community members consistently indicated high satisfaction with access to healthcare in our community. In general, participants are happy with the number of hospitals, clinics, pharmacies and similar medical facilities in our area, as well as with the variety of specialists and services. However, a few significant exceptions currently exist that pose challenges for our community members.

With the exception of the San Juan Islands, our community is not designated as either a Medically Underserved Area or a Medically Underserved Population. However, the ratio of primary care

providers to community members has deteriorated slightly in recent years. In 2015, Skagit County had 1,056 residents per primary care physician and San Juan County had 1,056 residents per primary care physician. In 2019, Skagit County increased to 1,280 residents and San Juan County increased to 1,260 residents per primary care physician. This change was reflected in community members' concern that our area needs more primary care providers.



According to the Population Health Institute, Skagit County's ratio of mental health providers (Psychiatrist, Psychologist, Clinical Social Worker, Psychiatric Nurse, Marriage & Family Therapist, or Licensed Professional Counselor) was 386 people per provider in 2015 and San Juan County's average was 283 people per provider. Each geographic area improved between 2015 and 2018, with Skagit County improving to 290 people per provider and San Juan County improving to 260 people per provider.

Despite the increase in mental health providers, community members expressed a need for specific behavioral health services and a general insufficiency of mental health facilities. A rising issue noted at the Skagit County Jail is the increasing number of inmates who suffer from mental health. In a perfect world, an inmate who is a danger to themselves and to the community would be transferred to an appropriate healthcare facility or be treated by appropriate personnel in a special jail facility. However, due to a lack of mental health beds at state facilities, these individuals are frequently put in isolation at the jail, without the full appropriate health care that they need, which only worsens their mental health issue.

Community members frequently discussed the insufficiency of inpatient mental health centers available to the community. Government-owned facilities and similar charitable groups do provide mental health services to the public at little to no cost, but these facilities are almost constantly full and may have longer-than-appropriate wait lists just because of the great demand across the state. Skagit Valley Public Hospital District #1, DBA: Skagit Valley Hospital, provides inpatient psychiatric services, which is an invaluable resource to community members. However, although Skagit Valley Hospital is in close proximity, the psychiatric inpatient beds are often full, which may require an individual to wait for access or to travel to a more distant facility. Additionally, that facility does not have specialty services for adolescents or the elderly. An additional problem with more distant facilities is the transportation to/from the facility for the struggling individual, as well as the difficulty family and friends face in trying to visit and support that individual. Private facilities may have availability, but their cost is frequently prohibitive for lower-income individuals.

Based on these, community members expressed a need for additional inpatient and outpatient beds for acute mental health and substance abuse problems. In addition, community members indicated a need for local post-acute treatment options, specifically:

- Clinical access that offers counseling and similar services 24-hours-a-day to either help people avoid acute problems or deal with the long-term aftermath of acute problems.
- Short-term (less than one year) congregate or assistive housing for people to recover from substance abuse and mental health problems.
- Local acute-care opportunities for children, adolescents and geriatrics.

For individuals living on the San Juan Islands, accessing health care is a significant concern. The access problems are primarily caused by the transportation limitations inherent to living on an island with no bridges to the mainland. Although helicopter and plane travel are possible for the wealthy, the primary method of transportation to and from the islands is by boat, with only one public transportation system available through the Washington State Department of Transportation. Ferries arrive at and leave Anacortes approximately once per hour with travel taking anywhere from 45 minutes to 2 hours, each way. Limitations on the number of vehicles necessitate arriving at least 30 minutes early if you wish to bring a vehicle. The limited number of trips combined with the length of the ride each way means a single medical appointment frequently requires an entire day of travel; participants indicated that the fastest possible would be approximately half a day. For individuals with frequent medical appointments, such as physical therapy and radiology, the travel can be extremely stressful, demanding and possible prohibitive.

