MultiCare Health System
820 A Street, Tacoma, WA 98402
PO Box 5299, Tacoma, WA 98415-0299 ~ multicare.org

December 30, 2021

RECEIVED
By CERTIFICATE OF NEED PROGRAM at 3:15 pm, Dec 29, 2021

CN22-26

Eric Hernandez, Manager
Washington State Department of Health
Certificate of Need Program
111 Israel Rd. S.E.
Tumwater, WA 98501

Re: PNW Hospice, LLC, a Washington limited liability company and wholly owned subsidiary of MultiCare Health System, Certificate of Need Application to Establish a Medicare Certified and Medicaid Eligible Hospice Agency to serve Spokane County

Dear Mr. Hernandez:

I submit this certificate of need request on behalf of PNW Hospice LLC. PNW Hospice, LLC is a Washington limited liability company and a wholly owned subsidiary of MultiCare Health System ("MultiCare"). PNW Hospice requests approval to establish and operate a Medicare certified and Medicaid eligible hospice agency to serve all Spokane County residents in need of hospice services. It will be located at 801 W. 5th Avenue, Suite 510, Spokane, Washington, 99204.

PNW Hospice is a new agency, however as a wholly owned subsidiary of MultiCare, it will draw upon the deep roots and experience of MultiCare. MultiCare is a locally governed, not-for-profit, integrated health system that owns and operates nine hospitals and over 240 primary, specialty, and urgent care clinics throughout the Puget Sound and Inland Northwest Regions. This includes MultiCare Home Health, Hospice and Palliative Care, which has been providing hospice services for more than three decades.

Thank you for your assistance regarding this request. I can be reached at: 253.403.8771 or at ekobberstad@multicare.org

Sincerely,

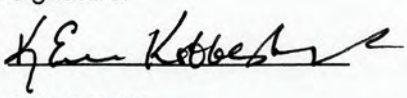
K. Erin Kobberstad, Vice President
Strategic Planning
MultiCare Health System
820 A Street, Tacoma WA 98402

Certificate of Need Application
Hospice Agency

RECEIVED
By CERTIFICATE OF NEED PROGRAM at 3:15 pm, Dec 29, 2021

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: K. Erin Kobberstad Vice President MultiCare Health System Signature:  **Email Address** ekobberstad@multicare.org	**Date:** December 30, 2021 **Telephone Number:** 253.403.8771
Legal Name of Applicant: PNW Hospice, LLC **Address of Applicant:** 801 W. 5th Avenue, Suite 510 Spokane, Washington, 99204	**Provide a brief project description:** ☒ New Agency ☐ Expansion of Existing Agency ☐ Other: _____ PNW Hospice LLC requests certificate of need approval to establish and operate a Medicare certified and Medicaid eligible hospice agency in Spokane County Washington. **Estimated capital expenditure**: $ 66,254.31
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 be submitted for each county separately. Spokane County Washington	

CN22-26

PNW Hospice, LLC

Certificate of Need Application

Proposal for a Medicare Certified and Medicaid Eligible Hospice Agency in Spokane County

December 30, 2021

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I. Introduction and Rationale

PNW Hospice, LLC is a Washington limited liability company and a wholly-owned subsidiary of MultiCare Health System ("MultiCare"). PNW Hospice is requesting approval to operate a Medicare certified and Medicaid eligible hospice agency to serve all Spokane County residents in need of hospice services. It will be located at 801 W. 5th Avenue, Suite 510, Spokane, Washington, 99204.

PNW Hospice is a new agency and received approval on October 29, 2021 to provide hospice services to residents of Thurston County. While not yet an existing agency, as a wholly-owned subsidiary of MultiCare, it will draw upon the deep roots and local experience of MultiCare in Spokane County. MultiCare is a locally-governed, not-for-profit, integrated health system that owns and operates nine hospitals and over 240 primary, specialty, and urgent care clinics throughout the Puget Sound and Inland Northwest Regions. This includes MultiCare Home Health, Hospice and Palliative Care, which has been providing hospice services for more than three decades.

As documented in our December 2020 application (CN21-39), Spokane County residents have faced a persistent need for additional hospice services. The release of the Department's 2021-2022 Hospice Numeric Methodology confirmed this earlier observation, and this application responds to the existence of numeric need in Spokane County. Hospice admissions at the three Spokane County hospice providers have not kept pace with increases in Spokane County resident population and deaths. This indicates that Spokane County residents have likely gone without needed hospice services. It is also possible they may have substituted other types of care, of which there are few or outmigrated to other counties. However, these factors indicate both current and growing future problems related to access to hospice services for Spokane County residents. Importantly, these factors will differentially impact individuals in poverty, for which these problems of access would be magnified. MultiCare has a documented history of providing significant and above-average amounts of financial assistance to financially indigent individuals across Washington State, and PNW Hospice, as a wholly-owned subsidiary, would continue this tradition for Spokane County residents in need of hospice services.

II. 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 applicant name is PNW Hospice, LLC. Its address is:

   801 W. 5th Avenue, Suite 510
   Spokane, Washington, 99204

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

   PNW Hospice, LLC is a Washington limited liability company and a wholly-owned subsidiary of MultiCare Health System ("MultiCare"). Its UBI number is 604 683 109.

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

   Lynn Siedenstrang, MS
   Vice President, Care Continuum
   820 A Street
   PO Box 5299
   Tacoma WA 98415
   Office phone: (253) 403-2760
   Email: siedely@multicare.org

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).**

   Frank Fox, PhD
   HealthTrends
   511 NW 162nd
   Seattle WA 98177
   Office phone: 206-366-1550
   Email: frankgfox@comcast.net

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

   Please see Exhibit 1 for an organizational chart.

6. **Identify all healthcare facilities and agencies owned, operated by, or managed by the applicant. 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**

    Please see Table 1 for a list of MultiCare facilities.

Table 1: MultiCare Facility Information, 2021

Facility/Agency Name	Address	License Number	Medicare Provider Number	Medicaid Provider Number
MultiCare Mary Bridge Children's Hospital	311 Martin Luther King Jr. Way, Tacoma WA 98403	HAC.FS.00000175	503301	3300340
MultiCare Auburn Medical Center	202 North Division St., Auburn WA 98001	HAC.FS.60311052	500015	2022467
MultiCare Behavioral Health - Auburn Medical Center	202 North Division St., Auburn WA 98001	BHA.FS.60872672	50-S015	3149101
MultiCare Deaconess Hospital	800 West 5th Ave Spokane, WA 99204	HAC.FS.60769397	500044	2083493
MultiCare Valley Hospital	12606 East Mission Ave. Spokane Valley 99216	HAC.FS.60769398	500119	2083494
MultiCare Covington Medical Center	17700 SE 272nd St, Covington, WA, 98042	HAC.FS.60803817	500154	2102039
MultiCare Tacoma General Hospital	315 Martin Luther King Jr. Way, Tacoma WA 98405	HAC.FS.00000176	500129	3300332
MultiCare Tacoma General Behavioral Health Adolescent Inpatient Services	315 Martin Luther King Jr Way, Tacoma, WA, 98405	BHA.FS.60873367	50-0129	2071315
MultiCare Allenmore Hospital (joint license with Tacoma General Hospital)	1901 S. Union Avenue, Tacoma WA 98405	HAC.FS.00000176	500129	3300332
MultiCare Good Samaritan Hospital	407 14th Ave. SE Puyallup, WA 98372	HAC.FS.60221541	500079	3308707
MultiCare Good Samaritan	401 15th Ave. SE, Puyallup, WA 98372	BHA.FS.61030776	50T079	3200094

Hospital, Inpatient Rehabilitation				
NAVOS	2600 Southwest Holden, Seattle, WA 98126	HPSY.FS.00000019	504009	3500311
Wellfound Behavioral Health Hospital	3402 S. 19th Street, Tacoma, WA 98405	HPSY.FS.60919628	504016	150453
MultiCare Home Health, Hospice and Palliative Care	3901 S Fife St, Tacoma, WA, 98409	IHS.FS.60081744	HH - 507046; Hospice-501508	HH-1043537; Hospice-2012298
MultiCare Capital Medical Center	3900 Capital Mall Drive SW, Olympia, WA 98502	HAC.FS.60986502	500139	33065

Notes: All facilities listed above are Joint Commission (JC) accredited. The single exception is Good Samaritan Hospice, which is CARF accredited.

III. Project Description

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

   PNW Hospice was approved to provide hospice services in Thurston County on October 29, 2021. We anticipate this agency, located at 1313 Broadway in Tacoma, Washington 98402, to be operational in the fourth quarter of 2022. Since the Thurston agency is not yet operational, PNW Hospice is not an existing agency. This question is thus not applicable.

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.**

   PNW Hospice was approved to provide hospice services in Thurston County on October 29, 2021. However, since the Thurston agency is not yet operational PNW Hospice is not an existing agency. This question is thus not applicable.

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.**

   The name of the proposed agency is PNW Hospice, LLC. Its address is:

   801 W. 5th Avenue, Suite 510
   Spokane Washington 98204

4. **Provide a detailed description of the proposed project.**

   PNW Hospice LLC, a wholly-owned subsidiary of MultiCare, seeks Certificate of Need approval to operate a Medicare certified and Medicaid eligible hospice agency to serve residents of Spokane County in Washington State.

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

   We confirm this agency will be available and accessible to all residents of Spokane County.

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

Event	Anticipated Month/Year
CN Approval	8/15/2022
Design Complete (if applicable)	8/15/2022
Construction Commenced (if applicable)	N/A
Construction Completed (if applicable)	N/A
Agency Prepared for Survey	12/13/2022
Agency Providing Medicare and Medicaid hospice services in the proposed county	7/1/2023

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.**

☒Skilled Nursing	☒Durable Medical Equipment
☒Home Health Aide	☐IV Services
☐Physical Therapy	☐Nutritional Counseling
☐Occupational Therapy	☒Bereavement Counseling
☐Speech Therapy	☒Symptom and Pain Management
☐Respiratory Therapy	☐Pharmacy Services
☒Medical Social Services	☐Respite Care
☐Palliative Care	☒Spiritual Counseling
☒Other (See Below)	

In addition to the categories checked above, PNW Hospice plans to provide services related to Pediatric Hospice Care and Case Management. Additional services, such as Speech Therapy, Physical Therapy, Occupational Therapy, Dietary Services, durable medical equipment and pharmacy services, will be provided on a contract basis. PNW Hospice will also contract for its medical director position.

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).**

PNW Hospice was approved to provide hospice services in Thurston County on October 29, 2021. However, since the Thurston agency is not yet operational PNW Hospice is not an existing agency. This question is thus not applicable.

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.**

PNW Hospice was approved to provide hospice services in Thurston County on October 29, 2021. However, since the Thurston agency is not yet operational PNW Hospice is not an existing agency. This question is thus not applicable.

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

The proposed agency will serve all patient age groups in need of Hospice services in Spokane County, with an emphasis on underserved populations. PNW Hospice will provide comprehensive Hospice services to all qualifying patients, regardless of payer coverage, or ability to pay.

That said, hospice patients tend to be older and fall within a small number of diagnoses. We present hospice use rates by age in Table 2.

Table 2: Hospice Use Rates by Age, United States 2015 to 2016

	Percentage of patients	Hospice Patients (2015-16)	US Population (2015-16)	Use Rate
Less than 65 years	5.50%	78,430	272,984,393	0.03%
65 to 74 years	17.50%	249,550	27,485,188	0.91%
75 to 84 years	29.30%	417,818	13,903,702	3.01%
More than 85 years	47.80%	681,628	6,261,880	10.89%

Source: National Center for Health Statistics (NCHS). (2019). Long-term Care Providers and Services Users in the United States, 2015-2016, Table VIII, p. 76. https://www.cdc.gov/nchs/data/series/sr_03/sr03_43-508.pdf, last accessed February 11, 2021.

Notes: Hospice patient counts based on the total hospice patients equal to 1,426,000 (NCHS 2019). Use rates defined as the simple ratio between hospice patients and population.

As presented in Table 2, hospice use increases with age, with use rates increasing exponentially as individuals age. This observation informs the likely distribution of patients and is particularly important in a county such as Spokane, whose residents are both older and aging faster than Washington State residents overall.[1]

Given the age-specific hospice use rates presented in Table 2, we can project the likely age-distribution of hospice patients for the proposed project. We present these estimates in Table 3.

Table 3: Projected Spokane County Unserved Patients by Age

Projected Unserved Patients by Age	Hospice Patient Age Structure	2021	2022	2023
Less than 65 years	4.8%	4	8	13
65 to 74 years	19.8%	18	35	52
75 to 84 years	29.9%	27	53	79
More than 85 years	45.4%	40	80	119
Total	100%	89	176	263

Sources: Hospice Patient Age Structure based on use rates from Table 2 and the OFM Medium Series Estimates for 2020 Spokane County Resident population by age. Total unserved patients by age based on unmet need admissions of 89, 176, and 263 in the Department of Health 2021-2022 Hospice Numeric Need Methodology, p. 7.

[1] In 2015, the proportion of persons age 65+ is estimated to be about 15.12% in Spokane County and 14.55% in Washington State. This reflects a difference of about 0.56 percentage points. In 2025, these proportions are expected to be about 22% in Spokane County and 20.84% in Washington State. This difference is equal to about 1.17 percentage points.

From Table 3, the number of unserved patients over the age of 85 is estimated to equal approximately 40 persons in 2021 and grow to about 119 persons in 2023. This age group is thus likely to constitute about 45% of all unserved patients in Spokane County. We further note that since Spokane County residents are forecast to continue to age, this distribution will continue to shift towards older ages.

Given the likely age distribution of hospice patients presented in Table 3, hospice services tailored towards elderly individuals, especially those over the age of 75, will be critical to Spokane County resident hospice access. Given the above, PNW Hospice will provide targeted services and programs to elderly individuals. PNW Hospice anticipates adding geriatric interventions, including care for dementia, mobility problems, and building improved palliative care programs to fill gaps in delivery.

We note that many 85+ year old persons do not live at home, but in facilities. As such, their access to hospice care in these skilled nursing facilities is much more problematic, given it is harder to deliver consistent hospice care in these facilities. Thus, for these elderly persons in need of hospice care, access can be much harder. This would be another area of focus. Finally, we would plan to focus on pain and symptom management for these hospice patients in skilled nursing facilities.

For those 85+ year old persons who do live at home, we would provide in-home hospice care, and importantly, help these persons remain in their residences for as long as they choose.

In addition to a hospice patient population with a high number of individuals in the oldest age groups, PNW Hospice anticipates certain diagnoses to be more prevalent. There exists no Washington State publicly available data on hospice use by patient diagnosis, so we present national-level estimates in Table 4.

Table 4: Distribution of Hospice Admissions by Patient Diagnosis

Diagnosis	NHPCO 2018
Cancer	29.6%
Circulatory/Heart	17.4%
Dementia	15.6%
Other	14.7%
Respiratory	11.0%
Stroke	9.5%
Chronic Kidney Disease	2.2%

Source: NHPCO Facts and Figures, 2020 Edition. https://www.nhpco.org/wp-content/uploads/NHPCO-Facts-Figures-2020-edition.pdf, Last Accessed November 10, 2021.

From Table 4, most hospice admissions to U.S. residents occurred for persons with cancer diagnoses. These individuals accounted for nearly 30% of admissions for U.S. hospice agencies in 2018. The next largest source of hospice admissions was circulatory/heart disease, which accounted for about 17% of admissions. Dementia accounted for about 16% of admissions, pulmonary disease about 11% of admissions, stroke about 9.5% of admissions, and kidney disease about 2.2% of admissions.

In the absence of local data, we rely on these national-level estimates to forecast the likely distribution of patient diagnoses and expect Cancer and Circulatory/Heart Disease to comprise most patient diagnoses. Leading causes of death for Spokane County residents consisted of, in order, Cancer, Heart Disease, and Alzheimer's Disease, further supporting the importance of these disease diagnoses in hospice patient care for Spokane residents.[2]

PNW Hospice will offer comprehensive services tailored to patient and family needs associated with these diagnoses and ensure coordination with specialists and care team members towards alleviating symptoms specific to each disease process. PNW Hospice will also create close relationships with specialty clinics, hospitals and long-term care facilities to provide the most appropriate care at the right time in the right setting. Services will focus on:

- Care Coordination – Nurse case manager ensures that information flows between all physicians, nurses, social workers and, at the patient's request, clergy. The hospice team coordinates all medications, medical supplies and medical equipment related to the diagnosis to ensure all the patients' needs are met.

- Pain and symptom management ensuring patient's symptoms are continuously controlled. Each of the disease processes listed has specific symptoms that are inherent to the progression of the disease process. The RN case manager will work closely with Hospice Medical Director, Hospice team, and the primary care provider for specialized management of the disease specific symptoms.

- Emotional and spiritual assistance through provision of resources and comfort care therapies to help patients maintain emotional and spiritual well-being. Comfort therapists also are able to provide non-pharmacological symptom management to enhance comfort medications.

- Caregiver education and training focusing on the trajectory of the patient progression towards end of life, safe caregiving techniques, and medication management and administration.

- Nursing services 24/7 to address any care concerns throughout the duration of care.

- Financial assistance – Social workers can assist families with financial planning and finding financial assistance during hospice care.

[2] Washington State Department of Health Mortality Dashboards, https://www.doh.wa.gov/DataandStatisticalReports/HealthDataVisualization/MortalityDashboards/AllDeathsDashboard, Last Accessed November 10, 2021.

- Bereavement services to support the surviving loved ones express and cope with their grief in their own productive way.

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).

Please see Exhibit 2 for a copy of the Letter of Intent.

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

This agency will be licensed and certified by Medicare and Medicaid, as will the Thurston County location in Olympia, WA. Given the latter is approximately a year away from being operational, it does not yet have Medicare or Medicaid numbers or an existing license number.

IV. 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.**

   PNW Hospice was approved to provide hospice services in Thurston County on October 29, 2021. However, since the Thurston agency is not yet operational PNW Hospice is not an existing agency. This question is thus not applicable.

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.**

   The projected utilization for the proposed agency is based on the DOH 2021-2022 Hospice Need Methodology, included as Exhibit 3. The 2021-2022 need methodology is extrapolated to 2026 to cover the first three full years of operation using linearly interpolated population forecast estimates from the Washington State Office of Financial Management (OFM). We present the forecasted population and extrapolated need estimates in Table 5 and our corresponding utilization assumptions in Table 6.

Table 5: Spokane County Forecasted Population and Hospice Need, 2023 to 2026

Spokane County Unmet Need	Row	2022	2023	2024	2025	2026
Population						
0 to 64	1	428,033	429,326	430,619	431,912	434,052
65+	2	97,979	101,288	104,597	107,906	110,710
Admissions per Capita						
0 to 64	3	0.0008	0.0008	0.0008	0.0008	0.0008
65+	4	0.0261	0.0261	0.0261	0.0261	0.0261
Potential Volume						
0 to 64 ([1]*[3])	5	342	343	344	345	347
65+ ([2]*[4])	6	2,554	2,641	2,727	2,813	2,886
All ages ([5]+[6])	7	2,897	2,984	3,071	3,158	3,233
Supply (2018-2020 Spokane Avg)	8	2,721	2,721	2,721	2,721	2,721
Unmet Admissions ([8]-[7])	9	176	263	351	438	513

ALOS (WA Avg.)	10	62.12	62.12	62.12	62.12	62.12
Unmet Patient Days ([9]*[10])	11	10,934	16,357	21,780	27,203	31,851
Unmet ADC ([11}/365)	12	30	45	60	75	87

Sources: Admissions per person from DOH 2021-2022 Hospice Need Methodology for the 0 to 64 and 65+ age cohort groups. Population from OFM Medium Series and a linear interpolation between forecast years.

Notes: Patient days based on Washington State ALOS average of 62.12. ADC calculated by dividing patient days by 365. Numbers presented in table reflect rounding for presentation purposes.

Table 6: Utilization Forecast Assumptions

Utilization Assumptions	Row	2022	2023	2024	2025	2026
Unmet Admissions	1	176	263	351	438	513
Proportion of Unmet Need	2	0%	30%	35%	40%	50%
Total Admissions ([1]*[2])	3	0.00	79.00	122.70	175.20	256.40
Patients per Month ([3]/12)	4	0.0	6.6	10.2	14.6	21.4

Sources: Table 5 and self-calculations.

From the number of unmet patient days in Table 5 and the assumed proportion of unmet need in Table 6, we forecast patient counts and patient days over the first three full years of operation in Table 7. Additional assumptions include an average length of stay ("ALOS") equal to 62.12 and a facility opening date of July 1, 2023.

We note that the assumed proportion of unmet need equal to 50% in Year 3 represents a conservative estimate and indicates the potential for Spokane County providers to expand utilization even with the presence of the proposed agency.

Table 7: PNW Hospice Projected Utilization

Utilization Forecast	Row	2023 (Q3 and Q4	2024	2025	2026
Months	1	6	12	12	12
Patients per Month	2	6.6	10.2	14.6	21.4
Unduplicated hospice patients ([1]*[2])	3	39.6	122.4	175.2	256.8
ALOS (WA Avg.)	4	62.12	62.12	62.12	62.12
Total visits ([3]*[4])	5	2,460	7,603	10,883	15,952
ADC [5]/365	6	13.5	20.8	29.8	43.7

Source: Applicant
Notes: The Total Admissions presented in Table 6 differ slightly from the Unduplicated Hospice Patients in Table 7 because of rounding the calculated patients per month to the nearest decimal.

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

As we document below in Table 8, hospice admissions at the three Spokane County hospice providers have not increased commensurate with population and deaths of Spokane County residents. This indicates that Spokane County residents have either (1) gone without needed hospice services, (2) substituted other types of care, or (3) outmigrated and changed their residency to other planning areas. However, all these possibilities indicate factors which currently restrict access and will become more restrictive over time. The first is self-explanatory – Spokane County residents in need of hospice services have not received the needed care and have simply gone without. As unmet need grows over time, as forecasted in Table 5, this problem will intensify.

Another possibility is that Spokane County residents have and/or will use alternatives to hospice services. These include the use of skilled nursing facilities or nursing homes, which may provide services related to physical and mental therapies, bereavement services, spiritual counseling, and others. However, the most recent Department nursing home need methodology projects extreme shortages of nursing home capacity in Spokane County.[3] This suggests a limited availability of alternative providers of hospice-like services and an emphasis on the need for additional hospice agencies to not only meet the hospice need, but also to lessen the strain on other services and allow access to those services for other patients in the community.

Spokane County residents unable to obtain hospice services with existing providers may choose to move their residency to another county or state with greater capacity. However, moving is costly and time consuming, and not possible for all individuals. For these and other reasons, Spokane County residents will be differentially able to access hospice services, with many of the most vulnerable populations left out.

These factors outlined above indicate both current and future problems related to access to hospice services for Spokane County residents. Importantly, these factors will differentially impact individuals in poverty, for which these problems of access would be magnified. We highlight the emphasis on patient access within MultiCare, which has a documented history of providing significant and above-average amounts of financial assistance to financially indigent individuals across Washington State.

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.

There currently exist three providers within Spokane County. These include Kindred Hospice, Horizon Hospice, and Hospice of Spokane. We present hospice admissions by agency in Table 8 over the period 2017 to 2020.

[3] The 2021-2023 Nursing Home Bed need calculations project a shortage of 1,186 nursing home beds in 2023. (https://www.doh.wa.gov/Portals/1/Documents/2300/2018/NH-BedNeedMethodology.pdf, Last Accessed December 7, 2020).

Table 8: Spokane County Hospice Admissions by Agency, 2017 to 2020

Admissions by Agency	2017	2018	2019	2020	2017-2020 CAGR
Horizon Hospice	455	420	423	484	2.12%
Hospice of Spokane	2,062	1,939	1,981	2,197	2.18%
Kindred Hospice	347	289	100	329	-1.73%
All providers	2,864	2,648	2,504	3,010	1.70%

Sources: DOH 2018-2019 Hospice Numeric Need Methodology, 2021-2022 Hospice Numeric Need Methodology

Notes: CAGR defined as the Compound Annual Growth Rate

From Table 8, since 2017, hospice admissions to Spokane County providers have increased modestly, with all growth in 2020. On the other hand, deaths to Spokane County residents have increased by about 8.4% per year over the same period.[4] As we describe and present in Table 6, this application proposes to serve only a portion of the current and future unmet need expected across the first three full years of operation, so would not affect the volumes at existing Spokane County providers and would thus not represent an unnecessary duplication of services.

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

We confirm the proposed agency will be available and accessible for all Spokane County residents in need of hospice services.

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

PNW Hospice is guided by a mission to provide high quality, compassionate patient-centered care. We are committed to serving all patients, including those who lack health insurance coverage and who cannot pay for all or part of the essential care they receive. We are committed to maintaining Financial Assistance policies that are consistent with our mission and values and that consider an individual's ability to pay for medically necessary health care services. We have provided a copy of our financial assistance policy in Exhibit 4.

All referred patients of any age who meet eligibility criteria and desire hospice care will be considered for admission by the hospice Interdisciplinary Team (IDT). Patients will be accepted for referral without regard to race, gender, sexual orientation, national origin, religion, age, physical impairments, other protected class, or the ability to pay for medical care.

Hospice services are provided wherever the patient calls home. This may be a private home, an Assisted Living Community, Skilled Nursing Facility, or Adult Family Home.

[4] DOH 2018-2019 Hospice Numeric Need Methodology, 2021-2022 Hospice Numeric Need Methodology. This increase in deaths includes a large increase between 2019 and 2020, which likely accounts for the increased hospice admissions documented in Table 8.

7. **Provide a copy of the following policies:**
   - **Admissions policy**
   - **Charity care or financial assistance policy**
   - **Patient Rights and Responsibilities policy**
   - **Non-discrimination policy**
   - **Any other policies directly related with patient access (example, involuntary discharge)**

   Please see Exhibit 4 for a copy of our Financial Assistance Policy. Copies of our Admissions and Intake Policies are included in Exhibit 5, our Patient Rights and Responsibilities Policies in Exhibit 6, and our Policy related to Non-Discrimination and the handling of related complaints in Exhibit 7.

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.

   Given that there exists numeric need in the Spokane County Planning Area, consistent with the Department Evaluation of CN21-52, this question is not applicable.[5]

[5] We reference the discussion on page 28 of the Evaluation of CN21-52 where the Department states "WAC 246-310-290(12) is not intended to be used for counties that show numeric need".

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

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

1. **Provide documentation that demonstrates the immediate and long-range capital and operating costs of the project can be met. This should include but is not limited to:**
   - **Utilization projections. These should be consistent with the projections provided under the Need section. Include all assumptions.**
   - **Pro Forma revenue and expense projections for at least the first three full calendar years of operation. 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.**

     Our utilization projections are provided in Table 7 above. Our Pro Forma forecasts, including a Statement of Revenues and Expenses, a balance sheet and cash flow statement are included in Exhibit 11. This exhibit also includes documentation of all financial assumptions.

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.

   Please see the signed Medical Director Agreement and First Amendment included in Exhibit 8. None of the other listed agreements/contracts are applicable to the proposed project.

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 projection year. 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.**

Site control documents will include a signed, notarized lease between MultiCare and PNW Hospice and documentation demonstrating ownership of the proposed location by MultiCare. Documentation demonstrating MultiCare ownership of the building where PNW Hospice will lease space is included in Exhibit 9, as is the draft lease. The signed, notarized lease will be provided in screening in Exhibit 9.

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

Table 9: PNW Hospice Project Capital Expenditures

Item	Cost
a. Land Purchase	
b. Utilities to Lot Line	
c. Land Improvements	
d. Building Purchase	
e. Residual Value of Replaced Facility	
f. Building Construction	
g. Fixed Equipment (not already included in the construction contract)	
h. Movable Equipment	$60,839.59
i. Architect and Engineering Fees	
j. Consulting Fees	
k. Site Preparation	
l. Supervision and Inspection of Site	
m. Any Costs Associated with Securing the Sources of Financing (include interim interest during construction	
1. Land	

2. Building	
3. Equipment	
4. Other	
n. Washington Sales Tax (8.9%)	$5,414.72
Total Estimated Capital Expenditure	$66,254.31

Sources: See Equipment List in Table 11.

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.

MultiCare will finance all costs presented in Table 9, as well as start-up and working capital expenses for the proposed project from its corporate reserves. Please see Exhibit 10 for a letter affirming this commitment.

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.

Please see Exhibit 11, PNW Hospice financial statements. We have estimated pre-operational start-up costs and capital expenditures as equal to $222,914. This includes the equipment costs, noted above, and pre-operational costs to customize and implement Epic, staff recruitment/training and other costs. These costs are identified in Exhibit 11. There would also be the CN application fee, for a total of $244,882 in pre-operational expenditures, as identified in the Balance Sheet in Exhibit 11. Finally, there would be working capital requirements of $310,000 over the early years of operations to fund short-term operating losses.

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.

MultiCare will finance all start-up and working capital requirements for the proposed project. Please see Exhibit 10 for a letter affirming this commitment.

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

The equipment costs, start-up costs and working capital expenditures, outlined above reflect the capital required for PNW Hospice to become Medicare Certified and Medicaid Eligible. These amounts will be fully funded from existing MultiCare reserves, against which these project costs represent a relatively small proportion. Furthermore, PNW Hospice expects over 90% of its patients to be funded through Medicare or Medicaid programs, which operate based on set fee schedules. Thus, the proposed project will not impact costs or charges for health services in Spokane County.

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.

There are no construction costs associated with the proposed project. Please see our response to Question 8 above regarding the impact on costs and charges of the proposed project. There is thus no reason to expect that the costs of the project will result in an unreasonable impact on the costs and charges for health services in the planning area.

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."

Please see Table 10 for the projected payer mix by source[6].

Table 10: PNW Hospice Payer Mix

Payer	Pct. Payer Source	Pct. Patients
Medicare/ Managed Medicare	88.2%	88.2%
Medicaid/ Managed Medicaid	3.6%	3.6%
Commercial	3.9%	3.9%
Self-Pay	0.2%	0.2%
Health Care Exchange	0.5%	0.5%
Other (1)	3.6%	3.6%
Total	100.0%	100.0%

Source: Applicant

Notes: "Other" payers include Tricare, Veterans Admin., Worker Compensation, and Healthcare Exchange payers.

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.

PNW Hospice was approved to provide hospice services in Thurston County on October 29, 2021. However, since the Thurston agency is not yet operational PNW Hospice is not an existing agency. This question is thus not applicable.

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.

[6] These payer percentages are based off the historical experience of MultiCare's existing hospice agency.

Equipment proposed for this project include furnishings and other office machines and related equipment. Please see Table 11 for a full list of equipment with costs.

Table 11: PNW Hospice, Equipment List

Furniture	Unit Cost	Units	Total Cost
Desks	$1,362	12	$16,339
Conf Room Table	$1,128	1	$1,128
Conf Room Chairs	$245	8	$1,960
Office Chairs	$99	12	$1,188
Subtotal			**$20,615**
Sales Tax			$1,835
Furniture Total			**$22,449**
Equipment & Phone	**Unit Cost**	**Units**	**Total Cost**
Laptop Computer	$1,589	13	$20,657
Docking Station	$200	13	$2,600
24-inch Monitor, Keyboard and Mouse	$188	26	$4,888
Cables /Wires	$20	13	$260
Color copier, scanner, printer, and fax	$9,000	1	$9,000
Extra drawers/cabinet	$220	1	$220
Desk/Office Phone	$200	13	$2,600
Subtotal			**$40,225**
Sales Tax			$3,580
Equipment & Phone Total			**$43,805**
Equipment Total			**$66,254.31**

Sources: Furniture costs from Contract Design Associates. Equipment and phone costs from Applicant experience.

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

This project will be financed from MultiCare reserves. Please see Exhibit 10 for a letter of financial commitment.

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 question is not applicable.

15. Provide the most recent audited financial statements for:

- **The applicant, and**
- **Any parent entity responsible for financing the project.**

Please see Exhibit 12 for MultiCare audited financial statements for the period 2019 to 2020.

C. Structure and Process (Quality) of Care (WAC 346-310-230)

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.**

   The number of FTEs by occupational category is presented in Table 12.