In addition to the time requirements, the cost of travel can also be prohibitive for individuals living on the islands. A round-trip ticket from the islands to the mainland is $7.00 for youth and seniors and $14.00 for adults. For vehicles, a round-trip ticket ranges from $18.40 to $51.10, depending on the island and the size of the vehicle. For low-income individuals, the monetary cost of frequent trips can be extremely stressful and prohibitive. Each island has a local organization that can transport individuals by plane or private boat for emergencies and other limited medical situations. However, these organizations are not able to fill the demand for medical travel of San Juan County residents.

Conclusion

Island Hospital reached out to community participants in 2019 to identify those health needs that are viewed as most significant and highest priority by our community members. The health needs identified by participants were behavioral health, access to health care, and chronic diseases.

We are committed to improving the health of our community, both in the short-term and in the distant future. We are developing an Implementation Strategy that responds to these health needs. We hope that our efforts, combined with those of government agencies, other nonprofits and local organizations, will lead to a healthier and happier community.

Appendix – Community Health Resources

Island Hospital serves individuals in both Skagit and San Juan Counties. The Skagit County Public Health Department and San Juan County Department of Health and Community Services support our community members in numerous ways, including community health, mental health, substance abuse, violence prevention, child welfare, elderly services, veteran services and financial support. Each department can and should be used by residents as a primary resource when determining available services in their area. For a complete list of their activities, we recommend visiting their offices or websites:

Skagit County Public Health Department

- 700 South Second, Room 301, Mount Vernon
- www.skagitcounty.net/Departments/Health

San Juan County Department of Health and Community Services

- 145 Rhone Street, Friday Harbor
- www.sanjuanco.com/378/Health-Community-Services

In addition to governmental support, the following health care facilities and related organizations are currently available within our community.

Hospitals

Island Hospital, located at 1211 24th Street in Anacortes is one of several hospitals in our community.

- Skagit Valley Hospital – 1415 East Kincaid Street, Mt. Vernon
- PeaceHealth Peace Island Medical Center – 1117 Spring Street, Friday Harbor
- Whidbey General Hospital – 101 North Main Street, Coupeville
- Naval Hospital Oak Harbor – 3475 North Saratoga Street, Oak Harbor

Clinics

- Anacortes Family Medicine – 2601 M Avenue, Suite B, Anacortes
- Anacortes Health Care – 1220 22nd Street, Anacortes
- Cascade Medical Group – 1019 24th Street, Suite B, Anacortes
- Fidalgo Medical Associates – 1213 24th Street, #100, Anacortes
- Fidalgo Island Walk-In Clinic – 1500 Commercial Avenue, Anacortes
- Skagit Regional Clinic – Anacortes – 2511 M Avenue, Suite D, Anacortes
- Inter-Island Medical Center – 550 Spring Street, Friday Harbor
- Planned Parenthood – Friday Harbor Health Center – 470 Reed Street, Suite 2A, Friday Harbor
- San Juan Healthcare – 689 Airport Center, Suite B, Friday Harbor
- Dr. Robert Williams – 470 Spring Street, #200, Friday Harbor
- North Whidbey Community Clinic – 1300 Goldie Road, Oak Harbor
- Whidbey Health Primary Care – 275 SE Cabot Drive, b101, Oak Harbor
- Whidbey Medical Clinic – 231 SE Pioneer Way, #209, Oak Harbor

- Dr. Sarah Lyle, MD – 429 Madrona Street, Eastsound
- Orcas Family Health Center – 1286 Mt. Baker Road, Eastsound
- Orcas Island Family Medicine – 33 Ulmer Street, Suite 5, Eastsound
- Orcas Medical Center – 7 Deye Lane, Eastsound
- Lopez Island Medical Clinic – 103 Washburn Place, Lopez Village
- Mount Vernon Women's Clinic – 111 North 17th Street, Mt. Vernon
- North Cascade Family Physicians – 2116 East Section Street, Mt. Vernon
- North Cascade Women's Clinic – 125 North 18th Street, Suite A, Mt. Vernon
- Planned Parenthood – Mt. Vernon Health Center – 1805 East Division Street, Mt. Vernon
- Quick Care Medical Clinic – 205 Stewart Road, #104, Mt. Vernon
- QTC Medical Group – Suite 103, 205 I-5, Mt. Vernon
- Sea Mar Community Health Center – 1400 North Laventure Road, Mt. Vernon
- Sea Mar Mt. Vernon Healthcare for Homeless – 1010 East College Way, Mt. Vernon
- Skagit Family Health Clinic – 916 South 3rd Street, Mt. Vernon
- Skagit Regional Clinic – 819 South 13th Street, Mt. Vernon
- Skagit Regional Clinics – Mount Vernon – 1400 East Kincaid Street, Mt. Vernon
- Skagit Regional Clinics – Riverbend – 2320 Freeway Drive, Mt. Vernon
- PeaceHealth Medical Group – 835 East Fairhaven Avenue, Burlington

Our community also includes numerous specialty clinics serving various needs.

Behavioral Health
While the county health departments and many of the hospitals and clinics identified above provide mental health services and treatment for substance abuse, the following facilities are also available in our community:

- Inside Passage Counseling – 902 8th Street, Anacortes
- Sea Mar Anacortes Behavioral Health – 1004 M Avenue, Anacortes
- Dr. Christopher Tobey – 606 Commercial Avenue, #G, Anacortes
- Compass Health – 520 Spring Street, Friday Harbor
- McGuire Shahn – 55 2nd Street North, #204, Friday Harbor
- The Clearing – 2687 West Valley Road, Friday Harbor
- Island Assessment & Counseling – 520 East Whidbey Avenue, Suite 205, Oak Harbor
- Greg Rolnick – 840 SE 8th Avenue, #204, Oak Harbor
- Sea Mar Oak Harbor Behavioral Health Center – 31640 WA-20, #1, Oak Harbor
- Tri-Essence Care – 1121 SE Dock Street, Oak Harbor
- Bodymind Counseling – 229 Indralaya Road, Eastsound
- Brandon Adams, MS, LMFT – 188 A Street, Eastsound
- Ian Healing Arts Center – 453 North Beach Road, Eastsound
- Island Psychiatric Services – 374 North Beach Road, #D4, Eastsound
- Malcolm River – 11 Discovery Way, Eastsound
- Bitterroot Assessment and Counseling – 1310 East College Way, Mt. Vernon
- Bywater Psychiatric Consultation – 721 South 1st Street, Mt. Vernon
- Catholic Community Services – 320 Pacific Place, Mt. Vernon

- Compass Health – 1100 South 2nd Street, Mt. Vernon
- Dion Menser, LMFT – 1315 Cleveland Avenue, Mt. Vernon
- North Sound Behavioral Health – 301 Valley Mall Way, #110, Mt. Vernon
- Phoenix Recovery Services – 1601 East College Way, #1, Mt. Vernon
- Sea Mar Mount Vernon Behavioral Health Center – 1010 East College Way, Mt. Vernon
- Shifa Health – 1103 Cleveland Avenue, Mt. Vernon
- Skagit Behavioral Health – 406 South 1st Street, #30008, Mt. Vernon
- Skagit Recovery Center – 1905 Continental Place, Mt. Vernon
- Skagit Valley Reach Center – 1413 East College Way, Mt. Vernon
- Sunrise Community Mental Health – 2500 East College Way, Mt. Vernon
- Catholic Community Services – 614 Peterson Road, #200, Burlington
- Follman Agency – 910 South Anacortes Street, Burlington

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 Glacier Peak Healthcare, Inc., I am writing to affirm a commitment to fully finance the establishment of Alpha Hospice, in Skagit County, Washington. As the ultimate parent of Glacier Peak 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,

Morgan Boatman
Corporate Controller
The Pennant Group, Inc.
1675 E. Riverside Dr., Ste 150
Eagle, ID 83616

EXHIBIT 13

From: Schanno, Karen <Karen.Schanno@alphahhh.com>
Sent: Saturday, December 18, 2021 9:18 PM
To: Boettcher, Chris <Chris.Boettcher@alphahhh.com>
Subject: Re: Skagit Hospice