Table 12: PNW Hospice, Projected FTEs (Productive & Non-Productive) by Occupational Category

Internal Staffing, Productive & Non-Productive	2023 (Q3 & Q4)	2024	2025	2026
Administrator	0.50	1.00	1.00	1.00
Clinical Supervisor	0.50	1.00	1.50	1.50
Intake/Scheduling	0.50	1.00	1.00	2.00
Volunteer Coordinator	0.50	1.00	1.00	1.00
RN	1.44	4.44	6.35	9.31
Medical Social Worker	0.23	0.70	1.01	1.48
Chaplain	0.09	0.27	0.39	0.58
Hospice Aide	0.64	1.99	2.84	4.17
Total FTEs	**4.39**	**11.40**	**15.09**	**21.03**

Source: Applicant

Notes: 2023 FTE counts adjusted for the partial year of operations. Non-productive factor equals 10%.

In addition to the positions specified above, PNW Hospice will contract for the medical director, included in Professional Fees in the Statement of Revenues and Expenses (Exhibit 11) and for the positions listed in Table 13, as needed.

Table 13: PNW Hospice, List of Positions to be Contracted as Needed

External Staffing (Contracted as needed)
Massage Therapist
Music Therapist
Speech Therapist
Physical Therapist
Occupational Therapist
Dietary Technician

Source: Applicant

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.**

   PNW Hospice was approved to provide hospice services in Thurston County on October 29, 2021. However, since the Thurston agency is not yet operational PNW Hospice is not an existing agency. This question is thus not applicable.

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

   The projected FTE numbers for the clinical occupational categories of Registered Nurse, Medical Social Worker, Hospice Aide, and Chaplain are based on the Staff-to-Patient ratios presented in Table 14 below[7]. These FTE counts are linked directly to the projected increases in utilization presented in Table 7, then inflated by 10 percent for non-productive time.

   The administrative occupational categories, including Administrator, Clinical Supervisor, Intake/Scheduling, and Volunteer Coordinator, all reflect expected administrative requirements. Based off the experience of MultiCare Hospice, we expect PNW Hospice to require one FTE Administrator and one, increasing to two FTEs for Intake/Scheduling. In addition, we expect the one FTE for Clinical Supervisor to increase to 1.5 FTEs in 2026, and for the Volunteer Coordinator to equal one FTE per year.

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

   Staffing for the proposed PNW Hospice was based on baseline staff-to-admission ratios for an assumed distribution of admits by occupation. We present these assumptions in Table 14.

[7] Patients and admits are considered the same.

Table 14: Staff to Admit Ratio and Distribution by Occupational Category

Type of Staff	PNW Hospice Staff / Patient Ratio	Proportion of Visits by Occupation
RN	1:15.48	51.01%
Physical	Contracted	0.06%
Occupational	Contracted	0.01%
Medical	1:30	0.02%
Speech	Contracted	15.67%
Hospice	1:17	8.16%
Chaplain	1:40	25.08%

Source: Applicant

These ratios are comparable to national averages as published by the National Hospice and Palliative Care Organization. Please see Table 15 for the ratio of FTEs to agency ADC. We note that approximately 3/4s of the PNW staff is allocated to clinical operations.

Table 15: Comparison of Staff to ADC Ratio by Source

Type of Staff	PNW Hospice (Spokane)	NHPCO 2014 National Summary
Skilled Nursing	1:5	1:6
Physical Therapist	Contracted	N/A
Occupational Therapist	Contracted	N/A
Medical Social Worker	1:30	1:20
Speech Therapist	Contracted	N/A
Home Health / Hospice Aide	1:11	1:11
Chaplain / Spiritual Counselor	1:75	1:40

Sources: 2014 National Summary of Hospice Care, p. 13, Table 14. https://www.nhpco.org/wp-content/uploads/2019/06/NDS_2014_National_Summary.pdf, Last Accessed December 14, 2021

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.**

The planned medical director is Dr. Isam Dorna, MD60123479

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

   The planned medical director will be contracted. Please see Exhibit 8.

7. **Identify key staff by name and professional license number, if known. (nurse manager, clinical director, etc.)**

   PNW Hospice plans to hire key staff after the CN approval and prior to start-up operations. Thus, the specific individuals associated with the key staff positions are not known at this time.

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

   PNW Hospice was approved to provide hospice services in Thurston County on October 29, 2021. However, since the Thurston agency is not yet operational PNW Hospice is not an existing agency. This question is thus not applicable.

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.**

   As a new hospice provider in the Spokane County market, PNW Hospice will recruit and hire core leadership and clinical staff prior to admission of Hospice patients. MultiCare is a known entity in the Spokane market through the presence of its two hospitals and broad outpatient network in the Spokane area.

   PNW Hospice, as a wholly-owned subsidiary of MultiCare, will, like MultiCare, offer competitive wages, excellent benefit packages, and many advantages to potential candidates to work for a large well-established health system. PNW Hospice will utilize MultiCare's talent acquisition team, who are experienced in recruiting Home Health & Hospice staff for its hospice locations. PNW Hospice will also use outside recruiter organizations as needed for hard to fill leadership positions. We will offer incentives such as relocation assistance and sign-on bonus to qualified candidates.

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

    PNW Hospice office hours of operation will be Monday-Friday from 8 a.m. to 5 p.m. After hours and weekends, the PNW Hospice after-hours staff will triage all calls and conduct any patient visits required. A RN and Hospice physician or Advanced Practice Provider ("APP") will be on-call after hours, 7 days per week.

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

    This is not an existing agency, however as a wholly-owned subsidiary of MultiCare, it will utilize MultiCare's method for assessing customer satisfaction and quality improvement related to hospice care.

The MultiCare Hospice Quality Assurance and Performance Improvement Plan (QAPI) includes the following PI activities which are consistent with accreditation requirements established by Centers for Medicare and Medicaid (CMS), The Joint Commission (TJC) and the Washington State DOH. For each of these monitoring and identification areas, MultiCare Home Health, Hospice and Palliative Care identifies opportunities for improvement and implements Performance Improvement guidelines.

- Monitor procedures with the potential to place patients at risk of disability or death, identify discrepancies and determine causation; identify adverse events and determine causation.
- Monitor medication usage, significant medication errors and significant adverse drug reactions;
- Monitor infection rates;
- Assess patient perception of the safety and quality of care, treatment or services;
- Assess the staff's perception of the culture of patient safety;
- Monitor falls, fall reduction activities, to include assessment, interventions and education;
- Monitor injuries, negative health outcomes and any incidents injurious to patients;
- Review patient grievances, needs, expectations and satisfaction.

The MultiCare Hospice QAPI also includes PI activities deemed necessary by Hospice leadership and applicable regulations to optimize clinical and operational processes.

MultiCare Hospice Quality and Safety Steering Committee (QSSC)
This committee meets quarterly to provide oversight of the quality activities and initiatives. The QSSC approves policies and procedures throughout the year as policies are drafted or revised in compliance with accreditation and regulation. The committee evaluates contracted care and services annually and assures actions to improve services when identified. In addition, the leadership team develops the QAPI Plan annually and reviews data and other information related to improving clinical outcomes and patient safety; identifies opportunities for improvement; approves recommendations from improvement teams relating to standardization and improvement of care; and reviews and approves designated committee activities.

Hospice Leadership Team
Meets weekly and additionally, as needed. Provides a forum to oversee, discuss and approve issues as well as policies/procedures affecting patients, their families and the entire agency. Composition includes the department-specific Medical Director and administrative leadership staff.

Practice Council
Meets on a monthly basis. It is comprised of a majority of clinical and/or support staff with facilitation provided by leadership. The groups provide function-specific organizational direction and guidance for organizational performance improvement. They facilitate and provide direct support for the Hospice QAPI Initiatives based on the strategic plan, strategic objectives and other organizational initiatives. Practice Councils regularly monitor quality indicators, identify and present trends to the leadership team, review policies that impact the quality of patient care, and celebrate PI efforts.

MULTICARE HOSPICE QUALITY AND SAFETY GOALS

1. **Improve HPCAHPS likely to recommend score (Process Goal)**.

Goal Statement: Ensure that we consistently provide best practice care to all our patients in a manner that meets our mission, visions and values and provides a positive and healing experience to our patients.
Target: Improve score by 5% from previous year
Tool Utilized: Press Ganey scores

2. Hospice visits in the last days of life (Outcomes Goal)

Goal Statement: This is a new claims-based outcome measure starting in 2022. An RN and/or MSW will complete an in person visit on at least 2 of the last 3 days of life.
Target: Rank 60th percentile
Tool Utilized: Epic

CUSTOMER SATISFACTION

The Home Health and Hospice Consumer Assessment of Healthcare Providers and Systems surveys, HHCAHPS and HCAHPS respectively, are administered by Press Ganey which, in turn, provides reports with survey results and benchmarking information.
Procedure:

1. The HCAHPS Survey is sent to the primary bereaved of the Hospice patient in the month following the patient's death.

2. The above surveys are sent along with a cover letter and a self- addressed stamped envelope, using mailing lists generated by using the electronic health record.

3. The data is reviewed by the Hospice team for analysis and trending. Survey results are shared with staff on an on-going basis.

4. Concerns identified in the survey are forwarded to the appropriate discipline to be promptly addressed; the appropriate individual may be any one of the clinical or leadership teams.

Under Customer Satisfaction, the 2021 Quality Goals for MultiCare Hospice.

- Outcome Goal: **Getting Timely Care**
    - Goal Statement: To improve the patient's perception that help is received as soon as needed and available after hours, in order to improve the comfort and needs of the hospice patient.
    - Target: Improve score by 5% from previous year
    - Tool Utilized: Press Ganey Patient Satisfaction Scores

- Outcome Goal: **Getting Help for Symptoms**

- Goal Statement: To improve the patient's perception that they received appropriate help for the alleviation of symptoms related to pain, trouble breathing, constipation and anxiety or sadness.
- Target: Improve score by 5% from previous year
- Tool Utilized: Press Ganey Patient Satisfaction Scores

- In addition, "Likelihood to Recommend" is also measured on percentile ranking for Press Ganey. The goal targets differ each quarter.

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

PNW Hospice was approved to provide hospice services in Thurston County on October 29, 2021. However, since the Thurston agency is not yet operational PNW Hospice is not an existing agency. This question is thus not applicable.

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

PNW Hospice was approved to provide hospice services in Thurston County on October 29, 2021. However, since the Thurston agency is not yet operational PNW Hospice is not an existing agency. This question is thus not applicable.

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

PNW Hospice, as a wholly-owned subsidiary of MultiCare, will draw upon the deep roots of MultiCare Home Health, Hospice and Palliative Care, which has been providing Hospice services for more than three decades.

- Massage Therapy: PNW Hospice will contract with various massage therapists to provide services to its hospice patients.

- Music and Aroma Therapy: PNW Hospice will contract with various therapists to provide music and aroma services to its hospice patients.

- Reiki Therapy: PNW Hospice will contract with various therapists to provide Reiki Therapy services to its hospice patients.

- Bereavement Services: Bereavement services will be provided by PNW Hospice for 12-15 months after the death of a loved one. Services will include a wide variety of educational bereavement support groups, individual counseling, and memorial events.

- Medical Equipment: MultiCare Hospice has a relationship with Bellevue Healthcare, and it is anticipated that PNW Hospice will utilize this firm, and others, as required, to provide Hospice medical equipment for Spokane.

- Pharmacy: PNW Hospice, as a subsidiary of MultiCare Health System, will be able to use the MultiCare pharmacy network. In addition, PNW Hospice will develop relationships with local pharmacies as needed.

- Respite Care: MultiCare Hospice has agreements with several skilled nursing home facilities and health & rehab centers for providing respite care to hospice patients in Spokane. Room, board, and dietary services are also included. We anticipate that PNW Hospice, as a subsidiary of MultiCare, will also utilize these facilities, and additional ones, as needed. Please see below for a list of these nursing homes and rehab centers in Spokane.
    - Prestige Care and Rehab Center
    - Sunshine Health
    - Cheney Care Center
    - EmpRes Healthcare
    - Touchmark Health
    - ManorCare of Spokane

- Ambulance and Medical Transportation Services: PNW Hospice will establish contracts with local medical transport companies and utilize local EMS providers, as necessary.
    - American Medical Response

The current relationships will be utilized, and new ones created as needed, to allow PNW Hospice to comprehensively meet the service demands for the project. Once the project is approved, PNW Hospice will work to make any necessary adjustments to existing MultiCare agreements that might be used and/or create new relationships/agreements with additional organizations and individuals to provide the full spectrum of hospice services in Spokane County. In cases where the expansion of ancillary services into Spokane County is not possible with an existing provider, PNW Hospice will develop new relationships to meet the needs of hospice patients in Spokane County.

In addition, support services, including finance, billing (revenue cycle), human resources, and compliance and risk, are provided by internal enterprise shared services staff located in MultiCare's Spokane offices. The existing support staff is sufficient to support hospice services in Spokane County.

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

PNW Hospice was approved to provide hospice services in Thurston County on October 29, 2021. However, since the Thurston agency is not yet operational PNW Hospice is not an existing agency. This question is thus not applicable.

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

PNW Hospice was approved to provide hospice services in Thurston County on October 29, 2021. However, since the Thurston agency is not yet operational PNW Hospice is not an existing agency. This question is thus not applicable.

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

As a subsidiary of MultiCare, PNW Hospice will have working relationships with both MultiCare Deaconess and Valley hospitals as well as MultiCare Rockwood Clinic in Spokane.

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

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

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

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.

PNW Hospice, as a subsidiary of the MultiCare, will promote continuity of care and help prevent fragmentation of services within Spokane County. Both Deaconess and Valley hospitals within Spokane County are part of MultiCare, and PNW Hospice will complement their provision of services across the care continuum. Without additional Hospice agencies, Spokane County residents in need of Hospice services will likely go without needed care. This would contribute to a fragmentation of healthcare services, where Spokane County families would be forced to either out-migrate or manage and plan the care for their members without assistance or coordination.

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.

PNW Hospice, as a subsidiary of MultiCare, will cooperate with all other MultiCare-affiliated hospitals. This includes the two local inpatient providers, MultiCare Deaconess and Valley hospitals.

In this regard, it should be noted that Valley Hospital received an “A” rating from The Leapfrog Group in late December 2020.[8] Further, MultiCare has been received warmly

[8] In late December 2020, Bill Robertson, the CEO of MultiCare, announced The LeapFrog Award, stating: “Today, I am very pleased to share with you some outstanding news: MultiCare Valley Hospital was

in the community and we continue to improve access to care generally, quality of care, and community engagement.

PNW Hospice will work to build on these relationships and establish new connections with planning area healthcare providers, as necessary.

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.

PNW Hospice is a wholly-owned subsidiary of MultiCare, which owns an additional hospice agency in Washington State. Between June 11, 2018 and June 18, 2018, Surveyors from the Washington State Department of Health (DOH) conducted a Medicare recertification survey at MultiCare Home Health, Hospice and Palliative Care in Tacoma, WA. During the survey, DOH surveyors determined that MultiCare Home Health, Hospice and Palliative Care in Tacoma did not meet the Condition of Participation (COP) for Medicare Hospice related to the initial and comprehensive assessment of the patient (42 CFR §418.54 CoP). We have attached the applicable plan of correction, and the results from the DOH surveyor's onsite post-survey revisit, in Exhibit 13. This exhibit also includes the Final Accreditation Report by The Joint Commission and the three-year renewal for MultiCare home care.

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.

As explained above, in June 2018 DOH surveyors determined that MultiCare Home Health, Hospice and Palliative Care in Tacoma did not meet the Condition of Participation (COP) for Medicare Hospice related to the initial and comprehensive assessment of the patient (42 CFR §418.54 CoP). We have attached the applicable plan of correction, and the results from the DOH surveyor's onsite post-survey revisit, in Exhibit 13.

The onsite post-survey revisit from the DOH surveyor "confirmed that the health deficiencies cited during the recent recertification survey have been corrected, and that the Condition(s) of Participation listed above has been met."

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recently recognized as one of only 19 hospitals in Washington to receive an "A" rating in the Fall 2020 Leapfrog Hospital Safety Grades." The LeapFrog Group, a Washington D.C.-based organization aiming to improve health care quality and safety for consumers and purchasers, released the new LeapFrog Hospital Safety Grades this week. Known as the "gold standard" of patient safety ratings, The LeapFrog Group rates and assigns A, B, C, D or F grades to more than 2,600 general hospitals across the country. An "A" rating indicates that Valley demonstrates the highest commitment to patient safety and reducing avoidable harm, including hospital acquired infections, errors, and accidents. This recognition speaks to the hard work of all Valley team members, and their dedication to delivering on our promise to take great care of the communities we serve. Their achievement is a shining example to others of what MultiCare providers and staff can accomplish as they seek to improve patient quality and service.

There have been no other instances of condition-level findings, and the issue related to the initial and comprehensive assessment of the patient was rectified quickly and to the satisfaction of the DOH. We are confident that the proposed agency will operate in a manner that ensures safe and adequate care and conforms to applicable federal and state requirements.

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.**

   Prior to submitting this application, PNW Hospice considered doing nothing, or requesting approval to provide hospice services to Spokane County residents (The Project). PNW Hospice believes significant need for additional hospice services exists in Spokane County, and so has applied for CN approval to establish an agency there.

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

Table 16: Promoting Access to Healthcare Services

Alternative	Advantages/Disadvantages
Alternative 1: Do nothing	• Does nothing to improve access in a market where need for an additional hospice agency exists. (Disadvantage, "D") • Without an additional hospice agency, residents of Spokane County would be unable to access needed care, and families would be forced to manage the care of their elderly members without assistance. (D)
Alternative 2: Establish a hospice agency in Spokane County (The Project)	• Improves access to needed hospice services in Spokane County. (A)

Table 17: Promoting Quality of Care

Alternative	Advantages/Disadvantages
Alternative 1: Do nothing	• Need exists in Spokane County. Without sufficient access to needed hospice services, families may be required to manage the care of their family members without assistance, adding to their burden and risking inadequate provision of hospice-related services. (D) • Without sufficient access to needed hospice services, planning area residents may be burdened with preventable emergency room visits or hospitalizations. (D)
Alternative 2: Establish a hospice agency in Spokane County (The Project)	• Promotes quality and continuity of care for Spokane County residents. (A) • If approved, PNW Hospice, as a subsidiary of MultiCare, will work seamlessly with both Deaconess and Valley hospitals, as well as other planning area providers, to provide high quality care to resident inpatients in need of hospice services.

Table 18: Cost Efficiency and Capital Impacts

Alternative	Advantages/Disadvantages
Alternative 1: Do nothing	• No capital expenditures necessary. (N) • Least costly with respect to capital expenditures. However, lack of sufficient access to hospice services would potentially lead to increased use of more expensive alternatives at planning area providers of inpatient services (emergency room utilization, hospitalization, etc.). (D)
Alternative 2: Establish a hospice agency in Spokane County (The Project)	• Limited Capital Expenditure necessary. (D) • Improved access prevents unnecessary emergency room and hospitalization visits in Spokane County. (A)

Table 19: Legal Restrictions	
Alternative	Advantages/Disadvantages
Alternative 1: Do nothing	• There are no legal restrictions to doing nothing. (N)
Alternative 2: Establish a hospice agency in Spokane County (The Project)	• This option requires Certificate of Need approval in Spokane County. This requires time and expense greater than that of Alternative 1. (D)

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

    This question is not applicable. The applicant plans to lease space in an existing medical office building.

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.**

    The proposed project will improve access to hospice care in Spokane County, hence delivery of health services. In this regard, not only will patient access improve, but patients' costs of receiving hospice care will fall. This promotes cost containment/cost effectiveness.

V. 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.

VI. 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.

   PNW Hospice is not planning to submit any other hospice applications under either of this year's concurrent review cycles.

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.**

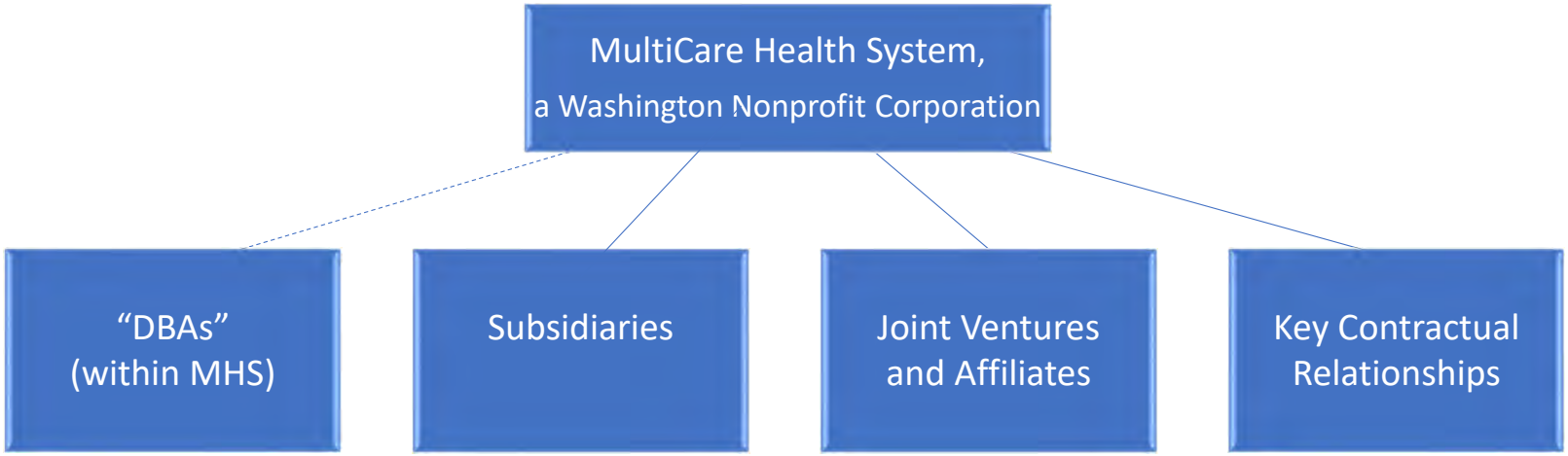
3. **Under the financial feasibility section, you should have provided a pro forma balance sheet showing the financial position of this project in the first three full calendar years of operation. Provide pro forma balance sheets for the applicant, assuming approval of this project showing the first 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.**

Exhibit 1

Organizational Chart

MultiCare – How We Are Organized and Conduct Business



Last updated 12/2/20

MultiCare Health System "Doing Business As"

Unless specifically noted, these DBAs operate within the MHS corporate entity as either divisions, programs or services of MultiCare.

Region

Puget Sound Region

HOSPITALS

- Auburn Medical Center
- Covington Medical Center
- Good Samaritan Hospital/ Parkland Off Campus ED
- Tacoma General / Allenmore Hospitals
- Capital Medical Center

CLINICS

- Gig Harbor Multi-specialty Medical Center
- Primary Care & Specialty Care Clinics
- MultiCare Medical Associates

OTHER

- New Adventures Daycare

Inland Northwest Region

- Deaconess Hospital/ North Deaconess Off Campus ED
- Valley Hospital
- Rockwood Clinic
- Neurosciences Institute

System

- Institute for Research & Innovation

Networks

Retail/Community

- Indigo Urgent Care
- Immediate Clinics
- Labs Northwest
- Virtual Health
- Occupational Health
- Home Health & Hospice
- Adult Day Health
- System Pharmacy

Pulse Heart Institute*

Mary Bridge

- Mary Bridge Children's Hospital Health Network
- ABC Pediatrics by Mary Bridge
- Woodcreek Pediatrics by Mary Bridge
- Treehouse

Behavioral Health

- Good Samaritan Behavioral Health
- Navos*
- Greater Lakes Mental Health*

Population Health

- MultiCare Connected Care, LLC*
- Physicians of Southwest Washington, LLC*
- PNWCIN, LLC* d/b/a Embright

* Operates through separate legal entity (see pg.3)

MultiCare Health System Subsidiaries*

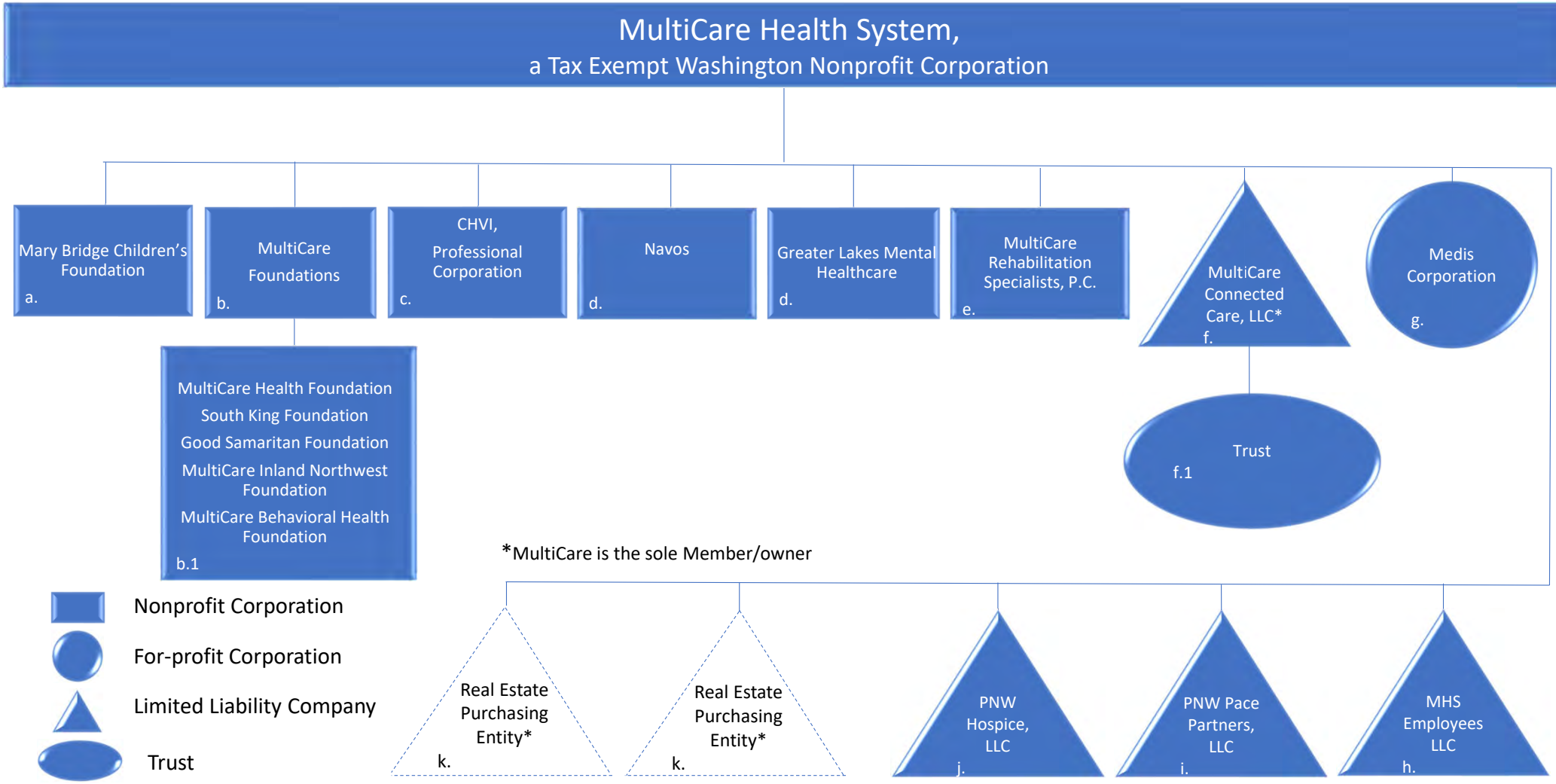


Exhibit 2

Letter of Intent

MultiCare Health System
820 A Street, Tacoma, WA 98402
PO Box 5299, Tacoma, WA 98415-0299 – multicare.org

RECEIVED
By CERTIFICATE OF NEED PROGRAM at 10:36 am, Nov 30, 2021

November 30, 2021

Eric Hernandez, Manager
Washington State Department of Health
Certificate of Need Program
111 Israel Rd. S.E.
Tumwater, WA 98501

Re: Letter of Intent for PNW Hospice, LLC, a Washington limited liability company and wholly owned subsidiary of MultiCare Health System, a Medicare Certified and Medicaid Eligible Hospice Agency to serve Spokane County

Dear Mr. Hernandez:

In accordance with WAC 246-310-080, PNW Hospice, LLC, a Washington limited liability company and wholly owned subsidiary of MultiCare Health System, hereby submits this Letter of Intent to operate a Medicare Certified and Medicaid Eligible Hospice Agency to serve residents of Spokane County.

1. Description of proposed service
   PNW Hospice, LLC, a Washington limited liability company and wholly owned subsidiary of MultiCare Health System, requests Certificate of Need approval to operate a Medicare Certified and Medicaid Eligible Hospice Agency in Spokane County.

2. Estimated cost of the project
   The estimated capital cost of the project is $66,254.

3. Identification of the service area
   The agency will serve Spokane County, as identified in WAC 246-310-290(3).

Please submit any notices, correspondence, communications and documents to:

Erin Kobberstad,
Vice President, Strategic Planning
MultiCare Health System
PO Box 5299, Mailstop: 820-4-SBD
Tacoma, WA 98415
ekobberstad@multicare.org

Thank you for your support. Please contact me if you have any questions.

Sincerely,

K Erin Kobberstad

K. Erin Kobberstad
Vice President, Strategic Planning
MultiCare Health System

Exhibit 3

DOH 2021-2022 Hospice Need Methodology

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

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

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

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

Hospice admissions ages 0-64	
Year	Admissions
2018	4,114
2019	3,699
2020	3,679
	average: 3,831

Deaths ages 0-64	
Year	Deaths
2018	14,055
2019	14,047
2020	16,663
	average: 14,922

Use Rates	
0-64	25.67%
65+	60.15%

Hospice admissions ages 65+	
Year	Admissions
2018	26,207
2019	26,017
2020	27,956
	average: 26,727

Deaths ages 65+	
Year	Deaths
2018	42,773
2019	44,159
2020	46,367
	average: 44,433

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

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

0-64				
County	**2018**	**2019**	**2020**	**2018-2020 Average Deaths**
Adams	28	35	20	**28**
Asotin	52	54	56	**54**
Benton	331	346	555	**411**
Chelan	130	137	224	**164**
Clallam	191	186	195	**191**
Clark	874	887	1,043	**935**
Columbia	6	7	7	**7**
Cowlitz	300	294	314	**303**
Douglas	51	63	42	**52**
Ferry	28	20	19	**22**
Franklin	145	123	100	**123**
Garfield	5	5	5	**5**
Grant	195	197	186	**193**
Grays Harbor	227	251	209	**229**
Island	135	167	110	**137**
Jefferson	64	72	68	**68**
King	3,264	3,275	4,456	**3,665**
Kitsap	515	557	454	**509**
Kittitas	68	90	78	**79**
Klickitat	58	46	42	**49**
Lewis	227	210	205	**214**
Lincoln	25	25	15	**22**
Mason	158	167	143	**156**
Okanogan	103	119	88	**103**
Pacific	64	66	55	**62**
Pend Oreille	43	31	41	**38**
Pierce	1,964	1,911	2,364	**2,080**
San Juan	19	20	18	**19**
Skagit	231	229	269	**243**
Skamania	27	19	26	**24**
Snohomish	1,533	1,533	1,587	**1,551**
Spokane	1,177	1,143	1,634	**1,318**
Stevens	113	112	86	**104**
Thurston	554	525	628	**569**
Wahkiakum	13	11	10	**11**
Walla Walla	110	118	150	**126**
Whatcom	360	394	457	**404**
Whitman	66	47	51	**55**
Yakima	601	555	653	**603**

65+				
County	**2018**	**2019**	**2020**	**2018-2020 Average Deaths**
Adams	72	93	59	**75**
Asotin	214	222	186	**207**
Benton	1,125	1,154	1,522	**1,267**
Chelan	573	626	785	**661**
Clallam	871	955	777	**868**
Clark	2,767	2,987	3,205	**2,986**
Columbia	43	52	43	**46**
Cowlitz	840	951	968	**920**
Douglas	255	270	160	**228**
Ferry	55	64	58	**59**
Franklin	278	313	263	**285**
Garfield	30	21	11	**21**
Grant	524	508	455	**496**
Grays Harbor	647	659	558	**621**
Island	675	642	505	**607**
Jefferson	336	338	273	**316**
King	9,917	10,213	11,186	**10,439**
Kitsap	1,713	1,811	1,714	**1,746**
Kittitas	239	266	241	**249**
Klickitat	158	160	113	**144**
Lewis	730	722	653	**702**
Lincoln	94	89	75	**86**
Mason	526	548	408	**494**
Okanogan	332	358	277	**322**
Pacific	279	265	177	**240**
Pend Oreille	130	125	101	**119**
Pierce	4,926	5,002	5,608	**5,179**
San Juan	114	127	94	**112**
Skagit	1,001	1,018	1,068	**1,029**
Skamania	56	87	47	**63**
Snohomish	4,055	4,081	4,278	**4,138**
Spokane	3,556	3,545	4,322	**3,808**
Stevens	373	345	248	**322**
Thurston	1,823	1,908	2,007	**1,913**
Wahkiakum	33	53	18	**35**
Walla Walla	445	450	522	**472**
Whatcom	1,252	1,461	1,481	**1,398**
Whitman	199	219	226	**215**
Yakima	1,517	1,451	1,675	**1,548**

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

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

0-64		
County	2018-2020 Average Deaths	Projected Patients: 25.67% of Deaths
Adams	28	7
Asotin	54	14
Benton	411	105
Chelan	164	42
Clallam	191	49
Clark	935	240
Columbia	7	2
Cowlitz	303	78
Douglas	52	13
Ferry	22	6
Franklin	123	31
Garfield	5	1
Grant	193	49
Grays Harbor	229	59
Island	137	35
Jefferson	68	17
King	3,665	941
Kitsap	509	131
Kittitas	79	20
Klickitat	49	12
Lewis	214	55
Lincoln	22	6
Mason	156	40
Okanogan	103	27
Pacific	62	16
Pend Oreille	38	10
Pierce	2,080	534
San Juan	19	5
Skagit	243	62
Skamania	24	6
Snohomish	1,551	398
Spokane	1,318	338
Stevens	104	27
Thurston	569	146
Wahkiakum	11	3
Walla Walla	126	32
Whatcom	404	104
Whitman	55	14
Yakima	603	155

65+		
County	2018-2020 Average Deaths	Projected Patients: 60.15% of Deaths
Adams	75	45
Asotin	207	125
Benton	1,267	762
Chelan	661	398
Clallam	868	522
Clark	2,986	1,796
Columbia	46	28
Cowlitz	920	553
Douglas	228	137
Ferry	59	35
Franklin	285	171
Garfield	21	12
Grant	496	298
Grays Harbor	621	374
Island	607	365
Jefferson	316	190
King	10,439	6,279
Kitsap	1,746	1,050
Kittitas	249	150
Klickitat	144	86
Lewis	702	422
Lincoln	86	52
Mason	494	297
Okanogan	322	194
Pacific	240	145
Pend Oreille	119	71
Pierce	5,179	3,115
San Juan	112	67
Skagit	1,029	619
Skamania	63	38
Snohomish	4,138	2,489
Spokane	3,808	2,290
Stevens	322	194
Thurston	1,913	1,150
Wahkiakum	35	21
Walla Walla	472	284
Whatcom	1,398	841
Whitman	215	129
Yakima	1,548	931

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

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

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**
Adams	**7**	**18,160**	18,456	18,622	18,787	7	7	7
Asotin	**14**	**16,715**	16,596	16,540	16,485	14	14	14
Benton	**105**	**167,984**	171,026	172,638	174,249	107	108	109
Chelan	**42**	**62,227**	62,512	62,562	62,611	42	42	42
Clallam	**49**	**52,494**	52,233	52,027	51,821	49	49	48
Clark	**240**	**411,278**	421,901	426,529	431,158	246	249	252
Columbia	**2**	**2,822**	2,745	2,710	2,675	2	2	2
Cowlitz	**78**	**85,817**	85,843	85,769	85,695	78	78	78
Douglas	**13**	**35,130**	35,803	36,080	36,356	14	14	14
Ferry	**6**	**5,628**	5,541	5,506	5,470	6	6	6
Franklin	**31**	**88,012**	92,443	94,784	97,124	33	34	35
Garfield	**1**	**1,581**	1,541	1,522	1,502	1	1	1
Grant	**49**	**86,033**	88,240	89,322	90,403	51	51	52
Grays Harbor	**59**	**57,387**	56,679	56,401	56,122	58	58	57
Island	**35**	**63,114**	63,280	63,296	63,312	35	35	35
Jefferson	**17**	**20,705**	20,636	20,550	20,463	17	17	17
King	**941**	**1,885,115**	1,918,470	1,930,192	1,941,913	958	963	969
Kitsap	**131**	**218,538**	220,614	221,192	221,771	132	132	133
Kittitas	**20**	**38,453**	39,286	39,556	39,827	21	21	21
Klickitat	**12**	**15,702**	15,439	15,304	15,168	12	12	12
Lewis	**55**	**62,700**	63,164	63,327	63,491	55	55	56
Lincoln	**6**	**7,864**	7,751	7,698	7,644	5	5	5
Mason	**40**	**50,632**	51,397	51,672	51,946	41	41	41
Okanogan	**27**	**32,364**	32,087	31,991	31,896	26	26	26
Pacific	**16**	**14,545**	14,322	14,242	14,161	16	16	15
Pend Oreille	**10**	**9,859**	9,769	9,727	9,684	10	10	10
Pierce	**534**	**756,339**	769,918	774,696	779,475	543	547	550
San Juan	**5**	**10,863**	10,730	10,707	10,684	5	5	5
Skagit	**62**	**100,807**	101,887	102,236	102,586	63	63	63
Skamania	**6**	**9,248**	9,223	9,205	9,186	6	6	6
Snohomish	**398**	**705,787**	721,527	726,273	731,019	407	410	412
Spokane	**338**	**423,256**	426,740	428,033	429,326	341	342	343
Stevens	**27**	**34,109**	33,917	33,841	33,766	26	26	26
Thurston	**146**	**238,190**	243,867	246,235	248,602	150	151	152
Wahkiakum	**3**	**2,498**	2,405	2,368	2,332	3	3	3
Walla Walla	**32**	**50,763**	51,028	51,075	51,121	33	33	33
Whatcom	**104**	**185,418**	189,267	190,722	192,178	106	107	107
Whitman	**14**	**43,222**	43,315	43,322	43,330	14	14	14
Yakima	**155**	**222,774**	225,822	227,147	228,473	157	158	159

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

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.

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
Adams	**45**	**2,227**	2,383	2,424	2,466	48	49	50
Asotin	**125**	**5,812**	6,175	6,344	6,514	132	136	140
Benton	**762**	**30,986**	33,373	34,597	35,820	821	851	881
Chelan	**398**	**15,876**	17,052	17,695	18,339	427	443	460
Clallam	**522**	**21,800**	22,901	23,535	24,168	548	563	579
Clark	**1,796**	**78,605**	85,686	89,247	92,807	1,958	2,039	2,121
Columbia	**28**	**1,236**	1,287	1,304	1,322	29	29	30
Cowlitz	**553**	**22,148**	23,719	24,470	25,220	592	611	630
Douglas	**137**	**7,976**	8,666	8,974	9,283	149	155	160
Ferry	**35**	**2,168**	2,289	2,337	2,386	37	38	39
Franklin	**171**	**9,188**	10,083	10,557	11,030	188	197	206
Garfield	**12**	**645**	669	680	692	13	13	13
Grant	**298**	**14,861**	16,071	16,665	17,258	322	334	346
Grays Harbor	**374**	**16,123**	17,133	17,612	18,092	397	408	419
Island	**365**	**20,239**	21,412	22,047	22,682	386	398	409
Jefferson	**190**	**11,588**	12,323	12,722	13,121	202	208	215
King	**6,279**	**310,572**	337,771	350,881	363,992	6,829	7,094	7,359
Kitsap	**1,050**	**53,833**	58,185	60,492	62,800	1,135	1,180	1,225
Kittitas	**150**	**7,647**	8,266	8,589	8,911	162	168	174
Klickitat	**86**	**5,829**	6,268	6,448	6,627	93	96	98
Lewis	**422**	**16,808**	17,697	18,175	18,652	444	456	468
Lincoln	**52**	**2,891**	3,039	3,119	3,200	54	56	57
Mason	**297**	**15,905**	17,167	17,836	18,504	321	333	346
Okanogan	**194**	**10,475**	11,210	11,519	11,827	207	213	219
Pacific	**145**	**6,747**	7,035	7,159	7,284	151	153	156
Pend Oreille	**71**	**3,925**	4,239	4,371	4,504	77	80	82
Pierce	**3,115**	**130,688**	142,422	148,729	155,037	3,395	3,545	3,695
San Juan	**67**	**5,768**	6,174	6,357	6,541	72	74	76
Skagit	**619**	**27,881**	30,314	31,460	32,607	673	698	724
Skamania	**38**	**2,670**	2,923	3,048	3,172	42	43	45
Snohomish	**2,489**	**119,333**	131,978	138,737	145,495	2,753	2,894	3,035
Spokane	**2,290**	**87,852**	94,670	97,979	101,288	2,468	2,554	2,641
Stevens	**194**	**11,360**	12,214	12,591	12,969	208	215	221
Thurston	**1,150**	**50,757**	54,900	56,967	59,035	1,244	1,291	1,338
Wahkiakum	**21**	**1,503**	1,580	1,595	1,611	22	22	22
Walla Walla	**284**	**11,006**	11,350	11,632	11,915	293	300	308
Whatcom	**841**	**40,902**	44,217	45,794	47,372	909	941	974
Whitman	**129**	**5,526**	6,008	6,201	6,395	140	145	149
Yakima	**931**	**37,530**	39,475	40,559	41,643	979	1,006	1,033

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

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	2021 potential volume	2022 potential volume	2023 potential volume	Current Supply of Hospice Providers	2021 Unmet Need Admissions*	2022 Unmet Need Admissions*	2023 Unmet Need Admissions*
Adams	55	56	57	**51.33**	4	5	6
Asotin	146	150	153	**105.00**	41	45	48
Benton	928	959	990	**1,016.67**	(88)	(57)	(26)
Chelan	469	486	502	**428.67**	41	57	73
Clallam	597	612	627	**392.80**	204	219	234
Clark	2,204	2,288	2,372	**2,584.47**	(380)	(296)	(212)
Columbia	30	31	31	**35.00**	(5)	(4)	(4)
Cowlitz	670	689	708	**788.00**	(118)	(99)	(80)
Douglas	163	168	174	**160.67**	2	8	13
Ferry	43	44	45	**32.00**	11	12	13
Franklin	221	231	240	**201.67**	19	29	39
Garfield	14	14	15	**6.00**	8	8	9
Grant	373	386	398	**292.33**	81	93	106
Grays Harbor	455	466	477	**295.57**	160	170	181
Island	422	433	445	**399.67**	22	34	45
Jefferson	219	226	232	**198.00**	21	28	34
King	7,786	8,057	8,328	**7,830.73**	(44)	226	497
Kitsap	1,267	1,312	1,358	**1,223.57**	43	89	134
Kittitas	182	189	195	**168.00**	14	21	27
Klickitat	105	108	110	**217.80**	(113)	(110)	(107)
Lewis	500	512	524	**445.33**	54	67	79
Lincoln	60	61	63	**29.00**	31	32	34
Mason	361	374	387	**304.57**	57	70	82
Okanogan	234	239	245	**188.33**	45	51	57
Pacific	166	169	171	**93.00**	73	76	78
Pend Oreille	87	89	92	**65.33**	22	24	26
Pierce	3,938	4,092	4,246	**3,596.23**	342	496	649
San Juan	77	79	81	**87.00**	(10)	(8)	(6)
Skagit	736	762	787	**729.00**	7	33	58
Skamania	48	50	51	**32.00**	16	18	19
Snohomish	3,160	3,303	3,447	**3,508.33**	(349)	(205)	(61)
Spokane	2,809	2,897	2,984	**2,720.50**	89	176	263
Stevens	235	241	247	**148.67**	86	92	99
Thurston	1,394	1,442	1,491	**1,565.30**	(171)	(123)	(75)
Wahkiakum	25	25	25	**9.33**	15	16	16
Walla Walla	326	333	340	**272.33**	53	60	68
Whatcom	1,015	1,048	1,081	**1,094.57**	(80)	(46)	(13)
Whitman	154	159	163	**158.17**	(4)	1	5
Yakima	1,136	1,164	1,192	**1,261.00**	(125)	(97)	(69)

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

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

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***
Adams	4	5	6	**62.12**	244	300	356
Asotin	41	45	48	**62.12**	2,563	2,786	3,009
Benton	(88)	(57)	(26)	**62.12**	(5,497)	(3,565)	(1,633)
Chelan	41	57	73	**62.12**	2,535	3,539	4,542
Clallam	204	219	234	**62.12**	12,682	13,613	14,543
Clark	(380)	(296)	(212)	**62.12**	(23,619)	(18,396)	(13,174)
Columbia	(5)	(4)	(4)	**62.12**	(281)	(258)	(235)
Cowlitz	(118)	(99)	(80)	**62.12**	(7,320)	(6,160)	(5,000)
Douglas	2	8	13	**62.12**	134	470	807
Ferry	11	12	13	**62.12**	691	737	784
Franklin	19	29	39	**62.12**	1,201	1,801	2,401
Garfield	8	8	9	**62.12**	506	518	531
Grant	81	93	106	**62.12**	5,021	5,799	6,578
Grays Harbor	160	170	181	**62.12**	9,916	10,589	11,261
Island	22	34	45	**62.12**	1,377	2,090	2,802
Jefferson	21	28	34	**62.12**	1,324	1,726	2,127
King	(44)	226	497	**62.12**	(2,759)	14,070	30,899
Kitsap	43	89	134	**62.12**	2,696	5,513	8,331
Kittitas	14	21	27	**62.12**	889	1,290	1,691
Klickitat	(113)	(110)	(107)	**62.12**	(6,994)	(6,835)	(6,676)
Lewis	54	67	79	**62.12**	3,378	4,132	4,886
Lincoln	31	32	34	**62.12**	1,917	2,004	2,091
Mason	57	70	82	**62.12**	3,529	4,319	5,108
Okanogan	45	51	57	**62.12**	2,823	3,173	3,523
Pacific	73	76	78	**62.12**	4,554	4,714	4,875
Pend Oreille	22	24	26	**62.12**	1,337	1,483	1,630
Pierce	342	496	649	**62.12**	21,240	30,788	40,337
San Juan	(10)	(8)	(6)	**62.12**	(639)	(507)	(375)
Skagit	7	33	58	**62.12**	435	2,029	3,623
Skamania	16	18	19	**62.12**	984	1,094	1,204
Snohomish	(349)	(205)	(61)	**62.12**	(21,649)	(12,726)	(3,802)
Spokane	89	176	263	**62.12**	5,511	10,934	16,357
Stevens	86	92	99	**62.12**	5,345	5,741	6,136
Thurston	(171)	(123)	(75)	**62.12**	(10,646)	(7,645)	(4,643)
Wahkiakum	15	16	16	**62.12**	956	967	977
Walla Walla	53	60	68	**62.12**	3,304	3,758	4,213
Whatcom	(80)	(46)	(13)	**62.12**	(4,953)	(2,888)	(823)
Whitman	(4)	1	5	**62.12**	(231)	50	330
Yakima	(125)	(97)	(69)	**62.12**	(7,760)	(6,032)	(4,305)

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

Sources: CPS MDCR Hospice 3 Report
Self-Report Provider Utilization Surveys for Years 2018-2020
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

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***
Adams	244	300	356	1	1	1
Asotin	2,563	2,786	3,009	7	8	8
Benton	(5,497)	(3,565)	(1,633)	(15)	(10)	(4)
Chelan	2,535	3,539	4,542	7	10	12
Clallam	12,682	13,613	14,543	35	37	40
Clark	(23,619)	(18,396)	(13,174)	(65)	(50)	(36)
Columbia	(281)	(258)	(235)	(1)	(1)	(1)
Cowlitz	(7,320)	(6,160)	(5,000)	(20)	(17)	(14)
Douglas	134	470	807	0	1	2
Ferry	691	737	784	2	2	2
Franklin	1,201	1,801	2,401	3	5	7
Garfield	506	518	531	1	1	1
Grant	5,021	5,799	6,578	14	16	18
Grays Harbor	9,916	10,589	11,261	27	29	31
Island	1,377	2,090	2,802	4	6	8
Jefferson	1,324	1,726	2,127	4	5	6
King	(2,759)	14,070	30,899	(8)	39	85
Kitsap	2,696	5,513	8,331	7	15	23
Kittitas	889	1,290	1,691	2	4	5
Klickitat	(6,994)	(6,835)	(6,676)	(19)	(19)	(18)
Lewis	3,378	4,132	4,886	9	11	13
Lincoln	1,917	2,004	2,091	5	5	6
Mason	3,529	4,319	5,108	10	12	14
Okanogan	2,823	3,173	3,523	8	9	10
Pacific	4,554	4,714	4,875	12	13	13
Pend Oreille	1,337	1,483	1,630	4	4	4
Pierce	21,240	30,788	40,337	58	84	111
San Juan	(639)	(507)	(375)	(2)	(1)	(1)
Skagit	435	2,029	3,623	1	6	10
Skamania	984	1,094	1,204	3	3	3
Snohomish	(21,649)	(12,726)	(3,802)	(59)	(35)	(10)
Spokane	5,511	10,934	16,357	15	30	45
Stevens	5,345	5,741	6,136	15	16	17
Thurston	(10,646)	(7,645)	(4,643)	(29)	(21)	(13)
Wahkiakum	956	967	977	3	3	3
Walla Walla	3,304	3,758	4,213	9	10	12
Whatcom	(4,953)	(2,888)	(823)	(14)	(8)	(2)
Whitman	(231)	50	330	(1)	0	1
Yakima	(7,760)	(6,032)	(4,305)	(21)	(17)	(12)

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

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

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

Application Year

Step 7 (Patient Days / 365) = Unmet ADC				Step 8 - Numeric Need	
County	**2021 Unmet Need ADC***	**2022 Unmet Need ADC***	**2023 Unmet Need ADC***	**Numeric Need?**	**Number of New Agencies Needed?****
Adams	1	1	1	FALSE	FALSE
Asotin	7	8	8	FALSE	FALSE
Benton	(15)	(10)	(4)	FALSE	FALSE
Chelan	7	10	12	FALSE	FALSE
Clallam	35	37	40	***TRUE***	***1***
Clark	(65)	(50)	(36)	FALSE	FALSE
Columbia	(1)	(1)	(1)	FALSE	FALSE
Cowlitz	(20)	(17)	(14)	FALSE	FALSE
Douglas	0	1	2	FALSE	FALSE
Ferry	2	2	2	FALSE	FALSE
Franklin	3	5	7	FALSE	FALSE
Garfield	1	1	1	FALSE	FALSE
Grant	14	16	18	FALSE	FALSE
Grays Harbor	27	29	31	FALSE	FALSE
Island	4	6	8	FALSE	FALSE
Jefferson	4	5	6	FALSE	FALSE
King	(8)	39	85	***TRUE***	***2***
Kitsap	7	15	23	FALSE	FALSE
Kittitas	2	4	5	FALSE	FALSE
Klickitat	(19)	(19)	(18)	FALSE	FALSE
Lewis	9	11	13	FALSE	FALSE
Lincoln	5	5	6	FALSE	FALSE
Mason	10	12	14	FALSE	FALSE
Okanogan	8	9	10	FALSE	FALSE
Pacific	12	13	13	FALSE	FALSE
Pend Oreille	4	4	4	FALSE	FALSE
Pierce	58	84	111	***TRUE***	***3***
San Juan	(2)	(1)	(1)	FALSE	FALSE
Skagit	1	6	10	FALSE	FALSE
Skamania	3	3	3	FALSE	FALSE
Snohomish	(59)	(35)	(10)	FALSE	FALSE
Spokane	15	30	45	***TRUE***	***1***
Stevens	15	16	17	FALSE	FALSE
Thurston	(29)	(21)	(13)	FALSE	FALSE
Wahkiakum	3	3	3	FALSE	FALSE
Walla Walla	9	10	12	FALSE	FALSE
Whatcom	(14)	(8)	(2)	FALSE	FALSE
Whitman	(1)	0	1	FALSE	FALSE
Yakima	(21)	(17)	(12)	FALSE	FALSE

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

**The numeric need methodology projects need for whole hospice agencies only - not partial hospice agencies. Therefore, the results are rounded down to the nearest whole number.

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

Department of Health
2021-2022 Hospice Numeric Need Methodology
Admissions - Summarized

0-64 Total Admissions by County

Sum of 0-64	Column Labels		
Row Labels	2018	2019	2020
Adams	6	8	4
Asotin	6	9	24
Benton	118	103	132
Chelan	34	28	32
Clallam	16	23	24
Clark	336	287	297
Columbia	1	3	3
Cowlitz	107	121	94
Douglas	10	19	17
Ferry	6	5	3
Franklin	30	26	34
Garfield	1	1	3
Grant	41	45	40
Grays Harbor	35	41	27
Island	38	43	54
Jefferson	21	26	17
King	1009	765	889
Kitsap	180	173	96
Kittitas	15	16	12
Klickitat	10	12	12
Lewis	56	50	47
Lincoln	7	3	5
Mason	14	34	43
Okanogan	21	27	31
Pacific	13	15	12
Pend Oreille	8	4	17
Pierce	543	556	425
San Juan	6	6	8
Skagit	48	77	70
Skamania	2	1	3
Snohomish	422	342	361
Spokane	400	329	362
Stevens	30	20	21
Thurston	114	115	129
Wahkiakum	2	0	3
Walla Walla	24	41	41
Whatcom	117	138	80
Whitman	19	12	12
Yakima	248	175	195

65+ Total Admissions by County

Sum of 65+	Column Labels		
Row Labels	2018	2019	2020
Adams	34	54	48
Asotin	121	71	84
Benton	887	837	973
Chelan	386	385	421
Clallam	187	234	283
Clark	2124	2060	2238
Columbia	23	25	50
Cowlitz	600	735	707
Douglas	136	130	170
Ferry	29	25	28
Franklin	155	166	194
Garfield	2	4	7
Grant	261	236	254
Grays Harbor	180	212	186
Island	348	341	375
Jefferson	155	181	194
King	6359	6315	7131
Kitsap	1021	1074	921
Kittitas	135	169	157
Klickitat	81	90	87
Lewis	420	362	401
Lincoln	29	22	21
Mason	161	193	263
Okanogan	148	171	167
Pacific	72	98	69
Pend Oreille	53	65	49
Pierce	3175	3170	2714
San Juan	79	73	89
Skagit	680	705	607
Skamania	20	33	37
Snohomish	2636	2214	2636
Spokane	2247.5	2175	2648
Stevens	121	126	128
Thurston	936	947	1070
Wahkiakum	5	7	11
Walla Walla	227	242	242
Whatcom	770	995	978
Whitman	226.5	77	128
Yakima	977	998	1190

Total Admissions by County - Not Adjusted for New

County	2018	2019	2020	Average
Adams	40	62	52	**51.33**
Asotin	127	80	108	**105.00**
Benton	1005	940	1105	**1016.67**
Chelan	420	413	453	**428.67**
Clallam	203	257	307	**255.67**
Clark	2460	2347	2535	**2447.33**
Columbia	24	28	53	**35.00**
Cowlitz	707	856	801	**788.00**
Douglas	146	149	187	**160.67**
Ferry	35	30	31	**32.00**
Franklin	185	192	228	**201.67**
Garfield	3	5	10	**6.00**
Grant	302	281	294	**292.33**
Grays Harb	215	253	213	**227.00**
Island	386	384	429	**399.67**
Jefferson	176	207	211	**198.00**
King	7368	7080	8020	**7489.33**
Kitsap	1201	1247	1017	**1155.00**
Kittitas	150	185	169	**168.00**
Klickitat	91	102	99	**97.33**
Lewis	476	412	448	**445.33**
Lincoln	36	25	26	**29.00**
Mason	175	227	306	**236.00**
Okanogan	169	198	198	**188.33**
Pacific	85	113	81	**93.00**
Pend Oreill	61	69	66	**65.33**
Pierce	3718	3726	3139	**3527.67**
San Juan	85	79	97	**87.00**
Skagit	728	782	677	**729.00**
Skamania	22	34	40	**32.00**
Snohomish	3058	2556	2997	**2870.33**
Spokane	2647.5	2504	3010	**2720.50**
Stevens	151	146	149	**148.67**
Thurston	1050	1062	1199	**1103.67**
Wahkiakun	7	7	14	**9.33**
Walla Wall	251	283	283	**272.33**
Whatcom	887	1133	1058	**1026.00**
Whitman	245.5	89	140	**158.17**
Yakima	1225	1173	1385	**1261.00**

Total Admissions by County - Adjusted for New

Adjusted Cells Highlighted in YELLOW

County	2018	2019	2020	Average
Adams	40	62	52	**51.33**
Asotin	127	80	108	**105.00**
Benton	1005	940	1105	**1016.67**
Chelan	420	413	453	**428.67**
Clallam	203	462.7	512.7	**392.80**
Clark	2460	2552.7	2740.7	**2584.47**
Columbia	24	28	53	**35.00**
Cowlitz	707	856	801	**788.00**
Douglas	146	149	187	**160.67**
Ferry	35	30	31	**32.00**
Franklin	185	192	228	**201.67**
Garfield	3	5	10	**6.00**
Grant	302	281	294	**292.33**
Grays Harb	215	253	418.7	**295.57**
Island	386	384	429	**399.67**
Jefferson	176	207	211	**198.00**
King	7368	7400.4	8723.8	**7830.73**
Kitsap	1201	1247	1222.7	**1223.57**
Kittitas	150	185	169	**168.00**
Klickitat	272.7	281.7	99	**217.80**
Lewis	476	412	448	**445.33**
Lincoln	36	25	26	**29.00**
Mason	175	227	511.7	**304.57**
Okanogan	169	198	198	**188.33**
Pacific	85	113	81	**93.00**
Pend Oreill	61	69	66	**65.33**
Pierce	3718	3726	3344.7	**3596.23**
San Juan	85	79	97	**87.00**
Skagit	728	782	677	**729.00**
Skamania	22	34	40	**32.00**
Snohomish	3058	3378.8	4088.2	**3508.33**
Spokane	2647.5	2504	3010	**2720.50**
Stevens	151	146	149	**148.67**
Thurston	1255.7	1449.4	1990.8	**1565.30**
Wahkiakun	7	7	14	**9.33**
Walla Wall	251	283	283	**272.33**
Whatcom	887	1133	1263.7	**1094.57**
Whitman	245.5	89	140	**158.17**
Yakima	1225	1173	1385	**1261.00**

35 ADC * 365 days per year = 12,775 default patient days
12,775 patient days/62.12 ALOS = 205.7 default admissions
205.7 Default
For affected counties, the actual volumes from these recently approved agnecies will be subtracted, and default values will be added.

Sources:
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Recent approvals showing default volumes:

Olympic Medical Center - Clallam County. Approved in September 2019. Default volumes for 2019-2020
Providence Hospice - Clark County. Approved in 2019. Default volumes in 2019-2020
The Pennant Group - Grays Harbor County. Approved August 2021. No adjustment possible for 2021, adjustment in 2020 as proxy.
Wesley Homes Hospice - King County. Approved in 2015, operational since 2017. 2018 volumes exceed "default" - no adjustment for 2018. Adjustments in 2019.
Envision Hospice - King County. Approved in 2019. Default volumes for 2019-2020
Continuum Care of King - King County. CN issued March 2020. Default volumes for 2020
EmpRes Healthcare Group - King County. Approved in 2021. No adjustment possible for 2021, adjustment in 2020 as proxy.
Seasons Hospice - King County. Approved in 2021. No adjustment possible for 2021, adjustment in 2020 as proxy.
Envision Hospice - Kitsap County. Approved in 2020. Default volumes for 2020
Heart of Hospice - Klickitat County. Approved in August 2017. Operational since August 2017. Default volumes in 2018-2019.
The Pennant Group - Mason County. Approved September 2021. No adjustment possible for 2021, adjustment in 2020 as proxy.
Providence Health & Services - Pierce County. Approved in 2021. No adjustment possible for 2021, adjustment in 2020 as proxy.
Continuum Care of Snohomish - Snohomish County. Approved in July 2019. Default volumes in 2019-2020
Heart of Hospice - Snohomish County. Approved in November 2019. Default volumes for 2019-2020
Envision Hospice - Snohomish County. Approved in November 2019. Default volumes for 2019-2020
Glacier Peak Healthcare - Snohomish County. Approved in November 2019. Default volumes for 2019-2020
EmpRes Healthcare Group - Snohomish County. Approved in 2021. No adjustment possible for 2021, adjustment in 2020 as proxy.
Seasons Hospice - Snohomish County. Approved in 2021. No adjustment possible for 2021, adjustment in 2020 as proxy.
Envision Hospice - Thurston County. Approved in September 2018. Default volumes in 2018-2020.
Symbol Healthcare - Thurston County. Approved in November 2019. Default volumes for 2019-2020
Bristol Hospice - Thurston County. Approved March 2021. No adjustment possible for 2021, adjustment in 2020 as proxy.
MultiCare Health - Thurston County. Approved in 2021. No adjustment possible for 2021, adjustment in 2020 as proxy.
EmpRes Healthcare Group - Whatcom County. Approved in 2020. Default volumes for 2020

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Note: Kindred Hospice in Whitman and Spokane Counties did not respond to the department's survey for 2018 data. As a result, the average of 2016 and 2017 data was used as a proxy for 2018.