In my last two years of caring for home health patients in Skagit County, I have experienced several instances pertinent to the need for increased hospice care services.
I have been told when referring a patient that it would take a week or more to get a patient admitted.
I have had patients refuse Hospice of the Northwest due to experience with other family members. When explaining that there isn't another option in Skagit County, they have refused much needed services.
More than half of the patients I approach about hospice services do not understand what it is and how it could benefit them and their families.
There is large population in Skagit County and a great need for additional and diverse hospice services.
Thank you,
Karen Schanno, RN, BSN

Community Health Survey – Skagit County, 2021

(Voluntary and Anonymous. Please mark or circle responses)

1. Which best describes your context to local healthcare?
   (a.) Medical Provider
   b. Healthcare resource (DSHS, NWRC, Alzheimer's Association etc.)
   c. Community member

2. For Medical Providers - which best describes your practice in healthcare?
   a. Family Practice/Internal Medicine
   b. Emergency Medicine
   c. Geriatrics
   d. Oncology
   e. Hospitalist
   f. Specialist (please specify area of focus) Assisted Living Memory Care

3. Do you refer patients to Hospice for end-of-life services?
   (a.) YES
   b. NO

4. Do you support patient choice for Hospice in Skagit County?
   (a.) Yes
   b. No

5. In your experience/role, have you encountered any barriers to patients receiving Hospice services in Skagit County?
   a. YES (please circle all that apply)
      (i.) Timeliness of care
      ii. Education around Goals of Care
      iii. Location of service
      iv. Language or cultural barriers
      v. Insurance coverage
      (vi.) Choice in providers
      vii. Other (please specify_____)
   b. NO

6. Any other feedback that you would like to offer around end-of-life services?
   More people are moving to Skagit County everyday. Adding another hospice can only benefit Skagit County residents.

Community Health Survey – Skagit County, 2021

(Voluntary and Anonymous. Please mark or circle responses)

1. Which best describes your context to local healthcare?
   (a.) Medical Provider
   b. Healthcare resource (DSHS, NWRC, Alzheimer's Association etc.)
   c. Community member

2. For Medical Providers - which best describes your practice in healthcare?
   a. Family Practice/Internal Medicine
   b. Emergency Medicine
   c. Geriatrics
   d. Oncology
   e. Hospitalist
   f. Specialist (please specify area of focus) Assisted Living Memory Care

3. Do you refer patients to Hospice for end-of-life services?
   (a.) YES
   b. NO

4. Do you support patient choice for Hospice in Skagit County?
   (a.) Yes
   b. No

5. In your experience/role, have you encountered any barriers to patients receiving Hospice services in Skagit County?
   a. YES (please circle all that apply)
      (i.) Timeliness of care
      ii. Education around Goals of Care
      iii. Location of service
      iv. Language or cultural barriers
      v. Insurance coverage
      (vi.) Choice in providers
      vii. Other (please specify_____)
   b. NO

6. Any other feedback that you would like to offer around end-of-life services?
   More people are moving to Skagit County everyday. Adding another hospice can only benefit Skagit County residents.

Community Health Survey – Skagit County, 2021

(Voluntary and Anonymous. Please mark or circle responses)

1. Which best describes your context to local healthcare?
   a. Medical Provider
   b. Healthcare resource (DSHS, NWRC, Alzheimer's Association etc.)
   c. Community member

2. For Medical Providers - which best describes your practice in healthcare?
   a. Family Practice/Internal Medicine
   b. Emergency Medicine
   c. Geriatrics
   d. Oncology
   e. Hospitalist
   f. Specialist (please specify area of focus) _____

3. Do you refer patients to Hospice for end-of-life services?
   a. YES
   b. NO

4. Do you support patient choice for Hospice in Skagit County?
   a. Yes
   b. No

5. In your experience/role, have you encountered any barriers to patients receiving Hospice services in Skagit County?
   a. YES (please circle all that apply)
      i. Timeliness of care
      ii. Education around Goals of Care
      iii. Location of service
      iv. Language or cultural barriers
      v. Insurance coverage
      vi. Choice in providers
      vii. Other (please specify_____
   b. NO