Agency Name	License Number	County	Year	0-64	65+
Assured Home Health and Hospice (Central Basin/Assured Hospice)	IHS.FS.60092413	Grant	2018	40	254
Assured Home Health and Hospice (Central Basin/Assured Hospice)	IHS.FS.60092413	Lincoln	2018	6	28
Assured Home Health and Hospice (Central Basin/Assured Hospice)	IHS.FS.60092413	Adams	2018	6	34
Assured Home Health, Hospice & Home Care	IHS.FS.00000229	Jefferson	2018	1	11
Assured Home Health, Hospice & Home Care	IHS.FS.00000229	Mason	2018	4	44
Assured Home Health, Hospice & Home Care	IHS.FS.00000229	Clallam	2018	16	186
Assured Home Health, Hospice & Home Care	IHS.FS.00000229	Thurston	2018	24	273
Assured Home Health, Hospice & Home Care	IHS.FS.00000229	Lewis	2018	35	280
Astria Home Health and Hospice (Yakima Regional Home Health and Hospice)	IHS.FS.60097245	Yakima	2018	41	8
Central Washington Hospital Home Care Services	IHS.FS.00000250	Douglas	2018	10	133
Central Washington Hospital Home Care Services	IHS.FS.00000250	Chelan	2018	34	386
Community Home Health and Hospice CHHH Community Home Care Hospice	IHS.FS.00000262	Wahkiakum	2018	2	5
Community Home Health and Hospice CHHH Community Home Care Hospice	IHS.FS.00000262	Clark	2018	54	383
Community Home Health and Hospice CHHH Community Home Care Hospice	IHS.FS.00000262	Cowlitz	2018	87	524
Elite Home Health and Hospice	IHS.FS.60384078	Garfield	2018	1	2
Elite Home Health and Hospice	IHS.FS.60384078	Asotin	2018	6	121
Evergreen Health Home Care Services	IHS.FS.00000278	Island	2018	1	9
Evergreen Health Home Care Services	IHS.FS.00000278	Snohomish	2018	79	690
Evergreen Health Home Care Services	IHS.FS.00000278	King	2018	348	1989
Franciscan Hospice	IHS.FS.00000287	Kitsap	2018	141	693
Franciscan Hospice	IHS.FS.00000287	King	2018	102	921
Franciscan Hospice	IHS.FS.00000287	Pierce	2018	331	2110
Frontier Home Health and Hospice (Okanogan Regional)	IHS.FS.60379608	Douglas	2018	0	3
Frontier Home Health and Hospice (Okanogan Regional)	IHS.FS.60379608	Grant	2018	1	7
Frontier Home Health and Hospice (Okanogan Regional)	IHS.FS.60379608	Okanogan	2018	21	148
Gentiva Hospice (Odyssey Hospice)	IHS.FS.60330209	King	2018	37	180
Harbors Home Health and Hospice	IHS.FS.00000306	Pacific	2018	13	71
Harbors Home Health and Hospice	IHS.FS.00000306	Grays Harbor	2018	35	180
Heart of Hospice	IHS.FS.00000185	Skamania	2018	none repo	10
Heart of Hospice	IHS.FS.00000185	Klickitat	2018	1	23
Heartlinks Hospice and Palliative Care (Lower Valley Hospice)	IHS.FS.00000369	Benton	2018	6	137
Heartlinks Hospice and Palliative Care (Lower Valley Hospice)	IHS.FS.00000369	Yakima	2018	24	219
Home Health Care of Whidbey General Hospital (Whidbey General)	IHS.FS.00000323	Island	2018	20	235
Homecare and Hospice Southwest (Hospice SW)	IHS.FS.60331226	Skamania	2018	1	1
Homecare and Hospice Southwest (Hospice SW)	IHS.FS.60331226	Cowlitz	2018	20	76
Homecare and Hospice Southwest (Hospice SW)	IHS.FS.60331226	Clark	2018	243	1305
Horizon Hospice	IHS.FS.00000332	Spokane	2018	31	389
Hospice of Kitsap County	IHS.FS.00000335	Kitsap	2018	0	0
Hospice of Spokane	IHS.FS.00000337	Lincoln	2018	1	1
Hospice of Spokane	IHS.FS.00000337	Ferry	2018	6	29
Hospice of Spokane	IHS.FS.00000337	Pend Oreille	2018	8	53
Hospice of Spokane	IHS.FS.00000337	Stevens	2018	30	121
Hospice of Spokane	IHS.FS.00000337	Spokane	2018	346	1593
Hospice of Spokane	IHS.FS.00000337	Whitman	2018	none repo	none repor
Hospice of the Northwest (Skagit Hospice Service)	IHS.FS.00000437	Island	2018	6	60
Hospice of the Northwest (Skagit Hospice Service)	IHS.FS.00000437	Snohomish	2018	2	67
Hospice of the Northwest (Skagit Hospice Service)	IHS.FS.00000437	San Juan	2018	6	79
Hospice of the Northwest (Skagit Hospice Service)	IHS.FS.00000437	Skagit	2018	48	680
IRREGULAR-COMMUNITY HOME HEALTH & HOSPICE	IHS.FS.00000262	Pacific	2018	0	1
IRREGULAR-MULTICARE	IHS.FS.60639376	Clallam	2018	0	1
Jefferson Healthcare Home Health and Hospice (Hospice of Jefferson County)	IHS.FS.00000349	Jefferson	2018	20	144
Kaiser Permanente Continuing Care Services	IHS.FS.00000353	Clark	2018	39	436
Kaiser Permanente Continuing Care Services	IHS.FS.00000353	Cowlitz	2018	none repo	none repor
Kaiser Permanente Continuing Care Services	IHS.FS.00000353	Skamania	2018	none repo	none repor
Kaiser Permanente Home Health and Hospice (Group Health)	IHS.FS.00000305	Snohomish	2018	14	94
Kaiser Permanente Home Health and Hospice (Group Health)	IHS.FS.00000305	Kitsap	2018	14	96
Kaiser Permanente Home Health and Hospice (Group Health)	IHS.FS.00000305	Pierce	2018	35	198
Kaiser Permanente Home Health and Hospice (Group Health)	IHS.FS.00000305	King	2018	25	416
Kindred Hospice (Gentiva Hospice	IHS.FS.60308060	Whitman	2018	19	226.5
Kindred Hospice (Gentiva Hospice	IHS.FS.60308060	Spokane	2018	23	265.5
Kittitas Valley Home Health and Hospice	IHS.FS.00000320	Kittitas	2018	15	135
Klickitat Valley Home Health & Hospice (Klickitat Valley Health)	IHS.FS.00000361	Klickitat	2018	5	40
Kline Galland Community Based Services	IHS.FS.60103742	King	2018	29	368
Memorial Home Care Services	IHS.FS.00000376	Yakima	2018	183	750
MultiCare Home Health, Hospice and Palliative Care	IHS.FS.60639376	King	2018	32	158

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MultiCare Home Health, Hospice and Palliative Care	IHS.FS.60639377	Kitsap	2018	25	232
MultiCare Home Health, Hospice and Palliative Care	IHS.FS.60639378	Pierce	2018	177	867
Providence Hospice (Hospice of the Gorge)	IHS.FS.60201476	Skamania	2018	1	9
Providence Hospice (Hospice of the Gorge)	IHS.FS.60201476	Klickitat	2018	4	18
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Island	2018	11	44
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Snohomish	2018	316	1772
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	King	2018	none repo	none repor
Providence Hospice of Seattle	IHS.FS.00000336	Snohomish	2018	11	13
Providence Hospice of Seattle	IHS.FS.00000336	King	2018	407	1959
Providence SoundHomeCare and Hospice	IHS.FS.00000420	Mason	2018	10	117
Providence SoundHomeCare and Hospice	IHS.FS.00000420	Lewis	2018	21	140
Providence SoundHomeCare and Hospice	IHS.FS.00000420	Thurston	2018	90	663
Tri-Cities Chaplaincy	IHS.FS.00000456	Franklin	2018	30	155
Tri-Cities Chaplaincy	IHS.FS.00000456	Benton	2018	112	750
Walla Walla Community Hospice	IHS.FS.60480441	Columbia	2018	1	23
Walla Walla Community Hospice	IHS.FS.60480441	Walla Walla	2018	24	227
Wesley Homes	IHS.FS.60276500	King	2018	29	368
Whatcom Hospice (Peacehealth)	IHS.FS.00000471	Whatcom	2018	117	770
Alpha Home Health	IHS.FS.61032013	Snohomish	2019	0	0
Alpowa Healthcare Inc. d/b/a Elite Home Health and Hospice	IHS.FS.60384078	Asotin	2019	9	71
Alpowa Healthcare Inc. d/b/a Elite Home Health and Hospice	IHS.FS.60384078	Garfield	2019	1	4
Central Washington Homecare Services	IHS.FS.00000250	Chelan	2019	28	385
Central Washington Homecare Services	IHS.FS.00000250	Douglas	2019	19	125
Chaplaincy Health Care 2018	IHS.FS.00000456	Benton	2019	96	700
Chaplaincy Health Care 2018	IHS.FS.00000456	Franklin	2019	26	164
Community Home Health/Hospice	IHS.FS.00000262	Cowlitz	2019	98	636
Community Home Health/Hospice	IHS.FS.00000262	Wahkiakum	2019	0	7
Community Home Health/Hospice	IHS.FS.00000262	Clark	2019	60	453
Continuum Care of King LLC	IHS.FS.61058934	King	2019	0	0
Continuum Care of Snohomish LLC	IHS.FS.61010090	Snohomish	2019	0	0
Envision Hospice of Washington	IHS.FS.60952486	Thurston	2019	2	22
EvergreenHealth	IHS.FS.00000278	King	2019	225	2025
EvergreenHealth	IHS.FS.00000278	Snohomish	2019	53	471
EvergreenHealth	IHS.FS.00000278	Island	2019	1	11
Franciscan Hospice	IHS.FS.00000287	King	2019	92	921
Franciscan Hospice	IHS.FS.00000287	Kitsap	2019	118	757
Franciscan Hospice	IHS.FS.00000287	Pierce	2019	364	2236
Frontier Home Health & Hospice	IHS.FS.60379608	Okanogan	2019	27	171
Frontier Home Health & Hospice	IHS.FS.60379608	Douglas	2019	0	5
Frontier Home Health & Hospice	IHS.FS.60379608	Grant	2019	4	8
Harbors Home Health and Hospice	IHS.FS.00000306	Grays Harbor	2019	41	212
Harbors Home Health and Hospice	IHS.FS.00000306	Pacific	2019	15	98
Heartlinks	IHS.FS.00000369	Benton	2019	7	137
Heartlinks	IHS.FS.00000369	Yakima	2019	21	180
Heartlinks	IHS.FS.00000369	Franklin	2019	0	2
Horizon Hospice	IHS.FS.00000332	Spokane	2019	30	393
Hospice of Jefferson County, Jefferson Healthcare	IHI.FS.00000349	Jefferson	2019	26	172
Hospice of Spokane	IHS.FS.00000337	Spokane	2019	289	1692
Hospice of Spokane	IHS.FS.00000337	Stevens	2019	20	126
Hospice of Spokane	IHS.FS.00000337	Ferry	2019	5	25
Hospice of Spokane	IHS.FS.00000337	Pend Oreille	2019	4	65
Hospice of the Northwest	IHS.FS.00000437	Island	2019	14	56
Hospice of the Northwest	IHS.FS.00000437	San Juan	2019	6	73
Hospice of the Northwest	IHS.FS.00000437	Skagit	2019	77	705
Hospice of the Northwest	IHS.FS.00000437	Snohomish	2019	5	58
Inspiring Hospice Partners of Oregon dba Heart of Hospice	IHS.FS.60741443	Skamania	2019	0	17
Inspiring Hospice Partners of Oregon dba Heart of Hospice	IHS.FS.60741443	Klickitat	2019	2	24
Inspiring Hospice Partners of Oregon dba Heart of Hospice	IHS.FS.60741443	Clark	2019	0	3
Inspiring Hospice Partners of Oregon dba Heart of Hospice	IHS.FS.60741443	Snohomish	2019	0	0
Kaiser Continuing Care Services Hospice	IHS.FS.00000353	Clark	2019	43	387
Kaiser Permanente Home Health and Hospice	IHS.FS.00000305	King	2019	37	489
Kaiser Permanente Home Health and Hospice	IHS.FS.00000305	Kitsap	2019	18	123
Kaiser Permanente Home Health and Hospice	IHS.FS.00000305	Pierce	2019	25	176
Kaiser Permanente Home Health and Hospice	IHS.FS.00000305	Snohomish	2019	7	62
Kindred Hospice	IHS.FS.60308060	Spokane	2019	10	90
Kindred Hospice	IHS.FS.60308060	Whitman	2019	12	77
Kindred Hospice	IHS.FS.60330209	King	2019	6	217
Kittitas Valley Healthcare Home Health and Hospice	IHS.FS.00000320	Kittitas	2019	16	169

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Klickitat Valley Hospice	IHS.FS.00000361	Klickitat	2019	1	44
Kline Galland Community Based Services	IHS.FS.60103742	King	2019	35	345
Memorial Home Care Services	IHS.FS.00000376	Yakima	2019	148	730
MultiCare Hospice	IHS.FS.60639376	King	2019	27	149
MultiCare Hospice	IHS.FS.60639376	Pierce	2019	167	758
MultiCare Hospice	IHS.FS.60639376	Kitsap	2019	37	194
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Clallam	2019	23	234
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Jefferson	2019	0	9
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Lewis	2019	17	244
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Mason	2019	6	45
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Thurston	2019	22	240
Olympic Medical Hospice	IHS.FS.00000393	Clallam	2019	0	0
PeaceHealth Hospice	IHS.FS.60331226	Clark	2019	184	1217
PeaceHealth Hospice	IHS.FS.60331226	Cowlitz	2019	23	99
PeaceHealth Hospice	IHS.FS.60331226	Skamania	2019	0	1
PeaceHealth Whatcom	IHS.FS.00000471	Whatcom	2019	138	995
Providence Hospice	IHS.FS.60201476	Klickitat	2019	9	22
Providence Hospice	IHS.FS.60201476	Skamania	2019	1	15
Providence Hospice	IHS.FS.60201476	Clark	2019	0	0
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Snohomish	2019	272	1613
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Island	2019	1	29
Providence Hospice of Seattle	IHS.FS.00000336	King	2019	338	2083
Providence Hospice of Seattle	IHS.FS.00000336	Snohomish	2019	5	10
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Thurston	2019	91	685
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Mason	2019	28	148
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Lewis	2019	33	118
Puget Sound Hopsice	IHS.FS.61032138	Thurston	2019	0	0
Walla Walla Community Hospice	IHS.FS.60480441	Walla Walla	2019	41	242
Walla Walla Community Hospice	IHS.FS.60480441	Columbia	2019	3	25
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Adams	2019	8	54
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Grant	2019	41	228
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Lincoln	2019	3	22
Wesley Homes	IHS.FS.60276500	King	2019	5	86
WhidbeyHealth Home Health, Hospice	IHS.FS.00000323	Island	2019	27	245
Yakima HMA Home Health, LLC	IHS.FS.60097245	Yakima	2019	6	88
Alpha Hospice	IHS.FS.61032013	Snohomish	2020	1	30
Alpowa Healthcare, Inc. d/b/a Elite Home Health & Hospice	IHS.FS.60384078	Asotin	2020	24	84
Alpowa Healthcare, Inc. d/b/a Elite Home Health & Hospice	IHS.FS.60384078	Garfield	2020	3	7
Astria Hospice	IHS.FS.60097245	Yakima	2020	0	56
Central Washington Home Care Service	IHS.FS.00000250	Chelan	2020	32	421
Central Washington Home Care Service	IHS.FS.00000250	Douglas	2020	13	159
Chaplaincy Health Care	IHS.FS.00000456	Benton	2020	118	821
Chaplaincy Health Care	IHS.FS.00000456	Franklin	2020	30	192
Community Home Health/Hospice	IHS.FS.00000262	Cowlitz	2020	78	616
Community Home Health/Hospice	IHS.FS.00000262	Pacific	2020	1	3
Community Home Health/Hospice	IHS.FS.00000262	Wahkiakum	2020	3	11
Community Home Health/Hospice	IHS.FS.60547198	Clark	2020	61	430
Continuum Care of King LLC	IHS.FS.61058934	King	2020	0	0
Continuum Care of Snohomish	IHS.FS.61010090	King	2020	2	40
Continuum Care of Snohomish	IHS.FS.61010090	Snohomish	2020	12	131
Eden Hospice at Whatcom County, LLC	IHS.FS.61117985	Whatcom	2020	0	0
Envision Hospice of Washington LLC	IHS.FS.60952486	King	2020	1	76
Envision Hospice of Washington LLC	IHS.FS.60952486	Kitsap	2020	0	0
Envision Hospice of Washington LLC	IHS.FS.60952486	Pierce	2020	1	20
Envision Hospice of Washington LLC	IHS.FS.60952486	Thurston	2020	1	24
Envision Hospice of Washington LLC	IHS.FS.60952486	Snohomish	2020	0	0
EvergreenHealth	IHS.FS.00000278	King	2020	316	2451
EvergreenHealth	IHS.FS.00000278	Snohomish	2020	70	672
EvergreenHealth	IHS.FS.00000278	Island	2020	0	6
Frontier Home Health & Hospice	IHS.FS.60379608	Douglas	2020	4	11
Frontier Home Health & Hospice	IHS.FS.60379608	Grant	2020	0	3
Frontier Home Health & Hospice	IHS.FS.60379608	Okanogan	2020	30	167
Harbors Home Health and Hospice	IHS.FS.00000306	Grays Harbor	2020	27	186
Harbors Home Health and Hospice	IHS.FS.00000306	Pacific	2020	11	66
HEART OF HOSPICE	IHS.FS.60741443	Clark	2020	0	3
HEART OF HOSPICE	IHS.FS.60741443	Klickitat	2020	2	21
HEART OF HOSPICE	IHS.FS.60741443	Skamania	2020	2	18
HEART OF HOSPICE	IHS.FS.60741443	Snohomish	2020	0	0

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Heartlinks	IHS.FS.00000369	Benton	2020	14	152
Heartlinks	IHS.FS.00000369	Yakima	2020	20	181
Heartlinks	IHS.FS.00000369	Franklin	2020	4	2
Horizon Hospice & Palliative Care	IHS.FS.00000332	Spokane	2020	28	456
Hospice of Jefferson County	IHS.FS.00000349	Jefferson	2020	17	178
Hospice of Spokane	IHS.FS.00000337	Spokane	2020	302	1895
Hospice of Spokane	IHS.FS.00000337	Stevens	2020	21	128
Hospice of Spokane	IHS.FS.00000337	Ferry	2020	3	28
Hospice of Spokane	IHS.FS.00000337	Pend Oreille	2020	17	49
Hospice of Spokane	IHS.FS.00000337	Lincoln	2020	0	0
Hospice of Spokane	IHS.FS.00000337	Whitman	2020	0	1
Hospice of Spokane	IHS.FS.00000337	Okanogan	2020	1	0
Kaiser Permanente Continuing Care Services	IHS.FS.00000353	Clark	2020	42	433
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	King	2020	49	446
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	Kitsap	2020	13	114
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	Pierce	2020	30	181
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	Snohomish	2020	3	84
Kindred Hospice	IHS.FS.60308060	Spokane	2020	32	297
Kindred Hospice	IHS.FS.60308060	Whitman	2020	12	127
Kindred Hospice	IHS.FS.60330209	King	2020	9	200
Kittitas Valley Home Health and Hospice	IHS.FS.00000320	Kittitas	2020	12	157
Klickitat Valley Health Home Health & Hospice	IHS.FS.00000361	Klickitat	2020	4	38
Kline Galland Hospice	IHS.FS.60103742	King	2020	83	896
Memorial Home Care Services	IHS.FS.00000376	Yakima	2020	175	953
Multicare Home Health, Hospice	IHS.FS.60639376	Pierce	2020	161	866
Multicare Home Health, Hospice	IHS.FS.60639376	King	2020	36	137
Multicare Home Health, Hospice	IHS.FS.60639376	Kitsap	2020	12	126
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Clallam	2020	24	283
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Jefferson	2020	0	16
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Lewis	2020	15	226
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Mason	2020	8	70
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Pierce	2020	0	1
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Thurston	2020	22	268
Olympic Medical Hospice	IHS.FS.00000393	Clallam	2020	0	0
PeaceHealth Hospice Southwest	IHS.FS.60331226	Clark	2020	194	1372
PeaceHealth Hospice Southwest	IHS.FS.60331226	Cowlitz	2020	16	91
PeaceHealth Hospice Southwest	IHS.FS.60331226	Skamania	2020	0	3
Providence Hospice	IHS.FS.60201476	Klickitat	2020	6	28
Providence Hospice	IHS.FS.60201476	Skamania	2020	1	16
Providence Hospice	IHS.FS.60201476	Clark	2020	0	0
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Snohomish	2020	267	1645
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Island	2020	5	36
Providence Hospice of Seattle	IHS.FS.00000336	King	2020	338	2059
Providence Hospice of Seattle	IHS.FS.00000336	Snohomish	2020	0	0
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Thurston	2020	106	772
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Mason	2020	35	193
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Lewis	2020	32	175
Puget Sound Hospice	IHS.FS.61032138	Thurston	2020	0	6
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	Island	2020	20	81
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	San Juan	2020	8	89
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	Skagit	2020	70	607
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	Snohomish	2020	8	74
Virginia Mason Franciscan Hospice & Palliative Care	IHS.FS.00000287	King	2020	52	716
Virginia Mason Franciscan Hospice & Palliative Care	IHS.FS.00000287	Pierce	2020	232	1630
Virginia Mason Franciscan Hospice & Palliative Care	IHS.FS.00000287	Kitsap	2020	71	681
Walla Walla Community Hospice	IHS.FS.60480441	Walla Walla	2020	41	242
Walla Walla Community Hospice	IHS.FS.60480441	Columbia	2020	3	50
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Adams	2020	4	48
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Grant	2020	40	251
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Lincoln	2020	5	21
Wesley Homes Hospice, LLC	IHS.FS.60276500	King	2020	3	110
Wesley Homes Hospice, LLC	IHS.FS.60276500	Pierce	2020	1	16

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Prepared by DOH Program Staff

Department of Health
2021-2022 Hospice Numeric Need Methodology
Preliminary Death Data Updated October 12, 2021

	0-64			65+		
County	**2018**	**2019**	**2020**	**2018**	**2019**	**2020**
ADAMS	28	35	20	72	93	59
ASOTIN	52	54	56	214	222	186
BENTON	331	346	555	1,125	1154	1522
CHELAN	130	137	224	573	626	785
CLALLAM	191	186	195	871	955	777
CLARK	874	887	1043	2,767	2987	3205
COLUMBIA	6	7	7	43	52	43
COWLITZ	300	294	314	840	951	968
DOUGLAS	51	63	42	255	270	160
FERRY	28	20	19	55	64	58
FRANKLIN	145	123	100	278	313	263
GARFIELD	5	5	5	30	21	11
GRANT	195	197	186	524	508	455
GRAYS HARBOR	227	251	209	647	659	558
ISLAND	135	167	110	675	642	505
JEFFERSON	64	72	68	336	338	273
KING	3,264	3,275	4456	9,917	10213	11186
KITSAP	515	557	454	1,713	1811	1714
KITTITAS	68	90	78	239	266	241
KLICKITAT	58	46	42	158	160	113
LEWIS	227	210	205	730	722	653
LINCOLN	25	25	15	94	89	75
MASON	158	167	143	526	548	408
OKANOGAN	103	119	88	332	358	277
PACIFIC	64	66	55	279	265	177
PEND OREILLE	43	31	41	130	125	101
PIERCE	1,964	1,911	2364	4,926	5002	5608
SAN JUAN	19	20	18	114	127	94
SKAGIT	231	229	269	1,001	1018	1068
SKAMANIA	27	19	26	56	87	47
SNOHOMISH	1,533	1,533	1587	4,055	4081	4278
SPOKANE	1,177	1,143	1634	3,556	3545	4322
STEVENS	113	112	86	373	345	248
THURSTON	554	525	628	1,823	1908	2007
WAHKIAKUM	13	11	10	33	53	18
WALLA WALLA	110	118	150	445	450	522
WHATCOM	360	394	457	1,252	1461	1481
WHITMAN	66	47	51	199	219	226
YAKIMA	601	555	653	1,517	1451	1675

Sources:
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

Department of Health
2021-2022 Hospice Numeric Need Methodology
0-64 Population Projection

County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2018-2020 Average Population
Adams	17,637	17,768	17,899	18,029	18,160	18,291	18,456	18,622	18,787	18,953	19,118	18,160
Asotin	16,969	16,906	16,842	16,779	16,715	16,652	16,596	16,540	16,485	16,429	16,373	16,715
Benton	162,262	163,693	165,123	166,554	167,984	169,415	171,026	172,638	174,249	175,861	177,472	167,984
Chelan	61,284	61,520	61,755	61,991	62,227	62,463	62,512	62,562	62,611	62,661	62,710	62,227
Clallam	52,716	52,661	52,605	52,550	52,494	52,439	52,233	52,027	51,821	51,615	51,409	52,494
Clark	387,296	393,291	399,287	405,282	411,278	417,273	421,901	426,529	431,158	435,786	440,414	411,278
Columbia	2,988	2,947	2,905	2,863	2,822	2,780	2,745	2,710	2,675	2,640	2,605	2,822
Cowlitz	85,417	85,517	85,617	85,717	85,817	85,917	85,843	85,769	85,695	85,621	85,547	85,817
Douglas	33,540	33,938	34,335	34,732	35,130	35,527	35,803	36,080	36,356	36,633	36,909	35,130
Ferry	5,834	5,782	5,731	5,680	5,628	5,577	5,541	5,506	5,470	5,435	5,399	5,628
Franklin	79,651	81,742	83,832	85,922	88,012	90,102	92,443	94,784	97,124	99,465	101,806	88,012
Garfield	1,665	1,644	1,623	1,602	1,581	1,560	1,541	1,522	1,502	1,483	1,464	1,581
Grant	81,535	82,660	83,784	84,909	86,033	87,158	88,240	89,322	90,403	91,485	92,567	86,033
Grays Harb	59,105	58,675	58,246	57,817	57,387	56,958	56,679	56,401	56,122	55,844	55,565	57,387
Island	62,514	62,664	62,814	62,964	63,114	63,264	63,280	63,296	63,312	63,328	63,344	63,114
Jefferson	20,636	20,653	20,670	20,688	20,705	20,722	20,636	20,550	20,463	20,377	20,291	20,705
King	1,798,581	1,820,215	1,841,848	1,863,482	1,885,115	1,906,749	1,918,470	1,930,192	1,941,913	1,953,635	1,965,356	1,885,115
Kitsap	212,548	214,045	215,543	217,040	218,538	220,035	220,614	221,192	221,771	222,349	222,928	218,538
Kittitas	36,206	36,768	37,330	37,892	38,453	39,015	39,286	39,556	39,827	40,097	40,368	38,453
Klickitat	16,208	16,082	15,955	15,828	15,702	15,575	15,439	15,304	15,168	15,033	14,897	15,702
Lewis	61,494	61,796	62,097	62,398	62,700	63,001	63,164	63,327	63,491	63,654	63,817	62,700
Lincoln	8,101	8,042	7,982	7,923	7,864	7,805	7,751	7,698	7,644	7,591	7,537	7,864
Mason	48,672	49,162	49,652	50,142	50,632	51,122	51,397	51,672	51,946	52,221	52,496	50,632
Okanogan	33,087	32,906	32,726	32,545	32,364	32,183	32,087	31,991	31,896	31,800	31,704	32,364
Pacific	15,115	14,972	14,830	14,688	14,545	14,403	14,322	14,242	14,161	14,081	14,000	14,545
Pend Oreill	10,045	9,998	9,952	9,905	9,859	9,812	9,769	9,727	9,684	9,642	9,599	9,859
Pierce	721,137	729,937	738,738	747,538	756,339	765,139	769,918	774,696	779,475	784,253	789,032	756,339
San Juan	11,305	11,194	11,084	10,974	10,863	10,753	10,730	10,707	10,684	10,661	10,638	10,863
Skagit	97,885	98,616	99,346	100,076	100,807	101,537	101,887	102,236	102,586	102,935	103,285	100,807
Skamania	9,272	9,266	9,260	9,254	9,248	9,242	9,223	9,205	9,186	9,168	9,149	9,248
Snohomish	661,812	672,806	683,800	694,793	705,787	716,781	721,527	726,273	731,019	735,765	740,511	705,787
Spokane	414,493	416,684	418,875	421,066	423,256	425,447	426,740	428,033	429,326	430,619	431,912	423,256
Stevens	34,576	34,459	34,343	34,226	34,109	33,992	33,917	33,841	33,766	33,690	33,615	34,109
Thurston	224,951	228,261	231,571	234,880	238,190	241,500	243,867	246,235	248,602	250,970	253,337	238,190
Wahkiakun	2,726	2,669	2,612	2,555	2,498	2,441	2,405	2,368	2,332	2,295	2,259	2,498
Walla Wall	49,893	50,111	50,328	50,546	50,763	50,981	51,028	51,075	51,121	51,168	51,215	50,763
Whatcom	175,840	178,234	180,629	183,023	185,418	187,812	189,267	190,722	192,178	193,633	195,088	185,418
Whitman	42,880	42,965	43,051	43,137	43,222	43,308	43,315	43,322	43,330	43,337	43,344	43,222
Yakima	215,882	217,605	219,328	221,051	222,774	224,497	225,822	227,147	228,473	229,798	231,123	222,774

Sources:
2017 OFM Population Projections, Medium-Series
Prepared by DOH Program Staff

Department of Health
2020-2021 Hospice Numeric Need Methodology
65+ Population Projection

County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2018-2020 Average Population
Adams	1,773	1,887	2,000	2,114	2,227	2,341	2,383	2,424	2,466	2,507	2,549	2,227
Asotin	5,041	5,233	5,426	5,619	5,812	6,005	6,175	6,344	6,514	6,683	6,853	5,812
Benton	26,328	27,492	28,657	29,821	30,986	32,150	33,373	34,597	35,820	37,044	38,267	30,986
Chelan	13,746	14,279	14,811	15,343	15,876	16,408	17,052	17,695	18,339	18,982	19,626	15,876
Clallam	19,934	20,401	20,867	21,334	21,800	22,267	22,901	23,535	24,168	24,802	25,436	21,800
Clark	64,524	68,044	71,564	75,085	78,605	82,125	85,686	89,247	92,807	96,368	99,929	78,605
Columbia	1,102	1,135	1,169	1,202	1,236	1,269	1,287	1,304	1,322	1,339	1,357	1,236
Cowlitz	18,863	19,684	20,505	21,326	22,148	22,969	23,719	24,470	25,220	25,971	26,721	22,148
Douglas	6,450	6,831	7,213	7,595	7,976	8,358	8,666	8,974	9,283	9,591	9,899	7,976
Ferry	1,876	1,949	2,022	2,095	2,168	2,241	2,289	2,337	2,386	2,434	2,482	2,168
Franklin	7,499	7,921	8,343	8,765	9,188	9,610	10,083	10,557	11,030	11,504	11,977	9,188
Garfield	595	607	620	633	645	658	669	680	692	703	714	645
Grant	12,395	13,011	13,628	14,244	14,861	15,477	16,071	16,665	17,258	17,852	18,446	14,861
Grays Harb	14,005	14,535	15,064	15,594	16,123	16,653	17,133	17,612	18,092	18,571	19,051	16,123
Island	18,086	18,625	19,163	19,701	20,239	20,777	21,412	22,047	22,682	23,317	23,952	20,239
Jefferson	10,244	10,580	10,916	11,252	11,588	11,924	12,323	12,722	13,121	13,520	13,919	11,588
King	254,219	268,307	282,395	296,484	310,572	324,660	337,771	350,881	363,992	377,102	390,213	310,572
Kitsap	45,652	47,697	49,743	51,788	53,833	55,878	58,185	60,492	62,800	65,107	67,414	53,833
Kittitas	6,464	6,760	7,055	7,351	7,647	7,943	8,266	8,589	8,911	9,234	9,557	7,647
Klickitat	4,792	5,051	5,310	5,570	5,829	6,088	6,268	6,448	6,627	6,807	6,987	5,829
Lewis	15,166	15,576	15,987	16,398	16,808	17,219	17,697	18,175	18,652	19,130	19,608	16,808
Lincoln	2,619	2,687	2,755	2,823	2,891	2,959	3,039	3,119	3,200	3,280	3,360	2,891
Mason	13,528	14,123	14,717	15,311	15,905	16,499	17,167	17,836	18,504	19,173	19,841	15,905
Okanogan	8,773	9,198	9,624	10,050	10,475	10,901	11,210	11,519	11,827	12,136	12,445	10,475
Pacific	6,095	6,258	6,421	6,584	6,747	6,910	7,035	7,159	7,284	7,408	7,533	6,747
Pend Oreill	3,195	3,378	3,560	3,742	3,925	4,107	4,239	4,371	4,504	4,636	4,768	3,925
Pierce	108,983	114,409	119,836	125,262	130,688	136,114	142,422	148,729	155,037	161,344	167,652	130,688
San Juan	4,876	5,099	5,322	5,545	5,768	5,991	6,174	6,357	6,541	6,724	6,907	5,768
Skagit	22,735	24,021	25,308	26,595	27,881	29,168	30,314	31,460	32,607	33,753	34,899	27,881
Skamania	2,158	2,286	2,414	2,542	2,670	2,798	2,923	3,048	3,172	3,297	3,422	2,670
Snohomish	95,788	101,674	107,560	113,447	119,333	125,219	131,978	138,737	145,495	152,254	159,013	119,333
Spokane	73,817	77,325	80,834	84,343	87,852	91,361	94,670	97,979	101,288	104,597	107,906	87,852
Stevens	9,454	9,930	10,407	10,884	11,360	11,837	12,214	12,591	12,969	13,346	13,723	11,360
Thurston	42,459	44,534	46,608	48,683	50,757	52,832	54,900	56,967	59,035	61,102	63,170	50,757
Wahkiakun	1,254	1,316	1,379	1,441	1,503	1,565	1,580	1,595	1,611	1,626	1,641	1,503
Walla Wall	10,757	10,819	10,881	10,944	11,006	11,068	11,350	11,632	11,915	12,197	12,479	11,006
Whatcom	33,950	35,688	37,426	39,164	40,902	42,640	44,217	45,794	47,372	48,949	50,526	40,902
Whitman	4,370	4,659	4,948	5,237	5,526	5,815	6,008	6,201	6,395	6,588	6,781	5,526
Yakima	34,088	34,949	35,809	36,670	37,530	38,391	39,475	40,559	41,643	42,727	43,811	37,530

Sources:
2017 OFM Population Projections, Medium-Series
Prepared by DOH Program Staff

Exhibit 4

Financial Assistance Policy

MultiCare	*Administrative*

Title: Hospice Financial Assistance

Scope:

This policy applies to patients who qualify for Charity Care or Financial Assistance for services received from Hospice.

Policy Statement:

MHS is guided by a mission to provide high quality, patient-centered care. We are committed to serving all patients, including those who lack health insurance coverage and who cannot pay for all or part of the essential care they receive. We are committed to treating all patients with compassion. We are committed to maintaining Financial Assistance policies that are consistent with our mission and values and that take in to account an individual's ability to pay for medically necessary health care services.