6. Any other feedback that you would like to offer around end-of-life services?

   _____

   _____

Community Health Survey – Skagit County, 2021

(Voluntary and Anonymous. Please mark or circle responses)

1. Which best describes your context to local healthcare?
   a. Medical Provider
   b. Healthcare resource (DSHS, NWRC, Alzheimer's Association etc.)
   c. Community member

2. For Medical Providers - which best describes your practice in healthcare?
   a. Family Practice/Internal Medicine
   b. Emergency Medicine
   c. Geriatrics
   d. Oncology
   e. Hospitalist
   f. Specialist (please specify area of focus) _____

3. Do you refer patients to Hospice for end-of-life services?
   a. YES
   b. NO

4. Do you support patient choice for Hospice in Skagit County?
   a. Yes
   b. No

5. In your experience/role, have you encountered any barriers to patients receiving Hospice services in Skagit County?
   a. YES (please circle all that apply)
      i. Timeliness of care
      ii. Education around Goals of Care
      iii. Location of service
      iv. Language or cultural barriers
      v. Insurance coverage
      vi. Choice in providers
      vii. Other (please specify_____
   b. NO

6. Any other feedback that you would like to offer around end-of-life services?

   _____

   _____

Community Health Survey – Skagit County, 2021

(Voluntary and Anonymous. Please mark or circle responses)

1. Which best describes your context to local healthcare?
   a. Medical Provider
   b. Healthcare resource (DSHS, NWRC, Alzheimer's Association etc.)
   c. Community member

2. For Medical Providers - which best describes your practice in healthcare?
   a. Family Practice/Internal Medicine
   b. Emergency Medicine
   c. Geriatrics
   d. Oncology
   e. Hospitalist
   f. Specialist (please specify area of focus) _____

3. Do you refer patients to Hospice for end-of-life services?
   a. YES
   b. NO

4. Do you support patient choice for Hospice in Skagit County?
   a. Yes
   b. No

5. In your experience/role, have you encountered any barriers to patients receiving Hospice services in Skagit County?
   a. YES (please circle all that apply)
      i. Timeliness of care
      ii. Education around Goals of Care
      iii. Location of service
      iv. Language or cultural barriers
      v. Insurance coverage
      vi. Choice in providers
      vii. Other (please specify_____
   b. NO

6. Any other feedback that you would like to offer around end-of-life services?

   _____

   _____

Community Health Survey – Skagit County, 2021

(Voluntary and Anonymous. Please mark or circle responses)

1. Which best describes your context to local healthcare?
   a. Medical Provider
   b. Healthcare resource (DSHS, NWRC, Alzheimer's Association etc.)
   c. Community member

2. For Medical Providers - which best describes your practice in healthcare?
   a. Family Practice/Internal Medicine
   b. Emergency Medicine
   c. Geriatrics
   d. Oncology
   e. Hospitalist
   f. Specialist (please specify area of focus) LTC

3. Do you refer patients to Hospice for end-of-life services?
   a. YES
   b. NO

4. Do you support patient choice for Hospice in Skagit County?
   a. Yes
   b. No

5. In your experience/role, have you encountered any barriers to patients receiving Hospice services in Skagit County?
   a. YES (please circle all that apply)
      i. Timeliness of care
      ii. Education around Goals of Care
      iii. Location of service
      iv. Language or cultural barriers
      v. Insurance coverage
      vi. Choice in providers
      vii. Other (please specify_____
   b. NO

6. Any other feedback that you would like to offer around end-of-life services?

_____

_____

2624 Donovan Avenue
Bellingham WA 98225
December 16, 2021

Mr. Josh Mayer,

I'm happy to write this letter on behalf of VSED Resources Northwest in support of Alpha Home Health and Hospice's plans to develop a hospice program within Skagit County. I appreciate you reaching out to me, as representative of VRNW, in your new position as Business Development Manager. Because of our professional relationship when you worked with Eden Home Health and Hospice here in Whatcom County, I'm excited to learn of Alpha's plans for expansion and pleased to learn that you were chosen to help make this happen.