Definitions:

1. "Collection Efforts" and "Extraordinary Collections Actions" (ECA) are defined by the MHS Collection Guidelines policy.
2. "Charity Care" and/or "Financial Assistance" means medically necessary Hospice care rendered to Eligible Persons when Third-Party Coverage, if any, has been exhausted, to the extent that the persons are unable to pay for the care or to pay deductible or coinsurance amounts required by a third-party payer based on the criteria in this policy. When communicating with patients, the phrase "Financial Assistance" will be used in lieu of "Charity Care." Both terms are synonymous with one another for the purposes of this policy and MHS billing statements.
3. "Eligible Person(s)" is defined as those patients who have exhausted any third-party sources and whose income is equal to or below 500% the federal poverty standards adjusted for family size.
4. "Family" is defined as a group of two or more persons related by birth, marriage or adoption that live together; all such related persons are considered as members of one family.
5. "Income" is defined as total cash receipts before taxes derived from wages and salaries, welfare payments, Social Security payments, strike benefits, unemployment or disability benefits, child support, alimony and net earnings from business and investment activities.
6. Medically Necessary" is defined as appropriate medical services.
7. "Responsible Party" means that individual who is responsible for the payment of any charges not otherwise covered by a funding source as described below.

Policy Guidelines:

This policy provides a guideline for making consistent and objective decisions regarding eligibility for Financial Assistance. Financial Assistance is available for medically necessary health care services provided by MultiCare Health System.

Consideration for Financial Assistance will be given equally to all Eligible Persons, regardless of race, color, sex, religion, age, national origin, veteran's status, marital status, sexual orientation,

immigration status or other legally protected status. *See* MHS Policy: Patient Nondiscrimination

All information relating to the Financial Assistance application is confidential and protected by HIPAA guidelines. *See* HIPAA Privacy Compliance – Administrative policy.

This policy describes the processes for evaluating applications and awarding Financial Assistance for free and discounted care at the following levels based on the Federal Poverty Limit (FPL) adjusted for family size:
1. 100% Financial Assistance - Income levels at or below 300% of the (FPL); or
2. b) Sliding Scale Financial Assistance - Income levels between 300.5% and 500% of the FPL.

Procedure:

I. Eligibility Criteria
For a Responsible Party to be considered eligible for Financial Assistance, the following criteria must be met:

A. Exhaustion of All Funding Sources
1. Any of the following sources must first be exhausted before a Responsible Party will be considered for Financial Assistance.

B. *Accurate Completion of Financial Assistance application*.
1. Incomplete applications will be denied. Patients may appeal the denial and provide the missing information per the guidelines set forth below.
2. If the application places an unreasonable burden, taking into account any physical, mental, intellectual, or sensory deficiencies or language barriers which may hinder the Responsible Party's capability of complying with the application procedures on the Responsible Party, then the application process will not be imposed.

C. *Medicaid Eligibility Within 90 Days of Services in Lieu of Application*
1. A determination of Medicaid eligibility within (90) days of date of services may replace the Financial Assistance application and may be used to qualify the Responsible Party for 100% Financial Assistance except for spend down amounts. Proof of eligibility will be the presence of Medicaid coverage during the applicable timeframe in the patient’s coverage record in Epic.

D. *Presumptive determination or Extraordinary Circumstances*
1. The Responsible Party may qualify for Financial Assistance based on a presumptive determination or extraordinary life circumstances, as outlined below.

II. Proof of Income
Income will be evaluated based on the following criteria:

A. *Income Verification*
1. Any of the following types of documentation will be acceptable for purposes of verifying income:
    a. W2 withholding statements
    b. Payroll check stubs
    c. Most recent filed IRS tax returns
    d. Determination of Medicaid and/or state-funded medical assistance
    e. Determination of eligibility for unemployment compensation
    f. Written statements from employers or welfare agencies
2. For Social Security and Pension benefits, bank statements may be used to demonstrate the consistent monthly deposit.

3. In the event the Responsible Party is unable to provide the documentation described above, MHS must rely upon the written and signed statements from the Responsible Party for making a final determination of eligibility.

4. MHS may also use third party verification of ability to make a presumptive determination and apply a charity discount without receiving a financial assistance application.

B. *Calculation of Income*

1. MHS will use the following guidelines to calculate income:
    a. All Family income will be included in the calculation.
    b. Based on the type of documentation provided, the income will be calculated to represent a twelve (12) month period.

C. Timing of Determination

1. Income will be determined as of the time the services were provided.
2. Income at the time of application for Financial Assistance will be considered if the application is made within two years of the time the services were provided and the Responsible Party has been making good faith efforts towards payment for the services.

III. Process for Determination of Eligibility

A. At the time of registration or as soon as possible following the initiation of services, MultiCare will make an initial determination of eligibility following the patient's review of the FPL grid. If a patient is determined to likely fall below 200% of the FPL, they will not be asked for payment and will be referred to a Patient Financial Navigator (PFN), who will provide additional information about Financial Assistance and other programs that may be available to the patient.

B. Collection activity will cease for 30 calendar days for patients believed to be under 200% of the FPL and the Responsible Party will be asked to complete a Financial Assistance application. If no application is received within 30 days, collection activity will resume.

C. When an application is received, a PFN will review the application to determine eligibility.

D. Incomplete applications will be denied. The Responsible Party will be provided a letter specifying missing information and will may Appeal the decision per the requirements below.

E. A written notice of determination will be sent to the applicant within fourteen (14) calendar days from receipt of the complete application.

F. If approved, this notice will include the amount for which the Responsible Party is financially responsible, if any.

G. Approvals will be valid for 180 days and a new application will be required after such time. Awards to Eligible Persons on fixed incomes like Social Security shall be approved for one (1) year, at the discretion of the PFN reviewing the application.

IV. Appeals

A. The Responsible Party may appeal the determination by providing additional verification of income or family size within thirty (30) calendar days of receipt of the determination.

B. MultiCare will respond to the appeal within fourteen (14) calendar days from receipt of the appeal.

C. All appeals will be reviewed and approved or denied by the Supervisor or Manager, Patient Financial Navigation.

D. If an appeal is denied, it will be presented to the Executive Director, Patient Access, Vice President of Revenue Cycle or Chief Financial Officer (CFO) for final determination. If this determination affirms the previous denial of Financial Assistance, written notification

	will be sent to the Responsible Party and the Department of Health in accordance with state law. E. Collection efforts will be suspended during the thirty (30) calendar day appeal period and the fourteen (14) calendar day appeal review period. **V. Presumptive Eligibility** Eligibility may be determined presumptively. 1. MHS may utilize third party vendor software or software applications to determine an account's collectability. This is a "soft" credit check and will not impact the Responsible Party's credit standing. 2. If these reviews determine the patient may be at 200% or below of the FPL, an adjustment will be taken automatically assuming the account otherwise qualifies for Financial Assistance. **VI. Collection Efforts for Outstanding Patient Accounts** MHS will not initiate collection efforts or requests for deposits, provided that the Responsible Party within a reasonable time is cooperative with the system's efforts to reach a determination of Financial Assistance eligibility status. ECA may only be initiated after the Notification Period, in accordance with the MHS Policy: Collection Guidelines, Patient Accounts. The Responsible Party's financial obligation remaining after application of the sliding fee schedule will follow regular collection procedures to obtain payment, pursuant to Policy. In the event that a Responsible Party pays a portion or all of the charges related to health care services, and is subsequently found to have met the Financial Assistance criteria, any payments for services above the qualified amount will be refunded to the Responsible Party within 30 days of the eligibility determination.
	Related Standard Workflows: n/a
	Related Forms: n/a
	References:
	Point of Contact: Home Health & Hospice Director, 253-301-6400

Approval By:	***Date of Approval:***
Home Health & Hospice QSSC	

Distribution: MHS Intranet

Exhibit 5

Admissions and Intake Policies

Document Title: HOSPICE: ADMISSION AND ASSESSMENT PROCESS

Scope:

Hospice Staff

Policy Statement:

Patients are assessed at admission for care needs and services according to the physician's order and following all applicable federal and state regulations. All admitting disciplines follow the same basic procedure at admission for all patients. Admission assessments are completed and replicated through the electronic health record (EHR) within 24 hours of the initial visit per MultiCare Hospice ("Agency") policy.

RN, MSW, and Chaplain perform admission assessments specific to Hospice criteria. All staff at the Agency bases their clinical assessments on accepted professional standards and Hospice defined practice protocols.

The initial assessment visit will occur based upon physician order or within 48 hours of referral, or within 48 hours of a patient's return home, or as soon as possible determined by patient preference, facility discharge date, and availability of patient or other patient-driven factors. The initial telephone communication or contact with the patient, the status of the referral and a mutually agreeable first visit date, based on a time frame appropriate to the patient's medical and social needs, is documented in the EHR.

Procedure:

1. Explain to the patient and their caregivers the Agency services and reason(s) for the referral. At the time of the assessment, the patient and caregiver unit are informed of and provided written information regarding:
    a. Nature and goals of care, including anticipated frequency.
    b. Hours during which care is available.
    c. Cost of care to be borne by the individual, if any.
    d. Objectives and scope of care provided.
    e. The purpose and access to the on-call service to the patient and caregivers, including the appropriate use of 911.
    f. The interdisciplinary care team.
    g. Pay source requirements for Hospice Care.
2. Provide the patient and their caregivers with verbal and written information on Advance Directives and Durable Power of Attorney for Health Care Decisions and ascertain the patient's directive for resuscitation. Documentation of the patient response and health care directives is documented in the EHR. A verbal order is generated to be sent to the physician for signature to confirm a DNAR/DNR status on a patient.
3. Admission forms and information are provided at the initial visit.
    a. Forms requiring signature:

i. Patient Rights and Responsibilities and Consent for Care.
ii. Election of Hospice benefit.
iii. Medicare Secondary Payor Screening form.
iv. Patient Financial Responsibility form.
v. Advance Beneficiary Notification form, as appropriate.

b. Informational forms
i. Program brochure.
ii. Advance Directive information.
iii. Emergency Preparedness brochure.
iv. Home Safety instructions and evacuation plan.
v. Infection Control instructions.
vi. Hospice information call sheet.

4. All admitting disciplines complete the discipline-specific initial admission assessment forms in the Hospice EHR.
5. All admitting disciplines complete a full assessment at admission, see related workflows.
6. Develop the initial Plan of Care occurs based on assessment data and input from the patient, caregivers and physician, to include:
   a. Frequency and duration of visits; prn visits with indication.
   b. Anticipated and desired goals, both short and long term.
   c. Patient and caregiver participation in the care and the accomplishment of the goals.
   d. The identification of additional disciplines needed for assessment of the physical and/or psychosocial needs of the patient.
   e. Teaching and response to the initial interventions.
   f. Supplies needed to perform the prescribed interventions.
   g. The admitting clinician will contact the physician, advising of admission to the Agency and establishment of the Plan of Care. Communication must include the skilled or terminal care needs, the frequency and duration of the visits and the patient's terminal status. This information will be documented in the EHR as a order.
   h. When indicated, communicate appropriate assessment information is communicated to the reimbursement department to obtain authorization.
   i. Initiate secondary referrals as appropriate and as ordered by the physician and IDT.
   j. Review and record all medications according to policy with the oversight and consultation of the patient's primary physician, the Hospice medical director, and the Hospice pharmacist.
   k. Document all admission assessment information in the EHR according to policy.

	Non-Admit to the Agency: 1. If on the initial visit, a clinician determines a patient is not appropriate for admission to their discipline or program or the patient refuses hospice services, the patient, physician, and the referral source are notified of that decision and the reasons for the non-admit. 2. As appropriate, the patient is advised of other health care resources. 3. Documentation for patients not admitted is completed in the EHR and according to specific payor and regulatory requirements. 4. Included in the documentation for the non-admission is: a. The reason for the non-admit, b. The contact with the physician and referral source notifying each of the non-admit status of the patient, c. Referral to other health care resource.
	References: Joint Commission PC.01.02.01
	Point of Contact: Home Health & Hospice Director, 253-301-6400

Approval By: *HHH QSSC* Quality Safety Steering Council	***Date of Approval:*** ***8/15, 11/19*** ***12/19***
Original Date: Revision Dates: Reviewed with no Changes Dates:	*X/XX* *8/07, 8/09, 6/12, 11/19* *8/15*

Distribution: MSH Intranet

Document Title: HOSPICE INTAKE

Scope:

Hospice Referrals

Policy Statement:

All referred patients who meet eligibility criteria and desire hospice care will be considered for admission by the hospice Interdisciplinary Team (IDT).

Procedure:

Initial intake information will be obtained and forwarded to the medical director. The medical director will use available information/resources, to certify terminal prognosis.

An evaluation visit will be scheduled with an RN within 48 hours of referral unless the patient requests delay. The admission RN will contact the medical director if eligibility is in question and certification of terminal prognosis is undetermined.

Qualified staff must be available to meet the needs of the patient.

1. The following general criteria are used to evaluate patients referred to Hospice:
    a. Patients will be accepted for referral without regard to race, gender, sexual orientation, national origin, religion, age, physical impairments or the ability to pay for medical care.
    b. All patients must have a known place of residence with adequate facilities existing in the home to support safe care.
    c. A communication method will be determined and or plan made for necessary communication. The home will be evaluated to determine if the environment of care is safe for the patient, caregivers and Hospice. staff and If safety risk factors are identified, all reasonable efforts will be made to insure staff and patient safety. The referring provider, and patient or their representative will be notified if the environment of care cannot be made safe. Suggestions /alternatives will be offered but may be declined by the patient or their representative. This information will be documented in the medical record. If the patient has a designated Durable Power of Attorney for Health Care Decisions (DPOAHC) and the patient is not competent to provide consent, the DPOAHC must be identified and able to be present by phone or in person, to give consent for care and complete the Advance Directive/Code Status information.
    d. The patient and his/her caregivers are in agreement with the conditions of the admission evaluation visit. These conditions could include the presence of a parent or legal guardian for a minor patient, the presence of the DPOAHC, the date and time of the admission visit and the availability of necessary interpreters.
    e. A provider must order the admission evaluation visit and a primary physician must be confirmed to be responsible for the supervision of the mutually established care plan for the patient and their caregivers.

	2. Any referred patient determined to not meet the criteria for acceptance to Hospice services will be informed of the reasons for the non-acceptance and given alternate care options. This may include referral or transfer of their services to other health care providers or organizations.
	References: RI.01.01.01; PC.01.01.01, .01.02.03,2.20
	Point of Contact: Home Health and Hospice Director, 253-301-6400

Approval By: *HHH QSSC* MHS Quality Safety Steering Council	***Date of Approval:*** ***3/16, 3/20*** ***4/20***
Original Date: Revision Dates: Reviewed with no Changes Dates:	*2/91* *6/05, 12/07, 3/10, 3/13, 3/16, 3/20* *X/XX; X/XX*

Distribution: MHS Intranet

Exhibit 6

Patient Rights and Responsibilities Policy

Title: HOME HEALTH & HOSPICE: PATIENT RESPONSIBILITIES

Scope: Home Health and Hospice

Policy Statement: Patients will be informed of their rights and responsibilities at admission and during care delivery as appropriate by the clinicians providing care and/or a member of the leadership team.

Patient safety is enhanced when patients and their caregiver(s) or family members take an active role in their care delivery.

Patients, caregivers and family members will provide a safe environment for care delivery to include reasonable and responsible behavior toward Home Health and Hospice staff members.

Special Instructions:

1. Patients and their caregivers or families will be advised of responsibilities related to patient care, collaboration and communication.
2. The information below may be presented verbally and in written form, i.e. The Consent for Care form and the Patient Rights and Responsibilities form. (This list may not be inclusive.). The patient is responsible to:
    a. Remain under a doctor's care while receiving Home Health or Hospice care;
    b. Provide the agency with a complete and accurate health history;
    c. Actively participate in their care by asking questions and sharing concerns;
    d. Respect the limits of duties that Home Health and Hospice staff may provide;
    e. Treat Home Health and Hospice staff with respect and consideration;
    f. Sign the required consents and releases for billing;
    g. Provide the agency with all requested insurance and financial information, especially if changes occur during the course of care delivery.
    h. Provide a safe home environment during appointments by:
        i. Keeping pets or livestock out of the care delivery area;
        ii. Locking up weapons;
        iii. Not smoking; and
        iv. Not using offensive or threatening language or behavior.
    i. Use the Hospice Designated Pharmacy for medications covered by hospice. Choosing to use a non-hospice designated pharmacy may result in patient financial responsibility for those medications.

j. Communicate in a timely manner any changes in patient condition or changes to the plan of care.	
Related Policies: n/a	
Related Standard Workflows: n/a	
Related Forms: n/a	
References: Joint Commission RI.02.01.01	
Point of Contact: Home Health & Hospice Director, 253-301-6400	
Approval By:	*Date of Approval:*
Home Health Leadership Team and Hospice Policy & Procedure Committee	08/17
Original Date:	*5/11*
Revision Dates:	*8/14;8/17*
Reviewed with no Changes Dates:	*X/XX*

MultiCare	*Administrative*

Title: PATIENT RIGHTS AND RESPONSIBILITIES: ADULTS AND SPECIAL RIGHTS OF ADOLESCENTS

Scope:

This policy applies to all patients and their families within the MultiCare Health System (MHS).

This scope applies to all ambulatory and inpatient areas at MultiCare Health System. It includes Tacoma General Hospital/Allenmore Hospital, Mary Bridge Children's Hospital, Good Samaritan Hospital, Auburn Medical Center, Covington Medical Center, Deaconess Hospital and Valley Hospital.

Policy Statement:

This policy establishes the MHS procedure to define patient rights by law and policy and define the procedure for providing this information to patients and families with MultiCare.

A. Patients will be provided a copy of the Patient Rights and Responsibilities brochure. This occurs on an annual basis, usually at the time of registration (or as soon as feasible), or more frequently as desired by patient and family. Brochures will be available to patients and families in registration areas.

Procedure:

The following steps are to be followed to assure that the patients and families at MHS are aware of their rights and responsibilities:

A. MultiCare staff (employed, volunteer and contracted) will support and abide by the rights of patients who seek services within MultiCare Health System.

B. Personnel responsible for admitting patients to the "inpatient" status will provide a copy of the Patient Rights and Responsibilities brochure at the time of admission (or as soon as feasible) and validate that the patient has received a copy at least yearly.

C. Directors/Managers in patient registration areas will ensure the brochure is available for patients and families.

Related Policies: "Advanced Directives: Living Will and Mental Health", "Patient Grievances"

Related Forms: *Patient Rights and Responsibilities Booklet # 87-9158-0c*

References:
Joint Commission Standards on Patient Rights
CMS Conditions of Participation

Point of Contact: Executive Director, Patient Access 697.1865

Approval By: Patient Registration Leadership Quality Safety Steering Council	Approval Date: 4/19 4/14, 1/17, 6/19
Original Date: Revision Dates: Reviewed with no Changes Dates:	*9/90* *3/93, 2/95, 5/96, 11/97, 3/99, 2/01, 2/03, 11/05, 3/09, 4/14, 1/17, 4/19* *5/12*

Distribution: MSH Intranet

Scope/locations of services updated March, 2017.

4/11/18 - Approved at SKRB 3/26/18 and QSSC 4/10/18 to apply to Covington Medical Center

Exhibit 7

Discrimination Complaint Policy

Title: DISCRIMINATION COMPLAINTS AND GRIEVANCES (PUBLIC-FACING)

Scope:

This applies to all MultiCare Health System (MHS) workforce members, which includes but not limited to, employees, residents, students, volunteers and other persons who are under direct control of MHS, who access, use, disclose or come in contact with patient information, including Protected Health Information (PHI) and patient Personally Identifiable Information (PII) in any form (paper, electronic or verbal).

Location Scope:

MultiCare Health System adopts the following policy and procedure for the following locations: Tacoma General Hospital/Allenmore Hospital, Mary Bridge Children's Hospital, MultiCare Good Samaritan Hospital, MultiCare Auburn Medical Center, MultiCare Deaconess Hospital, MultiCare Valley Hospital, Covington Medical Center, MultiCare Connected Care, MultiCare Foundations, CHVI, NAVOS, Greater Lakes Mental Healthcare, Home Health and Hospice, and all ambulatory, community-based, administrative, and retail sites.

Policy Statement:

MultiCare does not discriminate against any person on the basis of age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity, citizenship, immigration status, military status, or any other basis prohibited by state or federal law in care and treatment or participation in its programs, services, activities or employment.

Special Instructions:

If you believe that you experienced discrimination at MultiCare, you can file a grievance or complaint with our Privacy & Civil Rights Office and Section 504 Coordinator. Complaints and grievances can be sent to:

Monica R. Freedle, M.J., CHC, CHPS, ADAC
Chief Privacy Officer and Sections 504 and 1557 Coordinator
MultiCare Privacy & Civil Rights Office
PO Box 5299
MS: 737–2–CCIA
Tacoma, WA 98415
Phone (Integrity Line): 866-264-6121
Fax: 253-459-7872
Email: compliance@multicare.org

Privacy & Civil Rights Office members will act as designees of the Coordinator.

Procedure:

A. Grievances can be submitted at any time, but please report allegations of discriminatory actions as soon as possible.

	B. You can file a grievance online, in writing, via ASL video, in person, by mail, fax, or email. If you need help filing a grievance, the Privacy & Civil Rights Office is available to help you. C. The grievance must state the problem or action alleged to be discriminatory and if applicable, the remedy or relief sought. You may also submit evidence relevant to your grievance. Any detail you can provide will be helpful. D. You can expect to be contacted by someone from the Privacy & Civil Rights Office within two business days of making your report. E. The Privacy & Civil Rights Office will conduct a thorough investigation of the grievance. The Privacy & Civil Rights Office will issue a written decision on the grievance, with efforts to issue this decision no later than 90 days after its filing. F. The person filing the grievance may appeal the decision of the Privacy & Civil Rights Office by escalating to the Section 504 Coordinator directly. The Coordinator shall issue a written decision in response to the appeal no later than 30 days after its filing. G. The availability and use of this procedure does not prevent a person from filing a complaint of discrimination with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint 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, D.C. 20201 ○ 1-800-368-1019, 800-537-7697 (TDD)
	Related Policies: Patient Grievances
	References: Section 504
	Point of Contact: MHS Privacy & Civil Rights Office - compliance@multicare.org

Approval By: Privacy and Civil Rights Director MHS Quality Safety Steering Council	***Date of Approval:*** ***9/20*** ***10/20***
Original Date: Revision Dates: Reviewed with no Changes Dates:	*9/2020*

Distribution: MSH Intranet; multicare.org

Exhibit 8

Medical Director Agreement and First Amendment

MEDICAL DIRECTOR'S AGREEMENT

This AGREEMENT ("Agreement") is made as of the 17th day of December, 2020.

Between:

PNW Hospice, LLC ("Agency")

And:

MultiCare Health System ("MHS")
a Washington nonprofit corporation,
315 Martin Luther King Jr Way
Tacoma, WA 98405

Agency and MHS are sometimes referred to in this Agreement individually as "Party" or, collectively, as the "Parties."

WHEREAS, Agency has determined that it requires the services of MHS with respect to Medical Director Services at PNW Hospice Agency in Spokane, Washington;

WHEREAS, MHS desires to provide Agency with a Medical Director who is experienced, knowledgeable, and available to provide the foregoing services for Agency;

NOW, THEREFORE, in consideration of the mutual promises contained in and the mutual benefits contemplated by this Agreement, Agency and MHS agree as follows:

GENERAL

MHS agrees to provide a physician to serve as Hospice Medical Director providing Medical Director Services ("Services") to Community Based Hospice patients in accordance with all applicable requirements of federal, state or local laws, rules and/or regulations to include official interpretations of those requirements by the entities charged with implementing and enforcing them, including but not limited to the requirements of 42 C.F.R. § 483.75(i) and applicable CMS guidance regarding the same. As set forth in detail below, the Services will include responsibility for (1) implementation of agency policies, and (2) coordination of medical care The Medical Director will perform those Services in accordance with accepted professional standards of

practice and use only qualified duly licensed, certified or registered health care professionals in the performance of these services.

LICENSE AND QUALIFICATIONS

The Medical Director ("Medical Director") must be a physician licensed to practice in Washington pursuant to chapter 18.71 RCW, and must fully meet all qualifications specified by the Washington State Medical Commission. The Medical Director shall hold a medical degree and have had at least two (2) years of experience relating to hospice and palliative care. Medical Director must at all times be qualified, professionally competent, duly licensed under the laws of Washington State, and have a current DEA number.

MHS represents and warrants that Medical Director is and shall during the term of this Agreement remain: licensed without restriction as a physician to practice medicine in the State of Washington; and in possession of a current unrestricted DEA permit. MHS further represents and warrants that, *unless disclosed in writing* to Agency: Medical Director's license to practice medicine in any state has never been suspended, restricted, or revoked; that he or she has never been reprimanded, sanctioned, or disciplined by any licensing board or state or local medical society, or specialty board; that he or she has never been denied membership on or reappointment to any medical staff, and no medical staff membership or clinical privileges of Medical Director have ever been suspended, curtailed, or revoked; that Medical Director has not been the subject of any report or disclosure to the National Practitioner Data Bank; and that there has never been a settlement by or on behalf of Medical Director or a final judgment entered against Medical Director in a malpractice action having an aggregate award to the plaintiff in excess of one hundred thousand dollars ($100,000.00), or in a sexual, racial, age, or other civil rights discrimination or harassment action having an award of any amount.

Medical Director and MHS hereby represent and warrant that neither Medical Director nor MHS is, nor has at any time been, excluded from participation in any federally funded health care program, including Medicare and/or Medicaid. Medical Director and MHS hereby agree to immediately notify Agency of any threatened, proposed, or actual exclusion from any federally funded health care program, including Medicare and/or Medicaid.

DUTIES

MHS shall provide a physician to serve as Agency Medical Director to provide the following Services:

1. The Medical Director will accountable for strategic planning, oversight of program development, business planning, policy setting, budget planning, expense control and the coordination of the overall day-to-day clinical operations to include the organization, direction, supervision, efficiency, compliance, productivity, quality and budget of the programs.
2. The Medical Director is responsible for the programs operating within and adhering to the applicable Medicare Conditions of Participation (CoPs), Washington State Administrative Codes (WAC), and Joint Commission accreditation standards.

3. In collaboration with Agency staff, including its nursing director, the administrator, and other health professionals, the Medical Director will develop, implement, and evaluate patient care policies and procedures for Agency that:

   - are consistent with current standards of practice and Agency policies.
   - provide for the total medical and psychosocial needs of the patients, including admissions, transfer, discharge planning, range of services available to patients, and frequency of physician visits, in accordance with patient needs and regulatory requirements
   - help enhance patient's rights as identified by the federally mandated Patient Bill of Rights.

   The Medical Director should help Agency ensure that patient care policies are carried out, as reflected and documented in drug regimen review and quality assurance committee activities.

4. Provide clinical input and guidance into quality monitoring programs established by the Agency, including by attending and participating in quarterly Quality Assurance meetings, and reporting any actions, concerns, and/or recommendations.

5. Review recommendations and reports of drug regimen review and quality assurance activities, and take appropriate and timely action as needed to implement recommendations.

6. Address issues related to the coordination of medical care identified through Agency's quality assessment and assurance committee and quality assurance program, and other activities related to the coordination of care.

7. In an emergency, be prepared to assume temporary responsibilities for the care of a patient, if the patient's own attending physician or the designated alternate physician is not available.

8. Develop, amend, recommend and implement appropriate clinical practices and medical care policies that help ensure that each patient's medical regime is incorporated appropriately into the plan of care.

9. Exercise medical and clinical leadership in a multi-disciplinary approach to patient care and care planning, including helping Agency to identify, evaluate, and address/resolve medical and clinical issues that affect patient care, medical care or patient quality of life, or are related to the provision of services by physicians and other health care practitioners

10. Help develop in-service clinical education of Agency personnel, continuing patient /family and community education, and other education programs and materials for professional staff, in cooperation with the Agency Staff Development Coordinator. The Staff Development Coordinator or his/her staff shall provide in-services to Agency staff on an as needed basis.

11. Attend weekly IDT meeting with hospice clinical team to review plan of care for every hospice patient addressing specific patient care issues, addressing family/caregiver needs and comfort therapy needs.

12. Help Agency administrator and professional staff ensure a safe and sanitary environment for patients and personnel by: reviewing incidents and accidents, identifying hazards of health and safety, and advising about possible correction or improvement of the environment.

13. Attain and provide information about federal, state and local regulations and codes applicable to hospice agencies when specifically requested by the Agency

14. Provide current information and advice about patient care, new treatment modalities, and the pathophysiology of illness.

15. Help Agency develop an ongoing program to evaluate and manage the health of Agency's employees, by establishing policy and procedures emphasizing freedom from significant infection, and compliance with local and state health regulations.

16. Help manage review and respond to federal, state or local surveys and inspections; and otherwise communicate with federal, state and county agencies

17. Act as Agency's medical representative in the community (including medical staff, referring physicians, hospitals and community and professional organizations) and be familiar with policies and programs of public health agencies that may affect patient care management.

18. Abide by applicable Agency's policies and procedures, respond to requests for services in a timely manner, and provide accurate and timely documentation to Agency of services provided to Agency's patients.

The Agency Shall:

1. Assure adequate personnel support to implement appropriate proposals and recommendations of the Medical Director.

2. Coordinate and schedule interdepartmental or committee meetings or conferences and notify the Medical Director of any anticipated need for his involvement therein.

3. Permit the Medical Director to exercise her independent, professional judgment concerning the type and manner of medical services and the monitoring of physician performance.

4. The Agency will provide the Medical Director with adequate space and administrative support, as well as all necessary equipment and supplies needed in order to perform their administrative and managerial functions.

Agency hereby represents and warrants that it is and at no time has been excluded from participation in any federally funded health care program, including Medicare and Medicaid. Agency hereby agrees to immediately notify MHS of any threatened, proposed, or actual exclusion from any federally funded health care program, including Medicare and/or Medicaid

TERMS

1. Hours of Service:

   Hours will be commensurate with the needs of the Agency as determined mutually by the Agency administrator and the Medical Director. The monthly obligation is expected to average between 30 and 40 hours per week.

2. Compensation:

   For services described herein, Agency shall compensate MHS $120.19 per hour (the equivalent of $250,000.00 for 2,080 hours per year for time spent by Medical Director attending to the duties required under this Agreement. The monthly obligation is expected to average between 30 and 40 hours per week.

   Any direct patient care provided by Medical Director is separate from the administrative functions under this Agreement. MHS will bill patients or their insurers directly and retain the collections for such direct care services.

   For Medical Director Services provided under this Agreement, MHS will submit an invoice quarterly to Agency. Agency shall pay MHS within fifteen (15) days following receipt of the invoice. Interest on payments not received within forty (40) days from Agency receipt of invoice shall accrue at one percent (1%) per month. Interest shall not accrue on overdue payments if Agency has submitted a written notice to MHS disputing such payment.

3. Duration of Agreement:

   This Agreement shall become effective on December 20, 2020 and shall remain in effect until December 31, 2025, unless sooner terminated by either Party pursuant to the provision set forth below. This Agreement may be terminated in the following events:

   a. Mutual written agreement of Agency and MHS;

   b. On ten (10) days written notice in the event of any material breach of this Agreement, and the failure of the Party in breach to remedy such breach within 5 days after receiving written notice of the existence of the breach;

   c. Upon thirty (30) days advance written notice, with or without cause;

d. Immediately on written notice for cause, which shall include the institution of proceedings against Agency that could lead to conviction of any of its officers of a crime, the Agency's engaging in actions tending to impair the health and safety of patients or the imposition of disciplinary sanctions against an officer of Agency by any governmental agency having jurisdiction over the Agency being sanctioned; or

e. Immediately, by either Party, if the other Party files, or has filed against it, a petition for voluntary or involuntary bankruptcy or pursuant to any other insolvency law, makes or seeks to make a general assignment for the benefit of its creditors or applies for, or consents to, the appointment of a trustee, receiver or custodian for a substantial part of its property.

This Agreement may be modified, expanded or changed at any point in the future only upon mutual written agreement by both Parties.

INSURANCE

A. Coverage provided by Agency for liability arising from Medical Director's Administrative duties. Agency will provide obtain and maintain professional liability and general liability insurance with limits of one million dollars ($1,000,000.00) per occurrence and three million dollars ($3,000,000.00) annual aggregate with companies insuring Agency and Medical Director for liability arising out of or resulting from alleged negligent acts or omissions in the performance or non-performance of Medical Director's administrative duties and obligations under the terms of this Agreement. In no way and under no circumstances shall Agency be responsible for providing professional liability, negligence, public liability and/or property damage insurance for, nor shall Agency be liable for, any cause of action or claim arising from the acts or omissions, including, without limitation, negligence or other misconduct of Medical Director in the provision of clinical care as an attending physician to any Agency patient. Agency shall provide proof of appropriate insurance upon request.