You remember that VRNW submitted letters to Washington State Department of Health in July 2020, when Eden submitted Certificate of Need Application to open hospice services. Our concerns at the time were two-fold, (1) access to compassionate end-of-life care and (2) access to a safe, compassionate site in which to die. At that time, Peace Health, the only hospital and hospice program in the county, was prohibited from providing service to individuals who chose to hasten their deaths via VSED (voluntarily stopping eating and drinking) or MAID (medical aid in dying), Washington State's Death with Dignity Law because of the affiliation with the Catholic Church. Our non-profit, VSED Resources Northwest, was created to provide information and support for people who wish information about VSED. We, therefore, wanted to support the expansion of such services.

This past year, our website, materials, and presentations about VSED have helped medical providers, hospice programs, death doulas, and individual families, not only throughout the Pacific Northwest, but throughout the country. We have an amiable relationship with Hospice of the Northwest and have found them supportive of both MAID and VSED. It is my personal opinion that there is certainly room for Alpha HH&H in Skagit County for two main reasons: (1) the forecast of the number of Boomers who will need hospice services in the next five years and (2) the elevation of quality of care resulting from the existence of more than one provider, thus providing 'choice' and a comparison of services.

If I can be of further support in this new endeavor, please feel free to contact me.

Sincerely,

Nancy A. Simmers, BSN, RN
Co-founder and Coordinator
VSED Resources Northwest
www.Vsedresources.com

Certified Spanish Medical Interpreter
Certificate No. MC11726
Business # 602901515

Eleanor Gordon
3214 Peabody St.
Bellingham, WA 98225
Bartola29@hotmail.com

To whom it may concern,

My name is Eleanor Gordon and I have been a Spanish medical interpreter in the Skagit and Whatcom communities since 2008 till the present. First, I freelanced through various agencies filling mostly DSHS medical and dental appointments. After this, I worked as an in-house interpreter at Skagit Valley hospital for 4 years and currently I am doing freelance interpreting serving clients that are under L&I.

During my 14-year experience of working with Hispanic clients I have witnessed firsthand the multiple barriers this population has with our healthcare system. The first and obvious barrier is language. Oftentimes, although my clients had an interpreter, many of the information pamphlets they were given after leaving the healthcare setting, were only available in English. This affects follow up care and limits their ability to navigate the healthcare system in general. In addition, questionnaires which are meant to obtain or help clarify the patient's needs are many times only in English as well.

Another obstacle for Hispanics to access care in our healthcare system is their level of Education. Many times, I have seen clients struggle with reading and filling out medical forms. I've noticed that there is a large proportion of illiterate or elementary grade level reading in the Hispanic community. This makes understanding medical information and or navigating our system very challenging. Furthermore, I have noticed doctors and medical staff use a higher register of language and the information given is sometimes not understood until I step in and ask the provider to please use layman terms.

In my opinion, immigration status and socioeconomic status are two other deterrents Hispanics face when accessing our healthcare system. Oftentimes the fear of getting asked if they have a social security number or believing they will have to pay the whole bill out of pocket prevents them from seeking care. Many times, the clients I have worked for are unfamiliar with the charity care programs or sliding fee scales available for paying bills or believe that without a social security number they will not qualify.

If you have ever used our healthcare system you know how complicated it is to figure out how to take care of your health needs such as: how to see a specialist, knowing specific types of therapies or programs, how to figure out what doctors are in-network and what the cost associated with it will be. When you add in a language barrier, an unfamiliar healthcare setting, lower level of education and socio-economic/immigration status, the hurdles unfortunately are hard to overcome, and Hispanics don't receive the care they need. Sincerely,

Eleanor C. Gordon

12/23/2021