B. Coverage provided by MHS for liability arising from non- administrative Medical and Professional services. MHS represents and warrants that during the term of this Agreement it will obtain and maintain, in full force and effect, professional liability insurance for Medical Director with limits of one million dollars ($1,000,000.00) per claim and three million dollars ($3,000,000.00) annual aggregate covering his or her acts and omissions arising out of his provision of direct patient care to patients of the Agency. In the event that such insurance coverage is of the "claims made" type, MHS shall provide evidence of "tail" insurance covering all acts and omissions with respect to clinical services provided to patients at Agency. MHS shall provide proof of appropriate insurance upon request.

C. Each Party shall notify the other thirty days in advance of any cancellation or material change in insurance coverage.

HOLD HARMLESS

Each Party agrees to indemnify and hold harmless the other from and against any and all claims, costs, actions, suits, judgments, damages, liabilities, losses, or expenses including, without limitation, reasonable attorneys' fees and the reasonable fees of expert witnesses and other consultants, as follows:

Agency shall defend, indemnify and hold MHS, its directors, officers, agents, and employees harmless from any and all claims for loss or liability arising out of or related to any alleged act or omission by any employee, shareholder or agent of Agency. Without limiting the generality of the foregoing, Agency shall indemnify, defend and hold harmless MHS from claims against MHS based on the quality of the Agency's or equipment and against allegations that MHS is vicariously liable for negligent acts of Agency, or its directors, officers, agents and employees.

Agency specifically and expressly waives its immunity and limitation of liability under any industrial insurance, RCW 51, or other employee benefit act of any jurisdiction that otherwise would be applicable in the defense of such claim, and Agency acknowledges that this waiver was mutually negotiated in accordance with RCW 4.24.115.

MHS shall defend, indemnify, and hold Agency, its directors, officers, agents, and employees harmless from any and all claims for loss or liability arising out of or related to any alleged act or omission by any employee, shareholder or agent of MHS. Without limiting the generality of the foregoing, MHS shall indemnify, defend and hold harmless Agency from claims against Agency based on negligent hiring of the Medical Director and against allegations that Agency is vicariously liable for negligent acts of MHS, or its directors, officers, agents and employees.

This provision shall survive termination of this Agreement. Nothing in this Agreement shall be construed to limit the indemnity or contribution rights that the Parties may have under law.

COOPERATIVE INVESTIGATION

In the event of an incident involving the performance of Services that could lead to a potential liability, Agency agrees to work cooperatively with MHS in its investigation and mitigation efforts and Agency shall make its employees available to MHS immediately for those purposes. Agency shall not take any action to obstruct MHS' investigation efforts. A breach of this Section shall be a material breach of the Agreement giving MHS the right, at its option, to terminate the Agreement.

INDEPENDENT CONTRACTOR

The relationship between Agency and MHS and between Agency and the Medical Director shall be that of independent contractors, not that of an employee - employer relationship. The Medical Director shall retain discretion and judgment regarding the manner and means of providing services to Agency subject to all applicable laws, regulations and Agency policies. Agency assumes professional and administrative responsibility for the services rendered only to the extent that Agency will assure itself that MHS and the Medical Director are satisfying the

obligations set forth herein in a timely manner. This Agreement shall not be construed as a partnership, and Agency shall not be liable for any obligations incurred by MHS or the Medical Director. Because the Medical Director is not an employee of Agency, Agency will not provide health insurance or any other fringe benefit of any kind to him.

The Parties hereto agree that payments to be made by Agency to MHS are for services as an independent contractor. Agency shall not make any deduction from the fees to be paid MHS including, but not limited to, social security, withholding taxes, unemployment insurance, and other such deductions. MHS assumes full responsibility, on an independent contractor basis, for all such taxes, contributions, and assessments and for worker's compensation insurance, agrees to indemnify Agency with respect thereto and agrees to meet all requirements with enforcement of any relevant state or federal act or regulation. MHS agrees to obtain and maintain any and all business licenses as may be required under any applicable federal or state laws for independent contractors or consultants and to provide MHS with proof of same immediately upon request.

OUTSIDE SERVICES

Nothing in this Agreement shall be construed as limiting or restricting in any manner the Medical Director's right during the term of this Agreement, to render the same or similar services as those covered by this Agreement to other individuals and entities, including other nursing homes and acute care facilities. MHS and the Medical Director understand and agree that this Agreement is subject to the right of Agency patients, patients' insurers or payors and patients 'physicians to choose services from another provider.

MHS agrees to make available, upon request, any relevant documents, records, or other materials, and the Agency needs to conduct business to deal with fiscal intermediaries, third-party payers, regulatory agencies, or other similar entities, but does not necessarily include books, records, documents deemed confidential under any evidentiary privileges, including the attorney/client, doctor/patient, or accountant/ client privileges.

Such right of access shall prevail consistent with state laws.

FEDERAL TAX FORM 1099

As required by law, Agency shall provide MHS with a Federal Tax Form 1099 indicating payment to MHS aggregating $600 or more in any calendar year.

CONVERSION

Notwithstanding any other provision of this Agreement, in the event that any payment made to MHS hereunder is determined by either Party, government agency, or a body having the power to exercise disciplinary authority over one or more of the Parties, to be improper for any reason, or is found to threaten the tax exempt status of Agency or MHS then, if capable of reformation, this Agreement shall be reformed by agreement of the Parties negotiating in good faith so as not to violate any such law or be improper for any reason. If the Parties are unable to agree on the terms of such reformation, they shall engage in mediation in good faith at the request of either

Party with Judicial Arbitration and Mediation Services, Inc. (or such other mediation service or mediator as the Parties shall mutually agree). In the event good faith mediation is unsuccessful, payments to MHS made during the term of this Agreement shall immediately be converted to loans from Agency to MHS bearing a commercially reasonable interest rate and repayable in cash over a reasonable time period, or through the provisions of free care over a reasonable time period.

RECORD OF SERVICES

MHS shall maintain appropriate records relating to all services rendered under this Agreement. MHS shall provide Agency, within five (5) business days following the last day of each calendar month in which services are provided, with documentation of the services provided by Medical Director to fulfill the terms of this Agreement.

ENTIRE AGREEMENT; MODIFICATIONS

This Agreement constitutes the entire agreement between the Parties regarding its subject matter and supersedes all prior agreements and understandings, whether oral or written. MHS acknowledges that it has relied solely on the covenants and representations set forth in this Agreement and no others. This Agreement may be only modified by a written document signed by the Party against whom enforcement is sought. No waiver of any provision of this Agreement shall be valid unless in writing and signed by or on behalf of the Party waiving such provision, and no such waiver when executed shall constitute a waiver of any further failure to comply with this Agreement.

SEVERABILITY

If any provision of this Agreement, or the application of such provision to any person or circumstances shall be held invalid, the remaining provisions of this Agreement or the application thereof to persons or circumstances other than those as to which it is held invalid, shall not be affected. However, in the event either Party's performance of any provision of this Agreement could jeopardize the full accreditation of MultiCare by the Joint Commission, or by any other regulatory agent, or if such performance would be deemed illegal, either Party may at its option give notice of termination; provided, however, that in the event of any such termination under this Section, the Parties agree to negotiate in good faith to revise this Agreement in a form consistent with all statutes, ordinances, or other requirements in effect at such time. Nothing in this limits the right to terminate under other Sections of this Agreement.

INTERPRETATION

This Agreement shall be interpreted according to, and enforced under, the laws of the State of Washington. Jurisdiction and venue shall lie in Pierce County, Washington.

//

PATIENT REFERRAL; INDEPENDENT MEDICAL JUDGMENT

The Parties agree that MHS, Medical Director, and Agency have no duty or obligation to refer patients to one another and patient referral is not an obligation of this Agreement. Nothing contained herein or in the relationship of Agency, MHS, and the Medical Director is intended to interfere with the exercise of independent medical judgment by the Medical Director.

PARAGRAPH HEADINGS

The paragraph headings contained in this Agreement are for convenience only and shall be construed as part of this Agreement.

BINDING EFFECT

This Agreement shall be binding upon and shall inure to the benefit of the Parties and to Parties' authorized successors and assigns.

ASSIGNMENT

Nothing contained in this Agreement shall be construed to permit the assignment by MHS or Agency of any rights or obligations hereunder. Such assignment by Agency or MHS is expressly prohibited, and shall automatically terminate this Agreement, unless there has been prior written consent of Agency.

TIME OF ESSENCE

Time is of the essence with respect to every term and condition of this Agreement in which time is a factor

ARBITRATION

In the event of any dispute under this Agreement, the Parties agree to binding arbitration in Tacoma, Washington in accordance with the Commercial Arbitration Rules of the American Arbitration Association and with discovery being governed by the Federal Rules of Civil Procedure applicable in the United States District Court for the Western District of Washington. One arbitrator will be named by each Party and a third neutral arbitrator will be named by the arbitrators so chosen. Judgment upon the award rendered by the arbitrators may be entered into the judgment docket of any court having jurisdiction thereof. The cost of arbitration shall be shared equally by the Parties to it. Each Party shall be solely responsible for its attorneys' fees, if any. The obligations set forth under this section shall survive the termination of this Agreement.

ATTORNEYS' FEES

If any action at law or in equity is brought to enforce or interpret the provisions of this Agreement, the prevailing Party will be entitled to all actual attorneys' fees and other costs incurred in that action, in addition to any other relief to which that Party may be entitled.

NOTICES

All notices, requests, demands, and other communications required by or permitted hereunder shall be in writing and shall be deemed to have been given when received in hand or electronically delivered by the Party to whom directed; provided, however, that notice shall be conclusively deemed given five (5) days following the time of its deposit in the United States mails when sent certified or registered mail, postage prepaid, return receipt requested, to the other Party at the following addresses, or at an address as shall be given in writing by a Party to the other:

MULTICARE HEALTH SYSTEM
315 Martin Luther King Jr. Way
Tacoma, WA 98405
Attn: Christi McCarren

PNW Hospice, LLC
820 A St
Tacoma, WA 98402
Attn: Lynn Siedenstrang

cc: contractsupport@multicare.org

AUTHORITY TO SIGN

In witness whereof, the Parties have caused this Agreement to be executed and do each hereby warrant and represent that their respective signatory whose signature appears below has been and is on the date of this Agreement duly authorized by all necessary and appropriate corporate action to execute this Agreement.

	MultiCare Health System:	**Agency**: PNW Hospice, LLC
By:	Christi McCarren (DIGITALLY SIGNED)	Lynn Siedenstrang (DIGITALLY SIGNED)
Print Name:	Christi McCarren	Lynn Siedenstrang
Title:	MHS Sr VP for Retail Health & Cmty Base	Executive Director for PNW Hospice
Date:	12/18/2020 05:28 PM EST	12/18/2020 04:26 PM EST
	MultiCare's Contact Information:	Agency's Contact Information:
Designated Representative:	Sophi Gwynne	Connie Torres
Designated Representative Title:	Executive Asst Sr	Executive Asst
Address:	315 Martin Luther King Jr. Way Tacoma, WA 98415-0299	820 A St Tacoma, WA 98402
Telephone:	253.403.2823	253- 403-2876
Email Address:	sgwynne@multicare.org	torreco@multicare.org
Copy to Email:	ContractSupport@multicare.org	

Exhibit A

The initial Medical Director will be Lea Coville, MD attached hereto is her CV.

LEA COVILLE, MD

Voice/Text: 715-896-3200
lcoville@multicare.org

PROFESSIONAL ACTIVITIES

MultiCare Health System 2017 – Present

- MultiCare Home Health & Hospice, Tacoma, WA (2019 – Present)
  - Medical Director
    Administrative Leader for provider team
    Clinical director for all medical care of census

- Rockwood Moran Prairie Clinic, Spokane, WA (2017-2019)
  - Family Medicine Physician
  - Women's Health, including Obstetrics until January 2019

Black River Memorial Palliative Care, Black River Falls, WI 2015 – 2017

- Medical Director

Black River Memorial Hospice, Black River Falls, WI 2006 – 2017

- Medical Director

Black River Memorial Hospital, Black River Falls, WI 2006 – 2017

- Staff Physician
  - Hysteroscopy & Endometrial Ablation
  - Obstetrics
  - Medical Executive Committee (MEC) 2009 – 2016
  - Chief of Staff 2014 – 2015
  - Vice Chief of Staff 2016

Krohn Clinic, LTD, Black River Falls, WI 2009 – 2017

- Board Member

Krohn Clinic, Black River Falls, WI 2006 – 2017

- Family Medicine Physician
  - Full-spectrum Family Medicine Clinic
  - Same-day/Urgent Care
  - Nursing Home
  - Women's Health, including Obstetrics
  - Ultrasound interpretation

Residency

Texas Tech University Health Science Center
- Family & Community Medicine, Odessa, Texas — 2003 – 2006

Education

MD **University of Texas Medical Branch** — February 2003
School of Medicine
Galveston, Texas

ASSN **Angelo State University** — May 1998
School of Nursing
San Angelo, Texas

Licensing & Certifications

American Board of Family Medicine, Family Medicine — 2007 – 2027
- Maintenance of Certification – Current
- Certificate of Added Qualification: Hospice & Palliative Medicine — 2008 – 2028

Wisconsin Medical Board — 2006 – 2021

Washington Medical Board — 2017 – Present

DEA — Current

National Provider Identifier (NPI) — Current

Basic Life Support (BLS) — 11/2019 – 11/2021

Professional Affiliations

- American Academy of Family Physicians — 2006 – Present
- Washington Academy of Family Physicians — 2017 – Present
- Wisconsin Academy of Family Physicians — 2006 – 2017
- American Academy of Hospice & Palliative Medicine — 2018 – Present

Volunteer Activities

Black River Falls United Methodist Church — 2009 – 2017
- Staff-Parish Relations Committee, Chairman
- Administrative Council
- Spirit! Special Music, Pianist
- JuBELLation Bell Choir

Shiphrah Birth Center (HELP, Inc), Philippines — May – October 1993
- Midwife

References

Will be provided on request.

FIRST AMENDMENT TO
MEDICAL' S DIRCTOR'S AGREEMENT

THIS FIRST AMENDMENT ("Amendment") to the Medical's Director's Agreement ("Agreement") is made and entered into by and between MultiCare Health System ("MHS"), a nonprofit corporation formed under the laws of the State of Washington and PNW Hospice, LLC ("Agency"). MHS and Agency are sometimes referred to in this Amendment individually as "Party" or, collectively, as the "Parties."

WHEREAS the Parties have previously entered into a Medical's Director's Agreement dated the 17th day of December, 2020;

WHEREAS the Parties wish to further revise the Agreement to replace Exhibit A in its entirety with the attached Exhibit A;

Now, therefore, in consideration of the mutual benefits, promises, payments and undertakings of the Parties, it is hereby agreed that:

FA-1. Exhibit A will be replaced in its entirety with the attached Exhibit A.

FA-2. Except as set forth in this Amendment, all terms and conditions of the Agreement, as previously amended, shall remain in full force and effect.

IN WITNESS WHEREOF, the Parties hereto have executed this First Amendment effective as of the last date shown below.

	MultiCare Health System:	Contractor: PNW Hospice, LLC
By:	Christi McCarren	Lynn Siedenstrang
Print Name:	Christi McCarren	Lynn Siedenstrang
Title:	Sr VP-Retail Health	Executive Director for PNW Hospice
Date:	11/30/2021 03:49 PM EST	11/30/2021 03:28 PM EST
	MultiCare's Contact Information:	**Contractor's Contact Information:**
Designated Representative:	Sophi Gwynne	Connie Torres
Designated Representative Title:	Executive Asst Sr	Executive Asst
Address:	PO Box 5299 Tacoma, Washington 98415	820 A St Tacoma, WA 98402
Telephone:	253.403.2823	253-403-2876
E-mail address:	sgwynne@multicare.org	torreco@multicare.org
Copy to Email:	ContractSupport@multicare.org	
Contractor's EIN (or UBI) No.:		

Exhibit A

The Medical Director will now be Isam Dorna attached hereto is Dr. Dorna's CV.

Curriculum Vitae

Name: Isam Dorna

Date of birth: Sept 26/1957

Contact address:
4524 Olympus Loop
Gig Harbor, WA 98332
Tel: (541) 324-8645
Email: isam.dorna@multicare.org

Medical Education:

-MBChB; University of Basrah-Iraq, Medical School, (11/1974- 6/1980)

Post-Graduate Certificates:

-Internal Medicine Diploma; University of Baghdad-Iraq (9/1989-0/1990).
-General Practitioner Diploma; Baghdad-Iraq (3/1991-3/1992).
-Board in Internal Medicine; Iraqi Commission for Medical Specialization (10/1988- 10/1992).
-The Royal Australian College of Physicians; Written Part (3/2000)
-The Royal Australian College of Physicians; Clinical Part (6/2001)
-American Board of Internal Medicine (08/24/2004) Recertified in 2014.
-Hospice and Palliative Medicine Board (11/2010)

Examinations:

-USMLE (Step One): 10/16/1996
-USMLE (Step Two): 8/31/1995
-USMLE (Step Three): 10/10/2000.
-New Zealand Registration Examination: 6/1997
-The Royal Australian College of Physicians; Written part (3/2000)
-The Royal Australian College of Physicians; Clinical part (6/2001)
-Certification Examination in Internal Medicine (10/2004)
-Certification Examination in Hospice and Palliative Medicine (11/2010)

Active Licenses:

-Oregon Board of Medical Examiners
-Washington State Department of Health
-California Medical board

Work Experience:

MultiCare Tacoma Hospice: (06/07/21-Present): Associate medical director/Hospice physician. Interim medical director. Interim medical director.

Assured hospice of Moses Lake/LHG group: (07/22/2011-07/22/2014); (01/01/2018-Present) Associate Medical Director and Hospice physician.

Daiya Health Care: (06/15/20-06/04/2021) Internal Medicine Physician for SNF.

Samaritan Hospital/Confluence Health: (3/1/2010-06/14/2020)**;** Hospitalist.

Providence Medford Medical Center;(4/1/2006-12/31/2009) Hospitalist.

Delta Health Center, Bolivar Medical Center;(10/11/2004-3/31/2006) Internist, Primary Care Physician and Hospitalist.

Nassau University Medical Center: (07/01/2001-06/31/2004); Internal Medicine Resident

The Gold Coast Hospital: Internal Medicine Resident in Australia (01/08/2001-06/24/2001); Internal Medicine Resident.

Dunedin Hospital in New Zealand: (12/08/ 1997-12/31/2000); Resident.

Dunedin Hospital in New Zealand: (09/08/1997-11/24/1997); Locum Intern.

Auckland Hospital in New Zealand:(10/01/1996-06/31/1997); clinical attachment for the New Zealand Licensing.

Sebha Teaching Hospital in Libya: (02/20/1995-08/31/1996); Hospitalist and medical school teaching staff member.

Al- Kinki Teaching Hospital in Iraq: (06/09/1994-10/12/1994); Hospitalist.

Khankin Hospital- Diala/ Iraq: (03/25/1993-06/05/1994); Hospitalist.

The Medical City Teaching hospital: (10/22/1988-03/16/1993); Internal Medicine Resident.

Al-Chu'wadir Hospital Baghdad/ Iraq: (05/07/1987-10/20/1988); Resident

Safwan Clinic-Basra/ Iraq: (09/20/1985-05/04/1987); Primary care physician.

Mandatory Military Service: (08/24/1981-09/15/1985); Physician.

Basra Teaching Hospital in Iraq: (08/05/1980-08/15/1981); Intern.

Research Experiences:

-Transthoracic Percutaneous Fine Needle Aspiration Biopsy for Peripheral Lung Lesions (10/1989-10/1991); Comparison between Transthoracic Percutaneous Fine Needle Aspiration Biopsy for diagnosis of peripheral lung lesions Vs more conventional methods (Sputum Examination and Fiber optic Bronchoscopy).

-Profile and pattern of Salmonella Typhi and Paratyphi in New Zealand (1/1996-11999). A study presented in the Grand Round in Dunedin Public Hospital.

Language Fluency (Other than English):

- Arabic

Volunteer Experiences:

- I volunteered, with a group of doctors, to go to the Great Sahara Desert for two months (July/1994-Sept/1994). We built mobile clinics for the indigent people in the remote areas with no health service at all.

- I volunteered in a free clinic set for Katrina Hurricane victims in Cleveland Mississippi.

Hobbies & Interests:
Traveling, photography, and reading.

Exhibit 9

Site Control Documents

DEACONESS MEDICAL OFFICE BUILDING
LEASE AGREEMENT

This Medical Office Space Building LEASE AGREEMENT (the "Lease") is entered into and effective as of December_____ 2021, ("Effective Date") between **MultiCare Health System**, a Washington nonprofit corporation ("Landlord"), and **PNW Hospice, LLC,** a Washington limited liability company ("Tenant"). Landlord and Tenant agree as follows:

1. **LEASE SUMMARY**.

a. Termination of Prior Lease. As of the Effective Date, that certain Deaconess Medical Office Building Lease Agreement dated December 31, 2020 for the property commonly referred to as Suite 317, 801 W. 5th Avenue, Spokane, Washington 99204 between Landlord and Tenant is hereby terminated and of no further force or effect.

b. Leased Premises. The leased commercial real estate (the "Premises") consists of an agreed area of approximately TWO THOUSAND SIXTEEN (2,016) rentable square feet, which consists of certain area located within Suite 510 together with certain area outside of Suite 510 representing a 15% allocation of the Common Areas in the Building for use by Tenant consistent with the terms governing Common Areas in this Lease, all as depicted on the floor plan attached as Exhibit A, located on the land legally described on attached Exhibit B, and is commonly known as Suite 510, 801 West 5th Avenue, Spokane, Washington 99204. The Premises do not include, and Landlord reserves, the exterior walls and roof of the Premises, the land beneath the Premises, the pipes and ducts, conduits, wires, fixtures, and equipment above the suspended ceiling or structural elements of the building in which the Premises are located (the "Building"). The Building, the land upon which it is situated, all other improvements located on such land, and all common areas appurtenant to the Building are referred to as the "Property."

c. Term; Renewal Option. The term of this Lease shall be THREE (3) years and ZERO (0) months, commencing on June 1, 2023 (the "Commencement Date") and terminating at midnight May 31, 2026 or such earlier or later date as provided in this Section or Section 3. Two two-year renewal options are available to the Tenant as set forth in Section 3(b).

d. Rent. The monthly rent ("Rent") shall be FOUR THOUSAND TWO HUNDRED AND NO/100THS ($4,200.00). Rent shall be payable on the 1st of the month at or such other place designated in writing by Landlord.

e. Index. Intentionally deleted.

f. Security Deposit. Intentionally deleted.

g. Permitted Use. The Premises shall be used only for the purpose of conducting a medical practice or administrative offices and for no other purpose without the prior written consent of Landlord.

h. Notice Addresses.

Landlord:

MultiCare Health System
c/o Goodale & Barbieri
818 W. Riverside Ave, #300
Spokane, WA 99201
frontdesk@g-b.com

With Copies to:

MultiCare Health System
Attn: General Counsel
315 Martin Luther King Jr. Way
MS: 820-4-LEG
PO Box 5299
Tacoma, WA 98415-0299
legal.services@multicare.org
contractsupport@multicare.org

DEACONESS MEDICAL OFFICE BUILDING
LEASE AGREEMENT

MultiCare Health System
c/o CBRE Real Estate Services
315 Martin Luther King Jr Way
MS: 1313-5-CON
PO Box 5299
Tacoma, WA 98415-0299
MHSrealestateleaseadministration@
multicare.org

Tenant:

Attn: Lynn Siedenstrang
Executive Director
PNW Hospice, LLC

2. **PREMISES.**

a. **Lease of Premises**. Landlord leases to Tenant, and Tenant leases from Landlord the Premises upon the terms specified in this Lease.

b. **Acceptance of Premises**. Except as specified elsewhere in this Lease, Landlord makes no representations or warranties to Tenant regarding the Premises, including the structural condition of the Premises and the condition of all mechanical, electrical, and other systems on the Premises. Tenant shall be responsible for performing any work necessary to bring the Premises into condition satisfactory to Tenant. By signing this Lease, Tenant acknowledges that it has had adequate opportunity to investigate the Premises, acknowledges responsibility for making any corrections, alterations and repairs to the Premises and acknowledges that the time needed to complete any such items shall not delay the Commencement Date.

c. **Tenant Improvement Allowance**. Landlord shall grant a "Tenant Improvement Allowance" in the amount $12,096.00 total, in order to make the Premises functional for its Permitted Use. The Tenant Improvement Allowance shall be paid by Landlord as a cash reimbursement to Tenant upon completion of construction of Tenant's work together with submission to Landlord of an unconditional lien release from Tenant's general contractor. Tenant shall have the right to use its own licensed architect and contractor. Landlord will only be obligated to reimburse Tenant for such improvements upon receipt of the documentation delineated above. However, Landlord shall reimburse Tenant within 30 days of receipt of such documentation. Tenant will not be required to submit for reimbursement by a specified date.

3. **TERM.**

a. **Initial Term.** The term of this Lease shall be THREE (3) years and ZERO (0) months unless sooner terminated as provided herein. The first "Lease Year" shall commence on the Commencement Date and shall end on the date which is twelve (12) months from the Commencement Date. Each successive Lease Year during the initial term and any extension terms shall be twelve (12) months, commencing on the first day following the end of the preceding Lease Year, except that the last Lease Year shall end on the Termination Date. Unless extended pursuant to Section 3(b), the term of this Lease shall expire on the date specified in Section 1.

b. **Renewal Terms**. Provided Tenant is not in default at the time of the exercise or upon the commencement of any extension term described below, Tenant shall have two successive options to extend the Term for two years each. If Tenant desires to exercise an extension option, it must deliver written notice to Landlord

not less than 90 days prior to the expiration of the then-current Term, time being of the essence in connection therewith. Upon timely and proper exercise of any option, the Term shall be extended for the period of the subject option upon all of the same terms, conditions, and covenants as set forth in this Lease, except that (i) the amount of the base monthly rent stated in the Lease shall be adjusted to be the fair market value of the Premises, as determined in the manner described below; and (ii) after exercise of Tenant's final extension term option, there shall be no further extension or renewal term options.

If Landlord and Tenant are unable to agree on the fair market rental value for the Premises during the applicable extension term, then, within 30 days after the date Tenant exercises the applicable extension term option, Landlord and Tenant shall agree within 10 days thereafter on one real estate appraiser (who shall be a member of the American Institute of Real Estate Appraisers ("M.A.I.") or equivalent) who will determine the fair market rental value of the Premises. If Landlord and Tenant cannot mutually agree upon an appraiser within said 10-day period, then one M.A.I.-qualified appraiser shall be appointed by Tenant and one M.A.I.-qualified appraiser shall be appointed by Landlord within 10 days of notice to the other of such disagreement. The two appraisers shall determine the fair market rental value of the Premises within 20 days of their appointment; provided, however, if either party fails to appoint an appraiser within such 10-day period, then the determination of the appraiser first appointed shall be final, conclusive, and binding upon both parties.

The appraisers appointed shall proceed to determine the fair market rental value within 20 days following such appointment. The conclusion shall be final, conclusive and binding upon both Landlord and Tenant. If said appraisers should fail to agree, but the difference in their conclusions as to fair market value is 10% or less of the lower of the two appraisals, then the fair market rental value shall be deemed the average of the two. If the two appraisers should fail to agree on the fair market rental value and the difference between the two appraisals exceeds 10% of the lower of the two appraisals, then the two appraisers thus appointed shall appoint a third M.A.I.-qualified appraiser, and in case of their failure to agree on a third appraiser within 10 days after their individual determination of the fair market rental value, either party may apply to the Presiding Judge of the Superior Court of the county in which the Premises is situated, requesting such Judge to appoint the third M.A.I.-qualified appraiser.

The third appraiser so appointed shall promptly determine the fair market rental value of the Premises and the average of the appraisals of the two closest appraisers shall be final, conclusive, and binding upon both parties. The fees and expenses of said third appraiser or the one appraiser Landlord and Tenant agree upon, shall be borne equally between Landlord and Tenant. Landlord and Tenant shall pay the fees and expenses of their respective appraiser if the parties fail to agree on a single appraiser. All M.A.I. appraisers appointed or selected pursuant to this subsection shall have at least 10 years' experience appraising commercial properties in the commercial leasing market in which the Premises are located. If the extension term commences without an agreement or determination of fair market rental value, the extension term shall commence at the expiration of the current term and the rental amount due to Landlord or credit due to Tenant shall be reconciled upon that determination with the next monthly rental payment due.

4. RENT.

a. Payment of Rent. Tenant shall pay Landlord without notice, demand, deduction or offset, in lawful money of the United States, the monthly Rent stated in Section 1 in advance on or before the 1st day of each month during the Lease term beginning on the

Commencement Date, and any other additional payments due to Landlord ("Additional Rent") (collectively, "rent" or "Rent") when required under this Lease. Payments for any partial month at the beginning or end of the Lease term shall be prorated. All payments due to Landlord under this Lease, including late fees and interest, shall be rent, and upon failure of Tenant to pay any such costs, charges or expenses, Landlord shall have the same rights and remedies as otherwise provided in this Lease for the failure of Tenant to pay rent. Monthly Rent shall include Tenant's pro-rata contribution to Operating Expenses, Real Estate Taxes, Insurance and Utilities.

b. Rent Adjustment. The monthly Rent shall be increased on the first day of second lease year and on each 1st of each Lease year thereafter during the term of this Lease (each an "Adjustment Date") to an amount determined by multiplying the monthly Rent payable during the month immediately preceding the Adjustment Date by three per cent (3%). Upon the calculation of each increase, Landlord shall notify Tenant of the new monthly rent payable hereunder. Within thirty (30) days of the date of Landlord's notice, Tenant shall pay Landlord the amount of any deficiency in Rent paid by Tenant for the period following the subject adjustment date, and shall thereafter pay the increased Rent until receiving the next notice of increase from Landlord.

c. Late Charges; Default Interest. If any sums payable by Tenant to Landlord under this Lease are not received within five (5) business days after their due date, Tenant shall pay Landlord in addition to the amount due, for the cost of collecting and handling such late payment, an amount equal to the greater of $100 or five percent (5%) of the delinquent amount. In addition, all delinquent sums payable by Tenant to Landlord and not paid within five (5) business days after their due date shall, at Landlord's option, bear interest at the rate of twelve percent (12%) per annum, or the highest rate of interest allowable by law, whichever is less (the "Default Rate"). Interest on all delinquent amounts shall be calculated from the original due date to the date of payment.

d Less Than Full Payment. Landlord's acceptance of less than the full amount of any payment due from Tenant shall not be deemed an accord and satisfaction or compromise of such payment unless Landlord specifically consents in writing to payment of such lesser sum as an accord and satisfaction or compromise of the amount which Landlord claims.

5. SECURITY DEPOSIT. Intentionally deleted.

6. USES. No act shall be done on or around the Premises that is unlawful or that will increase the existing rate of insurance on the Premises or the Building, or cause the cancellation of any insurance on the Premises or the Building. Tenant shall not commit or allow to be committed any waste upon the Premises, or any public or private nuisance. Tenant shall not do or permit anything to be done in the Premises or on the Property which will obstruct or interfere with the rights of other tenants or occupants of the Property, or their customers, clients and visitors, or to injure or annoy such persons.

a. Restrictive Covenant. The Premises are to be used only for the Permitted Use and for no other business or purpose without the prior written consent of Landlord, which consent may be withheld by Landlord in its sole discretion. Notwithstanding any other provisions of this Lease, Tenant shall not engage in, or bill for, the provision of the technical component of any imaging, radiology, pathology, laboratory or pharmacy services within the Premises, without the express written prior approval of Landlord, which approval may be withheld in Landlord's sole discretion. Further, Tenant shall neither use, nor permit the use of, the Premises on a commercial basis that competes with the products or services that are available to outpatients or inpatients of Landlord, except to the extent such products or services are used by Tenant in connection with the Permitted Use and are otherwise approved in advance by Landlord in its sole discretion.

7. COMPLIANCE WITH LAWS. Tenant shall not cause or permit the Premises to be used in any way which violates any law, ordinance, or governmental regulation or order. Landlord represents to Tenant that, to Landlord's knowledge, without duty of investigation, and with the exception of any Tenant's Work, as of the Commencement Date, the Premises comply with all applicable laws, rules, regulations, or orders, including without limitation, the Americans With Disabilities Act, if applicable, and Landlord shall be responsible to promptly cure at its sole cost any noncompliance which existed on the Commencement Date. Tenant shall be responsible for complying with all laws applicable to the Premises as a result of Tenant's particular use thereof, such as modifications required by the Americans With Disabilities Act as a result of Tenant opening the Premises to the public as a place of public accommodation. If the enactment or enforcement of any law, ordinance, regulation or code during the Lease term requires any changes to the Premises during the Lease term, the Tenant shall perform all such changes at its expense if the changes are required due to the nature of Tenant's activities at the Premises, or due to alterations that Tenant seeks to make to the Premises; otherwise, Landlord shall perform all such changes at its expense. In addition, Tenant and its employees, agents, and contractors shall comply with Landlord's reasonable rules and regulations related to healthcare use, including, without limitation, any rules and regulations Landlord implements to comply with executive orders or other regulations promulgated by any government authority

a. Patient Referral; Independent Medical Judgment. Each party agrees that no party to this Lease has a duty or obligation to refer patients to one another and patient referral is not an obligation of this Lease. Nothing contained herein or in the relationship of Landlord and Tenant is intended to interfere with the exercise of independent medical judgment by the Tenant**.**

The parties further agree:

b. The parties agree that the Lease payments represent Fair Market Value;

c. The Lease terms are commercially reasonable and not determined in a manner that takes into account the volume or value of referrals or other business generated between the parties;

d. The aggregate space and/or equipment rented does not exceed that which is necessary to accomplish the commercially reasonable business purpose of the rental; and

e. The parties shall document this Lease and all other arrangements between the parties (or between MultiCare Health System and a physician member of the other party or his or her family member) in a master contract list and/or repository that is maintained and updated centrally and available for review upon request by such party or any governmental agency with authority to request the information. MultiCare shall maintain the master policy/repository in a manner that preserves the historical record of the past arrangements between the parties.

8. UTILITIES AND SERVICES. Landlord shall provide the Premises the following services: water and electricity for the Premises seven (7) days per week, twenty-four (24) hours per day, and heating, ventilation and air conditioning from 7:00 a.m. to 6:00 p.m. Monday through Friday, and 7:00 a.m. to 12:00 p.m. on Saturday, and shall provide janitorial service, including lamp replacement, to the Premises and Building five (5) nights each week, exclusive of holidays. Heating, ventilation and air conditioning services will also be provided by Landlord to the Premises during additional hours on reasonable notice to Landlord, at Tenant's sole cost and expense, at an hourly rate reasonably established by Landlord from time to time and payable by Tenant, as billed, as Additional Rent Landlord shall not be liable for any loss, injury or damage to person or property caused by or resulting from any variation, interruption, or failure of utilities due to any cause whatsoever, and rent shall not abate as a result thereof.

Tenant shall furnish all other utilities (including, but not limited to, telephone and cable service if available) and other services which Tenant requires with respect to the Premises, except those to be provided by Landlord as described above, and shall pay, at Tenant's sole expense, the cost of all utilities separately metered to the Premises, and of all other utilities and other services which Tenant requires with respect to the Premises, except those to be provided by Landlord as described above. Notwithstanding the foregoing, if Tenant's use of the Premises incurs utility service charges which are above ordinary usage, Landlord reserves the right to require Tenant to pay a reasonable additional charge for such usage. For example, where Tenant installs and uses a number of electronic devices which is greater than normal, the increased usage may result in higher electrical charges and increased charges for cooling since overheating of rooms may result. Landlord shall not be liable for any loss, injury or damage to person or property caused by or resulting from any variation, interruption, or failure of utilities due to any cause whatsoever, and rent shall not abate as a result thereof, except to the extent due to the intentional misconduct or gross negligence of Landlord.

9. **TAXES**. Tenant shall pay all taxes, assessments, liens and license fees ("Taxes") levied, assessed or imposed by any authority having the direct or indirect power to tax or assess any such liens, by reason of Tenant's use of the Premises, and all Taxes on Tenant's personal property located on the Premises. Landlord shall pay all Taxes with respect to the Building and the Property, including any Taxes resulting from a reassessment of the Building or the Property due to a change of ownership or otherwise.

10. **COMMON AREAS**.

a. **Definition**. The term "Common Areas" means all areas, Premises and building systems that are provided and designated from time to time by Landlord for the general non-exclusive use and convenience of Tenant with other tenants and which are not leased or held for the exclusive use of a particular tenant. To the extent that such areas and Premises exist within the Property, Common Areas include hallways, entryways, stairs, elevators, driveways, walkways, terraces, docks, loading areas, restrooms, trash Premises, parking areas and garages, roadways, pedestrian sidewalks, landscaped areas, security areas, lobby or mall areas, common heating, ventilating and air conditioning systems, common electrical service, equipment and Premises, and common mechanical systems, equipment and Premises. Tenant shall comply with reasonable rules and regulations concerning the use of the Common Areas adopted by Landlord from time to time. Without advance notice to Tenant and without any liability to Tenant, Landlord may change the size, use, or nature of any Common Areas, erect improvements on the Common Areas or convert any portion of the Common Areas to the exclusive use of Landlord or selected tenants, so long as Tenant is not thereby deprived of the substantial benefit of the Premises. Landlord reserves the use of exterior walls and the roof, and the right to install, maintain, use, repair and replace pipes, ducts, conduits, and wires leading through the Premises in areas which will not materially interfere with Tenant's use thereof.

b. **Use of the Common Areas**. Tenant shall have the non-exclusive right, in common with such other tenants to whom Landlord has granted or may grant such rights, to use the Common Areas. Tenant shall abide by rules and regulations adopted by Landlord from time to time and shall use its best efforts to cause its employees, contractors, and invitees to comply with those rules and regulations, and not interfere with the use of Common Areas by others.

c. **Maintenance of Common Areas**. Landlord shall maintain the Common Areas in good order, condition and repair. In performing such maintenance, Landlord shall use reasonable efforts to minimize interference with Tenant's use and enjoyment of the Premises.

d. **Parking.** Tenant and its customers shall be entitled to share parking with Landlord's other tenants and their customers in the parking garage if available. Tenant shall comply and shall be responsible for the compliance of its employees and customers

with the terms of the Lease and any riders, reasonable rules and regulations adopted by Landlord from time to time for the safe and orderly sharing of parking.

11. ALTERATIONS. Tenant may make alterations, additions or improvements to the Premises, ("Alterations"), with the prior written consent of Landlord, which, with respect to Alterations not affecting the structural components of the Premises or utility systems therein, shall not be unreasonably withheld, conditioned, or delayed. Landlord shall have thirty (30) days in which to respond to Tenant's request for any Alterations so long as such request includes the name(s) of Tenant's contractors and reasonably detailed plans and specifications therefor. The term "Alterations" shall not include the installation of shelves, movable partitions, Tenant's equipment, and trade fixtures that may be performed without damaging existing improvements or the structural integrity of the Premises, and Landlord's consent shall not be required for Tenant's installation or removal of those items. Tenant shall perform all work within the Premises at Tenant's expense in compliance with all applicable laws, and shall complete all Alterations in accordance with plans and specifications approved by Landlord, using contractors approved by Landlord, and in a manner so as to not unreasonably interfere with other tenants. Tenant shall pay, when due, all claims for labor or materials furnished to or for Tenant at or for use in the Premises, which claims are or may be secured by any mechanics' or materialmen's' liens against the Premises or any interest therein.

12. REPAIRS AND MAINTENANCE; SURRENDER. Tenant shall, at its sole expense, maintain the Premises in good condition and promptly make all non-structural repairs and replacements necessary to keep the Premises safe and in good condition, including all HVAC components and other utilities and systems to the extent exclusively serving the Premises. Landlord shall maintain and repair the Building structure, foundation, subfloor, exterior walls, roof structure and surface, and HVAC components and other utilities and systems serving more than just the Premises, and the Common Areas. Tenant shall not damage any demising wall or disturb the structural integrity of the Premises and shall promptly repair any damage or injury done to any such demising walls or structural elements caused by Tenant or its employees, agents, contractors, or invitees. Notwithstanding anything in this Section to the contrary, Tenant shall not be responsible for any repairs to the Premises made necessary by the negligence or willful misconduct of Landlord or its agents, employees, contractors or invitees therein. If Tenant fails to perform Tenant's obligations under this Section, Landlord may at Landlord's option enter upon the Premises after ten (10) days' prior notice to Tenant and put the same in good order, condition and repair and the cost thereof together with interest thereon at the Default Rate shall be due and payable as Additional Rent to Landlord together with Tenant's next installment of Base Rent. Upon expiration of the Lease term, whether by lapse of time or otherwise, Tenant shall remove all personal property and office trade fixtures that may be readily removed without damage to the Premises or Building and promptly and peacefully surrender the Premises, together with all keys, to Landlord in as good condition as when received by Tenant from Landlord or as thereafter improved, reasonable wear and tear and insured casualty excepted. Landlord, at its option with written notice to Tenant, may require Tenant to remove any alterations, additions or improvements, including without limitation wiring and cabling, and to restore Premises and repair any damage caused thereby at expiration or earlier termination of the Lease.

13. ACCESS AND RIGHT OF ENTRY. After twenty-four (24) hours' notice from Landlord (except in cases of emergency, when no notice shall be required), Tenant shall permit Landlord and its agents, employees and contractors to enter the Premises at all reasonable times to make repairs, inspections, alterations or improvements, provided that Landlord shall use reasonable efforts to minimize interference with Tenant's use and enjoyment of the Premises. This Section shall not impose any repair or other obligation upon Landlord not expressly stated elsewhere in this Lease. After reasonable notice to Tenant, Landlord shall have the right to enter the Premises for the purpose of showing the Premises to prospective purchasers or lenders at any time, and to prospective tenants within one hundred eighty (180) days prior to the expiration or sooner termination of the Lease term, and for posting "for lease" signs within one hundred eighty (180) days prior to the expiration or sooner termination of the Lease term.

14. SIGNAGE. Tenant shall obtain Landlord's written consent as to size, location, materials, method of attachment, and appearance, before installing any signs upon the Premises. Tenant shall install any approved signage at Tenant's sole expense and in compliance with all applicable laws. Tenant shall not damage or deface the Premises in installing or removing signage and shall repair any injury or damage to the Premises caused by such installation or removal.

15. DESTRUCTION OR CONDEMNATION.

a. Damage and Repair. If the Premises or the portion of the Property necessary for Tenant's occupancy are partially damaged but not rendered untenantable, by fire or other insured casualty, then Landlord shall diligently restore the Premises and the portion of the Property necessary for Tenant's occupancy to the extent required below and this Lease shall not terminate; provided, however, Tenant may terminate the Lease if Landlord is unable to restore the Premises within six (6) months of the casualty event.

The Premises or the portion of the Property necessary for Tenant's occupancy shall not be deemed untenantable if less than twenty-five percent (25%) of each of those areas are damaged. Landlord shall have no obligation to restore the Premises if insurance proceeds are not available to pay the entire cost of such restoration. If insurance proceeds are available to Landlord but are not sufficient to pay the entire cost of restoring the Premises, or if Landlord's lender shall not permit all or any part of the insurance proceeds to be applied toward restoration, then Landlord may elect to terminate this Lease and keep the insurance proceeds, by notifying Tenant within sixty (60) days of the date of such casualty.

If the Premises is made untenable as defined above, or 50% or more of the rentable area of the Property are entirely destroyed, or partially damaged and rendered untenantable, by fire or other casualty, Landlord may, at its option: (a) terminate this Lease as provided herein, or (b) restore the Premises and the portion of the Property necessary for Tenant's occupancy to their previous condition to the extent required below; provided, however, if such casualty event occurs during the last six (6) months of the Lease term (after considering any option to extend the term timely exercised by Tenant) then either Tenant or Landlord may elect to terminate the Lease. If, within sixty (60) days after receipt by Landlord from Tenant of written notice that Tenant deems the Premises or the portion of the Property necessary for Tenant's occupancy untenantable, Landlord fails to notify Tenant of its election to restore those areas, or if Landlord is unable to restore those areas within six (6) months of the date of the casualty event, then Tenant may elect to terminate the Lease upon twenty (20) days' written notice to Landlord unless Landlord, within such twenty (20) day period, notifies Tenant that it will in fact restore the Premises or actually completes such restoration work to the extent required below, as applicable.

If Landlord restores the Premises or the Property under this Section, Landlord shall proceed with reasonable diligence to complete the work, and the base monthly rent shall be abated in the same proportion as the untenantable portion of the Premises bears to the whole Premises, provided that there shall be a rent abatement only if the damage or destruction of the Premises or the Property did not result from, or was not contributed to directly or indirectly by the act, fault or neglect of Tenant, or Tenant's officers, contractors, licensees, subtenants, agents, servants, employees, guests, invitees or visitors. No damages, compensation or claim shall be payable by Landlord for inconvenience, loss of business or annoyance directly, incidentally or consequentially arising from any repair or restoration of any portion of the Premises or the Property. Landlord will not carry insurance of any kind for the protection of Tenant or any improvements paid for by Tenant or as provided in Exhibit C or on Tenant's furniture or on any fixtures, equipment, improvements or appurtenances of Tenant under this Lease, and Landlord's restoration obligations hereunder shall not include any obligation to repair any damage thereto or replace the same.

b. Condemnation. If the Premises, the portion of the Property necessary for Tenant's occupancy, or 50% or more of the rentable area of the Property are made untenantable by eminent domain, or conveyed under a threat of condemnation, this Lease shall terminate at the option of either Landlord or Tenant as of the earlier of the date title vests in the condemning authority or the condemning authority first has possession of the Premises or the portion of the Property and all Rents and other payments shall be paid to that date. In case of taking of a part of the Premises or the portion of the Property necessary for Tenant's occupancy that does not render those areas untenantable, then this Lease shall continue in full force and effect and the base monthly rent shall be equitably reduced based on the proportion by which the floor area of any structures is reduced, such reduction in Rent to be effective as of the earlier of the date the condemning authority first has possession of such portion or title vests in the condemning authority. The Premises or the portion of the Property necessary for Tenant's occupancy shall not be deemed untenantable if less than twenty-five percent (25%) of each of those areas are condemned. Landlord shall be entitled to the entire award from the condemning authority attributable to the value of the Premises or the Property and Tenant shall make no claim for the value of its leasehold. Tenant shall be permitted to make a separate claim against the condemning authority for moving expenses, provided that in no event shall Tenant's claim reduce Landlord's award.

16. INSURANCE.

Tenant's Insurance. Tenant will carry and maintain, at its sole cost and expense, the following types of insurance, as applicable, in the amounts specified and in the form hereinafter required. Each policy shall be endorsed to provide that such coverage shall be primary and that any coverage maintained by Landlord shall be excess, secondary and non-contributing. Tenant shall provide Landlord with a certificate of insurance evidencing the insurance coverage required under each Section. Tenant shall promptly notify Landlord of any cancellation, reduction, or other material change in the amount or scope of any coverage required hereunder.

a. Liability. Commercial general liability insurance with coverage limits of not less than $1,000,000 each occurrence, $1,000,000 Personal and Advertising, $5,000 Medical Expense any one person, $1,000,000 Damage to Rented Premises and a general aggregate limit of $2,000,000, insuring against any and all liability of the insureds with respect to the Premises or arising out of the maintenance, use or occupancy thereof or related to the exercise of any rights of Tenant pursuant to this lease, subject to increases in amount as Landlord may reasonably require. Landlord may also require business auto liability coverage of $1,000,000 combined single limit.

b. Property Insurance. Causes of loss-special form property and business interruption insurance covering all of the personal property, equipment, and trade fixtures of Tenant and leasehold improvements and Alterations made by or for Tenant to the Premises in, on or about the Premises for 100% of its full replacement value including from damage from earthquake, flood, sprinkler leakage, vandalism, malicious mischief and such other additional perils as covered in a causes of loss – special form insurance policy. Any policy proceeds shall be used for the repair or replacement of the property damaged or destroyed unless the lease is terminated.

c. Workers' Compensation. Workers' compensation as required by law, including employer's liability coverage.

d. Medical Malpractice. Tenant shall procure and maintain in force during the term of this Agreement such medical malpractice as is reasonably necessary to protect against liability arising from or incident to the use of and provision of medical services by Tenant at the Clinic. Such insurance shall include coverage for any providers engaged by Tenant to assist in performing such services. Coverage under such insurance shall be not less than One Million ($1,000,000) Dollars and Three Million ($3,000,000) Dollars aggregate on

a claims make policy. In the event that such coverage is terminated by Tenant without replacement by a policy covering acts or omissions arising under this Agreement, Tenant shall purchase an extended reporting policy which shall cover any claims which are filed during a period of not less than twenty-four (24) months from the date this Agreement terminates

e. Miscellaneous. Tenant's insurance required under this Section shall be with companies rated A-/VII or better in Best's Insurance Guide. Tenant shall promptly notify Landlord in writing if such insurance policy is cancelled or reduced in coverage. As evidence of compliance with the policy limits required under this Section 16 and within ten (10) days of lease execution, but prior to possession of the Premises, and from time to time thereafter, Tenant shall deliver to Landlord 1) certificates of insurance naming MultiCare Health System and Goodale & Barbieri Company. as additional insureds and provide an additional insured endorsement for coverage under commercial general liability and, 2) a certificate of insurance providing evidence of property insurance naming Landlord as a loss payee under the business interruption coverage as respects loss of rents. In no event shall the limits of such policies be considered as limiting the liability of Tenant under this Lease. Tenant's failure to provide evidence of such coverage to Landlord shall constitute a default under the lease. If Tenant fails to acquire or maintain any insurance or provide any policy or evidence of insurance required by this Section, and such failure continues for three (3) days after written notice from Landlord, Landlord may, but shall not be required to, obtain such insurance for Landlord's benefit and Tenant shall reimburse Landlord for the costs of such insurance upon demand. Such amounts shall be Additional Rent payable by Tenant hereunder and in t event of non-payment thereof, Landlord shall have the same rights and remedies with respect to such non-payment as it has with respect to any other non-payment of rent hereunder.

Landlord's Insurance. Landlord shall carry broad form property insurance for the Building shell and core in the amount of their full replacement value, and such other insurance of such types and amounts as Landlord, in its discretion, shall deem reasonably appropriate.

Waiver of Subrogation. Landlord and Tenant hereby release each other and any other tenant, their agents or employees, from responsibility for, and waive their entire claim to the extent covered by and paid for by insurance for any loss or damage arising from any cause covered by insurance required to be carried or otherwise carried by each of them. Each party shall provide notice to the insurance carrier or carriers of this mutual waiver of subrogation, and shall cause its respective insurance carriers to waive all rights of subrogation against the other. This waiver shall not apply to the extent of the deductible amounts to any such policies or to the extent of liabilities exceeding the limits of such policies.

17. INDEMNIFICATION.

a. Indemnification by Tenant. Tenant shall indemnify and defend Landlord and its managing agents from any claim, liability, damage or loss occurring on the Premises, arising out of any activity by Tenant, its agents, or invitees or resulting from Tenant's failure to comply with any term of this Lease. Neither Landlord nor its managing agent shall have any liability to Tenant because of loss or damage to Tenant's property or for death or bodily injury caused by the acts or omissions of other tenants of the Building, or by third parties (including criminal acts).

b. Indemnification by Landlord.

Landlord shall indemnify and defend Tenant and its managing agents from any claim, liability, damage or loss occurring on the Premises, arising out of any activity by Landlord, its agents, or invitees or resulting from Landlord's failure to comply with any term of this Lease. Neither Tenant nor its managing agent shall have any liability to Landlord because

of loss or damage to Landlord's property or for death or bodily injury caused by the acts or omissions of other tenants of the Building, or by third parties (including criminal acts).

c. Waiver of Immunity. Landlord and Tenant each specifically and expressly waive any immunity that each may be granted under the Washington State Industrial Insurance Act, Title 51 RCW. Neither party's indemnity obligations under this Lease shall be limited by any limitation on the amount or type of damages, compensation, or benefits payable to or for any third party under the Worker Compensation Acts, Disability Benefit Acts or other employee benefit acts.

d. Exemption of Landlord from Liability. Except to the extent of claims arising out of Landlord's gross negligence or intentional misconduct, Landlord shall not be liable for injury to Tenant's business or assets or any loss of income therefrom or for damage to any property of Tenant or of its employees, invitees, customers, or any other person in or about the Premises.

e. Survival. The provisions of this Section shall survive expiration or termination of this Lease.

18. ASSIGNMENT AND SUBLETTING.

(a) This Lease and any right of Tenant hereunder or in the Premises may not be assigned, transferred, encumbered or sublet in whole or in part by Tenant, expressly or by operation of law or otherwise, without Landlord's prior written consent, which consent may be not be unreasonably withheld, conditioned or delayed.

(b) If Tenant is a professional corporation, any merger, consolidation, bankruptcy, dissolution, liquidation, or change in the ownership of or the power to vote the majority of its outstanding voting stock of the corporation, shall constitute an assignment whether as a result of a single transaction or a series of transactions. If Tenant is a partnership, the death, bankruptcy, dissolution, withdrawal or expulsion of a partner or partners owning, or transfer of interests representing, in the aggregate more than twenty-five (25%) of partnership profits or capital shall constitute an assignment, whether as the result of a single transaction or a series of transactions. If Tenant consists of more than one person, any transfer from one individual to another individual shall constitute an assignment.

(c) As a condition to Landlord's approval, any prospective assignee or sublessee otherwise approved by Landlord shall assume in writing all obligations of Tenant under this Lease and shall be jointly and severally liable with Tenant for the payment of Rent and the performance of all terms, conditions, covenants, and agreements contained in this Lease; provided that any approved sublessee shall be liable for rent in the amount set forth in the sublease. Tenant shall provide Landlord with copies of all assignments, subleases, and assumption documents.

(d) Any consent by Landlord to any assignment or subletting may be subject to such terms and conditions as Landlord shall determine and all such terms and conditions shall be binding upon any person holding by, under or through Tenant.

(e) If Landlord's consent to assignment or subleasing is requested, Landlord reserves the right to terminate this Lease, or if consent is requested for subleasing less than the entire Premises, to terminate this Lease with respect to the portion for which consent is requested, at the proposed effective date of such assignment or subleasing.

(f) All rent received by Tenant from its subtenant(s) in excess of the Rent payable by Tenant to Landlord under this Lease shall be paid to Landlord as additional Rent. Any sums to be paid to Tenant by an assignee of Tenant's interest under this Lease in consideration of the assignment of such interest shall be paid to Landlord as additional

Rent. If Tenant requests Landlord to consent to a proposed assignment or subletting, Tenant shall pay to Landlord whether or not consent is ultimately given, the sum of $250.00 plus Landlord's reasonable attorneys' fees incurred in connection with such request.

(g) Landlord may assign its interests, rights, duties and obligations under this Lease to any person without the consent of Tenant. Thereafter, only the new Landlord shall be liable to Tenant for performance of Landlord's duties and obligations hereunder and Tenant shall attorn to and become the tenant of Landlord's assignee.

19. LIENS. Tenant is not authorized to subject the Landlord's estate to any liens or claims of lien. Tenant shall keep the Premises free from any liens created by or through Tenant. Tenant shall indemnify and hold Landlord harmless from liability for any such liens including, without limitation, liens arising from any Alterations. If a lien is filed against the Premises by any person claiming by, through or under Tenant, Tenant shall, within ten (10) days after Landlord's demand, at Tenant's expense, either remove the lien or furnish to Landlord a bond in form and amount and issued by a surety satisfactory to Landlord, indemnifying Landlord and the Premises against all liabilities, costs and expenses, including attorneys' fees, which Landlord could reasonably incur as a result of such lien(s).

20. DEFAULT. The following occurrences shall each be deemed an Event of Default by Tenant. Any notice periods granted herein shall be deemed to run concurrently with and not in addition to any default notice periods required by law.

a. Failure To Pay. Tenant fails to pay any sum, including Rent, due under this Lease following five (5) days' written notice from Landlord of the failure to pay.

b. Vacation/Abandonment. Tenant vacates the Premises (defined as an absence for at least fifteen (15) consecutive days without prior notice to Landlord), or Tenant abandons the Premises (defined as an absence of five (5) days or more while Tenant is in breach of some other term of this Lease). Tenant's vacation or abandonment of the Premises shall not be subject to any notice or right to cure.

c. Insolvency. Tenant becomes insolvent, voluntarily or involuntarily bankrupt, or a receiver, assignee or other liquidating officer is appointed for Tenant's business, provided that in the event of any involuntary bankruptcy or other insolvency proceeding, the existence of such proceeding shall constitute an Event of Default only if such proceeding is not dismissed or vacated within sixty (60) days after its institution or commencement.

d. Levy or Execution. Tenant's interest in this Lease or the Premises, or any part thereof, is taken by execution or other process of law directed against Tenant, or is taken upon or subjected to any attachment by any creditor of Tenant, if such attachment is not discharged within fifteen (15) days after being levied.

e. Other Non-Monetary Defaults. Tenant breaches any agreement, term, covenant or any of the Building Rules and Regulations per Exhibit C of this Lease other than one requiring the payment of money and not otherwise enumerated in this Section or elsewhere in this Lease, and the breach continues for a period of thirty (30) days after notice by Landlord to Tenant of the breach.

f. Failure to Take Possession. Tenant fails to take possession of the Premises on the Commencement Date or fails to commence any Tenant's Work in a timely fashion.

Landlord shall not be in default unless Landlord fails to perform obligations required of Landlord within a reasonable time, but in no event less than thirty (30) days after written notice by Tenant to Landlord. If Landlord fails to cure any such default within the allotted time, Tenant's sole remedy shall be to seek actual money damages (but not consequential or punitive damages) for loss arising from Landlord's failure to discharge its obligations

under this Lease. Nothing herein contained shall relieve Landlord from its duty to perform of any of its obligations to the standard prescribed in this Lease.

21. **REMEDIES**. Landlord shall have the following remedies upon an Event of Default. Landlord's rights and remedies under this Lease shall be cumulative, and none shall exclude any other right or remedy allowed by law.

a. **Termination of Lease**. Landlord may terminate Tenant's interest under the Lease, but no act by Landlord other than written notice of termination from Landlord to Tenant shall terminate this Lease. The Lease shall terminate on the date specified in the notice of termination. Upon termination of this Lease, Tenant will remain liable to Landlord for damages in an amount equal to the rent and other sums that would have been owing by Tenant under this Lease for the balance of the Lease term, less the net proceeds, if any, of any re-letting of the Premises by Landlord subsequent to the termination, after deducting all Landlord's Reletting Expenses (as defined below). Landlord shall be entitled to either collect damages from Tenant monthly on the days on which rent or other amounts would have been payable under the Lease, or alternatively, Landlord may accelerate Tenant's obligations under the Lease and recover from Tenant: (i) unpaid rent which had been earned at the time of termination; (ii) the amount by which the unpaid rent which would have been earned after termination until the time of award exceeds the amount of rent loss that Tenant proves could reasonably have been avoided; (iii) the amount by which the unpaid rent for the balance of the term of the Lease after the time of award exceeds the amount of rent loss that Tenant proves could reasonably be avoided (discounting such amount by the discount rate of the Federal Reserve Bank of San Francisco at the time of the award, plus 1%); and (iv) any other amount necessary to compensate Landlord for all the detriment proximately caused by Tenant's failure to perform its obligations under the Lease, or which in the ordinary course would be likely to result from the Event of Default, including without limitation Reletting Expenses described below.

b. **Re-Entry and Reletting**. Landlord may continue this Lease in full force and effect, and without demand or notice, re-enter and take possession of the Premises or any part thereof, expel the Tenant from the Premises and anyone claiming through or under the Tenant, and remove the personal property of either. Landlord may relet the Premises, or any part of them, in Landlord's or Tenant's name for the account of Tenant, for such period of time and at such other terms and conditions, as Landlord, in its discretion, may determine. Landlord may collect and receive the rents for the Premises. To the fullest extent permitted by law, the proceeds of any reletting shall be applied: first, to pay Landlord all costs and expenses of such reletting (including without limitation, costs and expenses incurred in retaking or repossessing the Premises, removing persons or property therefrom, securing new tenants, and, if Landlord maintains and operates the Premises, the costs thereof); second, to pay any indebtedness of Tenant to Landlord other than rent; third, to the rent due and unpaid hereunder; and fourth, the residue, if any, shall be held by Landlord and applied in payment of other or future obligations of Tenant to Landlord as the same may become due and payable, and Tenant shall not be entitled to receive any portion of such revenue. Re-entry or taking possession of the Premises by Landlord under this Section shall not be construed as an election on Landlord's part to terminate this Lease, unless a written notice of termination is given to Tenant. Landlord reserves the right following any re-entry or reletting, or both, under this Section to exercise its right to terminate the Lease. Tenant will pay Landlord the rent and other sums which would be payable under this Lease if repossession had not occurred, less the net proceeds, if any, after reletting the Premises, after deducting Landlord's Reletting Expenses. "Reletting Expenses" is defined to include all expenses incurred by Landlord in connection with reletting the Premises, including without limitation, all repossession costs, brokerage commissions, attorneys' fees, remodeling and repair costs, costs for removing and storing Tenant's property and equipment, and tenant improvements and rent concessions granted by Landlord to any new Tenant, prorated over the life of the new lease.

c. Waiver of Redemption Rights. Tenant, for itself, and on behalf of any and all persons claiming through or under Tenant, including creditors of all kinds, hereby waives and surrenders all rights and privileges which they may have under any present or future law, to redeem the Premises or to have a continuance of this Lease for the Lease term, as it may have been extended.

d. Nonpayment of Additional Rent. All costs which Tenant is obligated to pay to Landlord pursuant to this Lease shall in the event of nonpayment be treated as if they were payments of Rent, and Landlord shall have all the rights herein provided for in case of nonpayment of Rent.

e. Failure to Remove Property. If Tenant fails to remove any of its property from the Premises at Landlord's request following an uncured Event of Default, Landlord may, at its option, remove and store the property at Tenant's expense and risk. If Tenant does not pay the storage cost within five (5) days of Landlord's request, Landlord may, at its option, have any or all of such property sold at public or private sale (and Landlord may become a purchaser at such sale), in such manner as Landlord deems proper, without notice to Tenant. Landlord shall apply the proceeds of such sale: (i) to the expense of such sale, including reasonable attorneys' fees actually incurred; (ii) to the payment of the costs or charges for storing such property; (iii) to the payment of any other sums of money which may then be or thereafter become due Landlord from Tenant under any of the terms hereof; and (iv) the balance, if any, to Tenant. Nothing in this Section shall limit Landlord's right to sell Tenant's personal property as permitted by law or to foreclose Landlord's lien for unpaid rent.

22. MORTGAGE SUBORDINATION AND ATTORNMENT. This Lease shall automatically be subordinate to any mortgage or deed of trust created by Landlord which is now existing or hereafter placed upon the Premises including any advances, interest, modifications, renewals, replacements or extensions ("Landlord's Mortgage"). Tenant shall attorn to the holder of any Landlord's Mortgage or any person(s) acquiring the Premises at any sale or other proceeding under any Landlord's Mortgage provided such person(s) assume the obligations of Landlord under this Lease. Tenant shall promptly and in no event later than fifteen (15) days after request execute, acknowledge and deliver documents which the holder of any Landlord's Mortgage may reasonably require as further evidence of this subordination and attornment. Notwithstanding the foregoing, Tenant's obligations under this Section to subordinate in the future are conditioned on the holder of each Landlord's Mortgage and each person acquiring the Premises at any sale or other proceeding under any such Landlord's Mortgage not disturbing Tenant's occupancy and other rights under this Lease, so long as no uncured Event of Default exists.

23. NON-WAIVER. Landlord's waiver of any breach of any term contained in this Lease shall not be deemed to be a waiver of the same term for subsequent acts of Tenant. The acceptance by Landlord of Rent or other amounts due by Tenant hereunder shall not be deemed to be a waiver of any breach by Tenant preceding such acceptance.

24. HOLDOVER. If Tenant shall hold over after the expiration or termination of the term, such tenancy shall be deemed to be on a month-to-month basis and may be terminated on 30 days written notice. During such tenancy, Tenant agrees to pay to Landlord the rental rate adjusted under Section 4b. If Landlord provides a termination notice or notice of eviction to Tenant, Tenant agrees to pay Landlord 150% of the rental rate last payable under this Lease for every day that Tenant holds over after such termination date or final eviction date. All other terms of the Lease shall remain in effect. Tenant acknowledges and agrees that this Section does not grant any right to Tenant to holdover, and that Tenant may also be liable to Landlord for any and all damages or expenses which Landlord may have to incur as a result of Tenant's holdover.

25. NOTICES. All notices under this Lease shall be in writing and effective (i) when delivered in person or via overnight courier, (ii) three (3) days after being sent by registered or certified mail to Landlord or Tenant, as the case may be, at the Notice Addresses set forth in Section 1; or

(iii) upon confirmed transmission by facsimile to such persons at the facsimile numbers set forth in Section 1 or such other addresses/facsimile numbers as may from time to time be designated by such parties in writing.

26. COSTS AND ATTORNEYS' FEES. If Tenant or Landlord engage the services of an attorney to collect monies due or to bring any action for any relief against the other, declaratory or otherwise, arising out of this Lease, including any suit by Landlord for the recovery of Rent or other payments, or possession of the Premises, the losing party shall pay the prevailing party a reasonable sum for attorneys' fees in such suit in mediation or arbitration, at trial, on appeal and in any bankruptcy proceeding.

27. ESTOPPEL CERTIFICATES. Tenant shall, from time to time, upon written request of Landlord, execute, acknowledge and deliver to Landlord or its designee a written statement specifying the following, subject to any modifications necessary to make such statements true and complete: (i) the date the Lease term commenced and the date it expires; (ii) the amount of minimum monthly Rent and the date to which such Rent has been paid; (iii) that this Lease is in full force and effect and has not been assigned, modified, supplemented or amended in any way; (iv) that this Lease represents the entire agreement between the parties; (v) that all conditions under this Lease to be performed by Landlord have been satisfied; (vi) that there are no existing claims, defenses or offsets which the Tenant has against the enforcement of this Lease by Landlord; (vii) that no Rent has been paid more than one month in advance; (viii) that no security has been deposited with Landlord (or, if so, the amount thereof); and (ix) such other factual matters concerning the Lease or the Premises as Landlord may reasonably request. Any such statement delivered pursuant to this Section may be relied upon by a prospective purchaser of Landlord's interest or assignee of any mortgage or new mortgagee of Landlord's interest in the Premises. If Tenant shall fail to respond within ten (10) days of receipt by Tenant of a written request by Landlord as herein provided, Tenant shall be deemed to have given such certificate as above provided without modification and shall be deemed to have admitted the accuracy of any information supplied by Landlord to a prospective purchaser or mortgagee.

28. TRANSFER OF LANDLORD'S INTEREST. This Lease shall be assignable by Landlord without the consent of Tenant. In the event of any transfer or transfers of Landlord's interest in the Premises, other than a transfer for security purposes only, upon the assumption of this Lease by the transferee, Landlord shall be automatically relieved of obligations and liabilities accruing from and after the date of such transfer, including any liability for any retained security deposit or prepaid rent, for which the transferee shall be liable, and Tenant shall attorn to the transferee.

29. LANDLORD'S LIABILITY. Anything in this Lease to the contrary notwithstanding, covenants, undertakings and agreements herein made on the part of Landlord are made and intended not as personal covenants, undertakings and agreements for the purpose of binding Landlord personally or the assets of Landlord except Landlord's interest in the Premises, but are made and intended for the purpose of binding only the Landlord's interest in the Premises, as the same may from time to time be encumbered. In no event shall Landlord or its partners, shareholders, or members, as the case may be, ever be personally liable hereunder.

30. RIGHT TO PERFORM. If Tenant shall fail to timely pay any sum or perform any other act on its part to be performed hereunder, Landlord may make any such payment or perform any such other act on Tenant's part to be made or performed as provided in this Lease. Tenant shall, within ten (10) days of demand, reimburse Landlord for its expenses incurred in making such payment or performance. Landlord shall (in addition to any other right or remedy of Landlord provided by law) have the same rights and remedies in the event of the nonpayment of sums due under this Section as in the case of default by Tenant in the payment of Rent.

31. HAZARDOUS MATERIAL. Tenant shall not cause or permit any Hazardous Material to be brought upon, kept, or used in or about, or disposed of on the Premises by Tenant, its agents, employees, contractors or invitees, except with Landlord's prior consent and then only upon strict compliance with all applicable federal, state and local laws, regulations, codes and ordinances.

Notwithstanding the foregoing, Tenant may handle Hazardous substances to the extent necessary for the Permitted Use, so long as Tenant promptly delivers to Landlord true copies of all governmental permits and approvals relating to the handling of Hazardous Substances and all correspondence sent or received by Tenant regarding any handling of Hazardous Substances in or about the Premises including without limitation, inspection reports and citations. In addition, Tenant may handle ordinary and general office supplies typically used in office buildings.

In the event that Tenant shall use or require the use of x-ray, radium, cobalt, or any other radioactive, hazardous, toxic, or special materials requiring the use of special storage, removal, or disposal procedures, devices or equipment, Tenant shall comply with all applicable federal, state, county and city laws, rules and regulations relating to the use, storage, disposal and removal of such materials. Upon the termination of this Lease, Tenant agrees to pay all costs associated with the removal or disposal of any such materials and/or equipment and the special cleaning of the Premises for such materials in order to return them to the condition existing as of the commencement of this Lease. In addition to any other provision of this Lease, Tenant agrees to indemnify, defend, protect and hold Landlord harmless from and against all liabilities and claims of every kind or nature in any manner relating to, arising out of, incident to or occasioned by the handling, use, disposal, or possession of such radioactive and hazardous materials and equipment by Tenant within the Premises.

If Tenant breaches the obligations stated in the preceding paragraphs, then Tenant shall indemnify, defend and hold Landlord harmless from any and all claims, judgments, damages, penalties, fines, costs, liabilities or losses including, without limitation, diminution in the value of the Premises, damages for the loss or restriction on use of rentable or usable space or of any amenity of the Premises, or elsewhere, damages arising from any adverse impact on marketing of space at the Premises, and sums paid in settlement of claims, attorneys' fees, consultant fees and expert fees incurred or suffered by Landlord either during or after the Lease term.

Without limiting the foregoing, if the presence of any Hazardous Material brought upon, kept or used in or about the Premises by Tenant, its agents, employees, contractors or invitees, results in any unlawful release of any Hazardous Material on the Premises or any other property, Tenant shall promptly take all actions, at its sole expense, as are necessary to return the Premises or any other property, to the condition existing prior to the release of any such Hazardous Material; provided that Landlord's approval of such actions shall first be obtained, which approval may be withheld at Landlord's sole discretion.

As used herein, the term "Hazardous Material" means any hazardous, dangerous, toxic or harmful substance, material or waste including biomedical waste which is or becomes regulated by any local governmental authority, the State of Washington or the United States Government, due to its potential harm to the health, safety or welfare of humans or the environment. The provisions of this Section shall survive expiration or termination of this Lease.

32. TERMINATION BY DEATH. If Tenant is a sole practitioner and Tenant dies, becomes completely disabled, or completely ceases to practice as a health care practitioner prior to the expiration of the lease, Landlord agrees that this Lease shall terminate as of the date Landlord is notified of Tenant's death, complete disability or cessation of practice. For purposes of this Lease, "complete disability" means that Tenant is unable to perform materially or substantially Tenant's duties as a healthcare practitioner due to accidental injury or sickness, or if Tenant has sustained the complete and irrevocable loss of sight, hearing, speech or the use of both hands or both feet.

33. QUIET ENJOYMENT. So long as Tenant pays the Rent and performs all of its obligations in this Lease, Tenant's possession of the Premises will not be disturbed by Landlord or anyone claiming by, through or under Landlord.

34. MERGER. The voluntary or other surrender of this Lease by Tenant, or a mutual cancellation thereof, shall not work a merger and shall, at the option of Landlord, terminate all or any existing subtenancies or may, at the option of Landlord, operate as an assignment to Landlord of any or all of such subtenancies.

35. GENERAL.

a. Heirs and Assigns. This Lease shall apply to and be binding upon Landlord and Tenant and their respective heirs, executors, administrators, successors and assigns.

b. Brokers' Fees. Intentionally deleted.

c. Entire Agreement. This Lease contains all of the covenants and agreements between Landlord and Tenant relating to the Premises. No prior or contemporaneous agreements or understanding pertaining to the Lease shall be valid or of any force or effect and the covenants and agreements of this Lease shall not be altered, modified or added to except in writing signed by Landlord and Tenant.

d. Severability. Any provision of this Lease which shall prove to be invalid, void or illegal shall in no way affect, impair or invalidate any other provision of this Lease.

e. Force Majeure. Time periods for either party's performance under any provisions of this Lease (excluding payment of Rent) shall be extended for periods of time during which the party's performance is prevented due to circumstances beyond such party's control, including without limitation, fires, floods, earthquakes, lockouts, strikes, embargoes, governmental regulations, acts of God, public enemy, war or other strife.

f. Governing Law. This Lease shall be governed by and construed in accordance with the laws of the State of Washington.

g. Memorandum of Lease. Neither this Lease nor any memorandum or "short form" thereof shall be recorded without Landlord's prior consent.

h. Submission of Lease Form Not an Offer. One party's submission of this Lease to the other for review shall not constitute an offer to lease the Premises. This Lease shall not become effective and binding upon Landlord and Tenant until it has been fully signed by both Landlord and Tenant.

i. No Light, Air or View Easement. Tenant has not been granted an easement or other right for light, air or view to or from the Premises. Any diminution or shutting off of light, air or view by any structure which may be erected on or adjacent to the Building shall in no way effect this Lease or the obligations of Tenant hereunder or impose any liability on Landlord.

j. Authority of Parties. Each party signing this Lease represents and warrants to the other that it has the authority to enter into this Lease, that the execution and delivery of this Lease has been duly authorized, and that upon such execution and delivery this Lease shall be binding upon and enforceable against the party on signing.

k. Time. "Day" as used herein means a calendar day and "business day" means any day on which commercial banks are generally open for business in the state where the Premises are situated. Any period of time which would otherwise end on a non-business day shall be extended to the next following business day. Time is of the essence of this Lease.

36. CONFIDENTIALITY. In performing their obligations under this Agreement, the parties do not expect to exchange any protected health information as defined under federal and state law but Landlord or its agent may be exposed to confidential information if present on the Premises. Both parties, their officers, employees, and subcontractors shall agree to maintain confidentiality regarding all information obtained during the Lease Term and shall be responsible for ensuring that their employees and agents abide by such obligations. Neither party, its employees, and

subcontractors shall engage in any practice that could compromise the confidentiality of patients, guests or staff, or information maintained at the Premises.

If at some point the Health Insurance Portability and Accountability Act of 1996 is found to apply to the parties under the terms of the Lease, the parties agree to enter into a business associate agreement.

37. EXHIBITS AND RIDERS. The following exhibits and riders are made a part of this Lease, and the terms thereof shall control over any inconsistent provision in the sections of this Lease:

Exhibit A Floor Plan/Outline of the Premises
Exhibit B Legal Description
Exhibit C Rules and Regulations

(signatures begin on the following page)

IN WITNESS WHEREOF, the parties have executed this Lease as of the date first written above.

Landlord:

MultiCare Health System,
a Washington nonprofit corporation

_____
By: _____
Its: _____

STATE OF WASHINGTON)
) ss.
COUNTY OF _____)

On this _____ day of _____, 2021 personally appeared before me, _____, known to me to be the _____ of MultiCare Health System who executed the foregoing instrument, and acknowledged the said instrument to be the free and voluntary act and deed of said corporation, for the purposes therein mentioned, and that she/he was authorized to execute said instrument.

I certify that I know or have satisfactory evidence that the person appearing before me and making this acknowledgment is the person whose true signature appears on this document.

GIVEN under my hand and official seal hereto affixed the day and year in the certificate above written.

Signature_____

Print Name_____

NOTARY PUBLIC in and for the State of
Washington residing in _____.
My commission expires _____

IN WITNESS WHEREOF, the parties have executed this Lease as of the date first written above.

Landlord:

MultiCare Health System,
a Washington nonprofit corporation

_____
By: _____
Its: _____

STATE OF WASHINGTON)
) ss.
COUNTY OF _____)

On this _____ day of _____, 2021, personally appeared before me _____, known to me to be the _____ of MultiCare Health System who executed the foregoing instrument, and acknowledged the said instrument to be the free and voluntary act and deed of said corporation, for the purposes therein mentioned, and that he/she was authorized to execute said instrument.

I certify that I know or have satisfactory evidence that the person appearing before me and making this acknowledgment is the person whose true signature appears on this document.

GIVEN under my hand and official seal hereto affixed the day and year in the certificate above written.

Signature_____

Print Name_____

NOTARY PUBLIC in and for the State of Washington residing in _____.
My commission expires _____

IN WITNESS WHEREOF, the parties have executed this Lease as of the date first written above.

Tenant:

PNW Hospice, LLC,
a Washington limited liability company

By: _____
Name: Lynn Siedenstrang

Its: Executive Director

STATE OF WASHINGTON)
) ss.
COUNTY OF SPOKANE)

On this _____ day of _____, 2021, personally appeared before me _____ known to me to be the _____ of _____ who executed the foregoing instrument, and acknowledged the said instrument to be the free and voluntary act and deed of said corporation, for the purposes therein mentioned, and that he was authorized to execute said instrument.

I certify that I know or have satisfactory evidence that the person appearing before me and making this acknowledgment is the person whose true signature appears on this document.

GIVEN under my hand and official seal hereto affixed the day and year in the certificate above written.

Signature_____

Print Name_____

NOTARY PUBLIC in and for the State of Washington residing in _____.
My commission expires _____

DEACONESS MEDICAL OFFICE BUILDING
LEASE AGREEMENT

EXHIBIT A

Floor Plan/Outline of the Premises

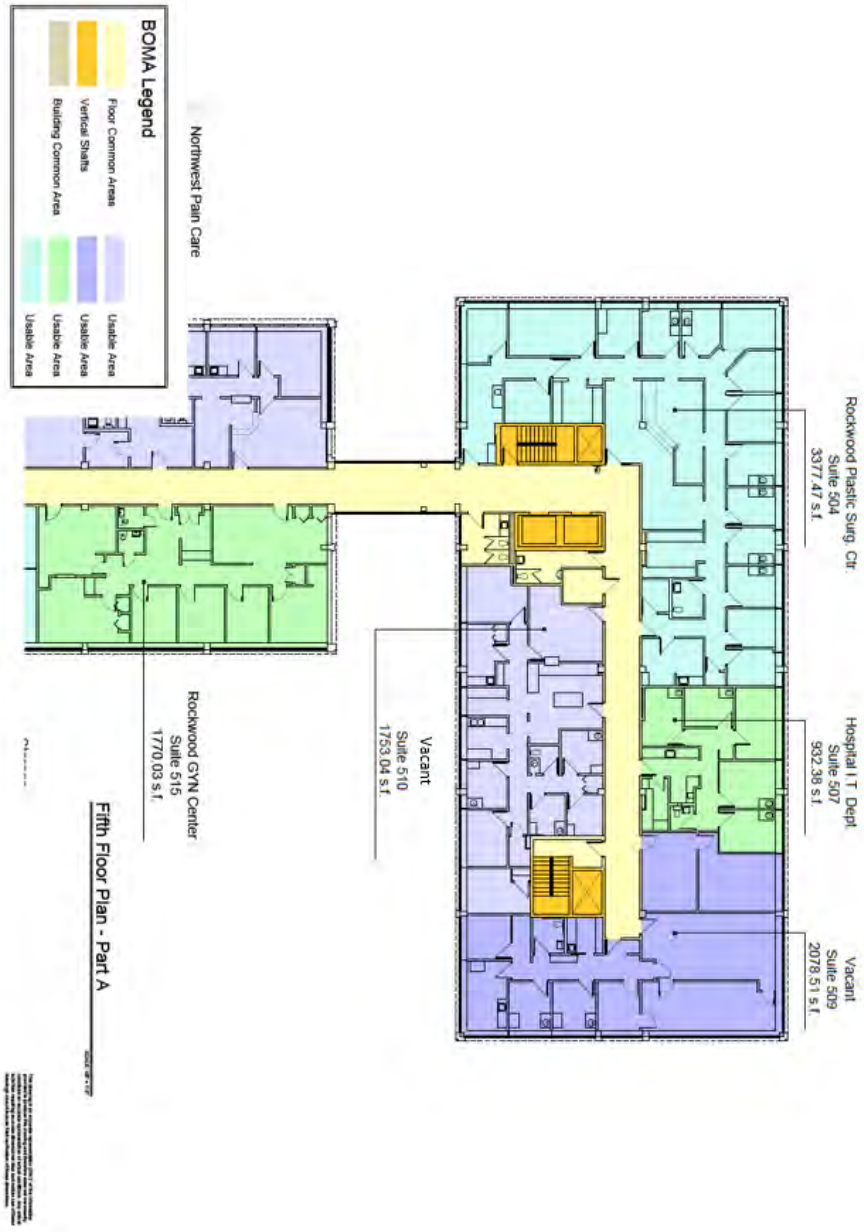


EXHIBIT B

Legal Description

THAT PORTION OF BLOCK B, AMENDED PLAT OF BLOCKS A AND B OF SECOND ADDITION TO THE RAILROAD ADDITION AS PER PLAT THEREOF RECORDED IN VOLUME "A" OF PLATS, PAGE 10, IN SPOKANE COUNTY, WASHINGTON, DESCRIBED AS FOLLOWS:

COMMENCING AT THE NORTHWEST CORNER OF SAID BLOCK;

THENCE EAST 426.35 FEET;
THENCE SOUTH 234 FEET;
THENCE WEST 100 FEET;
THENCE NORTH 7 FEET;
THENCE WEST 176.35 FEET;
THENCE NORTH 27 FEET;
THENCE WEST 150 FEET;
THENCE NORTH 200 FEET TO THE POINT OF BEGINNING;

ALSO THAT PORTION OF SAID BLOCK B DESCRIBED AS FOLLOWS:

BEGINNING 150 FEET WEST OF THE NORTHEAST CORNER OF SAID BLOCK;
THENCE SOUTH 170 FEET;

THENCE WEST 80 FEET;
THENCE SOUTH 64 FEET;
THENCE EAST 90 FEET;
THENCE NORTH 234 FEET;
THENCE WEST 10 FEET TO THE POINT OF BEGINNING.

DEACONESS MEDICAL OFFICE BUILDING
LEASE AGREEMENT

EXHIBIT C
Building Rules and Regulations

1. No tenant shall place any new or additional locks on any doors of the Premises or re-key any existing locks or change any plumbing or wiring without the prior written consent of Landlord.

2. Landlord reserves the right to exclude or expel from the common areas any person who, in the judgment of Landlord, is intoxicated, under the influence of drugs or who shall in any manner violate any of the rules and regulations.

3. No tenant shall do or permit to be done within the Premises anything, including the generation of any loud noise, which would unreasonably annoy or interfere with the rights of other tenants in the Building.

4. No tenant shall permit its employees or invitees to obstruct any of the parking, truck maneuvering or other common areas, or to place, empty or throw away any rubbish, litter, trash or material of any kind upon any common area.

5. No storage of materials, equipment or property of any kind is permitted outside the Premises or the Building. Any such property may be removed by Landlord at the tenant's risk and expense.

6. Nothing may be placed on the outside window ledges of the Building, and no tenant shall throw anything out of the doors, windows or down the passageways.

7. No animals (unless assisting the handicapped), bicycles, or vehicles of any kind are permitted in the Building.

8. No tenant may install any radio or television antenna which is connected to the Building without the prior written consent of Landlord.

9. No tenant shall display a "For Rent" sign upon the Premises, Building or Land.

10. Each tenant shall be responsible for keeping a copy of the tenant's Lease and Landlord's current rules and regulations at the tenant's Premises.

11. No tenant shall waste electricity or water. Each tenant shall cooperate fully with Landlord to assure the most effective and economical use of utility services provided to the Building by Landlord.

12. Each tenant shall keep Landlord advised of the current telephone numbers of the tenant's employees who may be contacted in emergency, i.e., fire, break-in, vandalism, etc. If Landlord shall deem it necessary to respond to such emergency on behalf of a tenant, the tenant shall pay all costs incurred for services ordered by Landlord to secure or otherwise protect the Premises and the contents thereof, including a premium charge for any time spent by Landlord's employees in responding to such emergency.

13. When closing its Premises at the end of the business day, each tenant shall close all windows and shall lock windows adjacent to fire escapes or which are otherwise accessible from the street level.

14. All deliveries to and removals from the Building or Premises of any freight or furniture must be scheduled in advance with Landlord to occur during such hours as Landlord requires in order to minimize disruption of normal Building activities. No article, the weight or nature of which may, in Landlord's reasonable determination, constitute a hazard to person or property, shall be permitted in the Building and Landlord shall have the right to require the tenant to remove or relocate articles which, individually or in the aggregate, may endanger person or property.

15. No tenant shall use or permit any part of its Premises to be used for lodging or sleeping.

16. Landlord, its employees and agents may retain a passkey to each tenant's Premises, and no third party shall be engaged by a tenant to do janitorial work on the Premises unless Landlord otherwise agrees in writing.

17. No tenant shall place upon or install on windows, walls or exterior doors of the Premises or any part of the Premises visible from the exterior of the Premises any object including without limitation signs, symbols, canopies, awnings, window coverings or other advertising or decorative material, without obtaining the prior written consent of Landlord.

18. No tenant shall put any curtains, draperies, signs, decals, or other hangings on or beside the windows in its Premises without first obtaining Landlord's consent.

19. In carpeted areas, each tenant shall provide chair pads for each occupied desk.

20. Specific parking areas within the Parking Building and the other common areas have been designated for patient parking, doctor parking, and employee parking. All doctors and authorized employees must register their vehicles with Landlord, and park only in the properly designated areas. Any employee or doctor vehicle observed in patient parking areas will be ticketed with a warning notice. If any one vehicle is ticketed more than twice, it may be towed at the vehicle owner's expense, with no further notice.

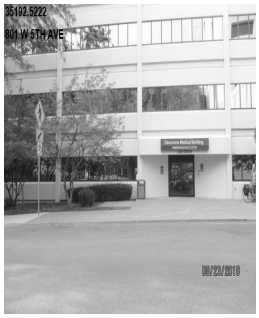
Parcel Information

Parcel Number: 35192.5222
Site Address: 801 W 5TH AVE

Data As Of: 12/28/2021

Parcel Image



Owner Name: MULTICARE HEALTH SYSTEM
Address: PO BOX 5299 MLSTP 222-1-LEG, TACOMA, WA, 98415

Taxpayer Name: MULTICARE HEALTH SYSTEM
Address: PO BOX 5299 MS: 737-4-AP, TACOMA, WA, 98415-0299

Site Address

Parcel Type	Site Address	City	Land Size	Size Desc.	Description	Tax Year	Tax Code Area	Status
R	801 W 5TH AVE	SPOKANE	100891	Square Feet	65 Service - Professional	2021	0010	Active

Assessor Description
AMENDED PLAT OF BLKS A & B OF 2ND ADD TO RAILROAD ADD;PTN BLK B DAF; BEG AT NW COR TH S 200FT TH E 150FT TH S 27FTTH E 176.35FT TH S 7FT TH E 190FT TH N 234FT TH W 10FT TH S170FT TH W 80FT TH N 170FT TH W 426.35FT TO POB

Appraisal

Parcel Class	Appraiser	Neighborhood Code	Neighborhood Name	Neighborhood Desc	Appraiser Name	Appraiser Phone
65 Service - Professional	**95**	546000	46000	Hospital-Major Medical	Amber	477-5916

Under Washington State Law (WAC 458-07-015) The Assessor's office is required to make an exterior observation of all properties at least once every six years. **This property is scheduled for inspection between October 2021 and May of 2022**.

Assessed Value

Tax Year	Taxable	Market Total	Land	Dwelling/Structure	Current Use Land	Personal Prop.
2022	4,178,883	5,517,500	2,219,600	3,297,900	0	0
2021	4,124,881	5,446,200	2,219,600	3,226,600	0	0
2020	4,120,246	5,440,080	2,421,380	3,018,700	0	0
2019	4,426,473	5,844,400	958,500	4,885,900	0	0
2018	4,234,702	5,591,200	908,000	4,683,200	0	0

Characteristics
*** - Room counts reflect above grade rooms only.**

Description	Appraiser	Year Built	Year Remodeled	Number of Floors
Medical Office	95	1974		4
Medical Office	95	1977		5

Commercial Details

Description	Area
All Extensions	**67,485**
Medical Office	67,485

Land Number	Soil ID	Frontage	Depth	Lot(s)
1	CO19	0	0	0

Sales

Sale Date	Sale Price	Sale Instrument	Excise Number	Parcel
06/26/2017	120,394,700.00	Bargain and Sale Deed	201709366	35192.5222
09/29/2008	71,683,419.00	Other	200812522	35192.5222
10/31/2005	3,700,000.00	Statutory Warranty Deed	200522878	35192.5222
10/31/2005	2,300,000.00	Statutory Warranty Deed	200522879	35192.5222

Property Taxes

Taxes are due April 30th and October 31st

Total Charges Owing: $0.00

Tax Year	Charge Type	Annual Charges	Remaining Charges Owing
	Total Taxes for 2021	**48,896.79**	**0.00**
2021	A/V Property Tax	48,896.79	0.00
	Total Taxes for 2020	**50,692.51**	**0.00**
2020	A/V Property Tax	50,692.51	0.00
	Total Taxes for 2019	**52,793.90**	**0.00**
2019	A/V Property Tax	52,793.90	0.00
	Total Taxes for 2018	**58,787.18**	**0.00**
2018	A/V Property Tax	58,780.25	0.00
2018	Soil Conservation Principal CNSV1	5.13	0.00
2018	Weed Control Principal WCWEED1	1.80	0.00

Tax Receipts

Tax Year	Receipt Number	Receipt Date	Receipt Amount
2021	8796505	10/21/2021	24,448.40
2021	8739425	06/02/2021	24,448.39
2020	8408094	10/21/2020	25,346.26
2020	8339964	05/07/2020	25,346.25
2019	8020952	10/14/2019	26,396.95
2019	7967950	04/30/2019	26,396.95
2018	7728282	10/24/2018	29,393.59
2018	7608155	05/02/2018	29,393.59

Disclaimer

We are pleased to give you online access to the Assessor's Office and Treasurer's Office property tax and valuation information. While we make every effort to produce and publish the most current and accurate information possible, portions of this information may not be current or correct. Neither Spokane County, the Assessor, nor the Treasurer makes any warranty, express or implied, with regard to the accuracy, reliability, or timeliness of information in this system, and shall not be held liable for losses caused by using this information. Any person or entity that relies on any information obtained from this system, does so at his or her own risk. Please feel free to contact us about any error you discover or to give comments and suggestions. Call the Assessor's Office at (509) 477-3698 or the Treasurer's Office at (509) 477-4713.

RCW 42.56.070 (9) prohibits the release of lists of individuals requested for commercial purposes. The requester expressly represents that no such use of any such list will be made by the user or its transferee(s) or vendee(s). I understand, acknowledge, and accept the statements above, and agree to adhere to the prohibitions listed in RCW 42.56.070 (9).

Exhibit 10

Letter of Financial Commitment

MultiCare

MultiCare Health System
820 A Street, Tacoma, WA 98402
PO Box 5299 Tacoma. WA 98415-0299 ~ 253 -403-1000 ~ multicare.org

December 17, 2021

Washington Department of Health
Certificate of Need Program
Mail Stop 47852
Olympia, WA 98504-7852

RE: Certificate of Need Request by PNW Hospice LLC. for the Establishment of a Hospice Agency in Spokane County, Washington

Dear Sir or Madam:

Please accept this letter as evidence of financial support for the certificate of need request by PNW Hospice LLC, a Washington limited liability company and a wholly owned subsidiary of MultiCare Health System to establish and operate a Hospice Agency in Spokane County, Washington.

MultiCare is pleased to commit from its corporate reserves, full funding for the estimated capital expenditures and for any working capital requirements associated with this project. MultiCare has sufficient cash reserves to fully fund the project.

Please contact me if there are any questions regarding this letter of financial commitment. I can be reached at steve.schramm@multicare.org or at 253.403.7614. Thank you for your time and assistance in this important matter.

Yours truly,

Steve Schramm
Interim Chief Financial Officer
MultiCare Health System

Exhibit 11

PNW Hospice Financial Statements

PNW Hospice LLC Revenue Assumptions

Utilization	**Assumptions (Forecasted Years 2023 - 2026)**
Hospice Admits	Unique patients served; see utilization forecast
Patient Days	Unique patients served times ALOS of 62.12 in WA
Averaged Daily Census (ADC)	Estimated to meet ADC of 43.70 by third full year of operations (2026).

Gross Patient Revenue	Payer Mix	Contractual Adjustment Rate	Charges per Admit
Medicare/Mgd Medicare	88.2%	10.65%	$17,303
Medicaid/Mgd Medicaid	3.6%	6.10%	$17,303
Commercial	3.9%	15.90%	$17,303
Self Pay	0.2%	0.00%	$17,303
Health Care Exchange	0.5%	6.40%	$17,303
Other (Tricare, Vet Admin, Workers Comp and Healthcare Exchange.)	3.6%	3.10%	$17,303

Other revenue adjustments	
Bad debt	Assumed constant at 0.52% of gross revenues based on 2021 Oct YTD levels.
Charity care	Assumed constant at 1.04% of gross revenues based on 2017-2019 Spokane County Planning Area average.

PNW Hospice LLC. Pro Forma Forecast 2023 - 2026
Revenue & Expense Statement

	Year 0 (2023 Q3 & Q4)	Year 1 (2024)	Year 2 (2025)	Year 3 (2026)
Hospice Admits	**Forecast**	**Forecast**	**Forecast**	**Forecast**
Medicare/Mgd Medicare	35	108	155	226
Medicaid/Mgd Medicaid	1	4	6	9
Commercial	2	5	7	10
Self Pay	0	0	0	1
Health Care Exchange	0	1	1	1
Other	1	4	6	9
Total Hospice Admits	**40**	**122**	**175**	**257**
Patient Days	**2,460**	**7,603**	**10,883**	**15,952**
Gross Revenue				
Medicare/Mgd Medicare	604,350	1,867,992	2,673,792	3,919,120
Medicaid/Mgd Medicaid	24,667	76,245	109,134	159,964
Commercial	26,723	82,598	118,229	173,294
Self Pay	1,370	4,236	6,063	8,887
Health Care Exchange	3,426	10,590	15,158	22,217
Other	24,667	76,245	109,134	159,964
Total Gross Revenue	**685,204**	**2,117,905**	**3,031,510**	**4,443,447**
Contractual Adjustments				
Medicare/Mgd Medicare	64,363	198,941	284,759	417,386
Medicaid/Mgd Medicaid	1,505	4,651	6,657	9,758
Commercial	4,249	13,133	18,798	27,554
Self Pay	0	0	0	0
Health Care Exchange	219	678	970	1,422
Other	765	2,364	3,383	4,959
Total Contractual Adjustments	**71,101**	**219,766**	**314,568**	**461,079**
Deductions				
Contractual Adjustments	71,101	219,766	314,568	461,079
Charity Care	7,126	22,026	31,528	46,212
Provision for Bad Debts	3,563	11,013	15,764	23,106
Total Deductions From Revenue	**81,790**	**252,806**	**361,859**	**530,396**
Net Revenue	**603,414**	**1,865,099**	**2,669,651**	**3,913,050**

PNW Hospice LLC. Pro Forma Forecast 2023 - 2026
Revenue & Expense Statement

	Year 0 (2023 Q3 & Q4)	Year 1 (2024)	Year 2 (2025)	Year 3 (2026)
Operating Expenses				
Salaries and Wages	411,560	1,052,970	1,392,910	1,885,730
Employee Benefits	97,540	249,559	330,120	446,918
Pharmaceutical Supplies	3,346	10,340	14,801	21,695
Medical Supplies	5,510	17,031	24,378	35,732
Office Supplies	74	228	326	479
Professional Fees	57,816	226,424	320,179	462,800
Epic Charges	42,500	85,000	127,500	170,000
Building Lease Space	29,400	51,282	52,821	54,405
Equipment Lease & Rent Fees	10,086	31,172	44,620	65,403
Purchased Services - PSI Pharmacy Prescriptions	7,798	24,102	34,499	50,568
Purchased Services - System License and Maintenance Fee	812	2,509	3,591	5,264
Mileage/Tolls/Parking	8,462	26,154	37,438	54,875
Copier and Fax Line	1,200	2,400	2,400	2,400
Cell Phone	1,405	7,296	9,657	13,458
Travel	98	304	435	638
System Allocation	54,686	169,015	241,929	354,613
Other Operating Costs	5,191	16,042	22,963	33,659
Total Operating Expenses	**737,484**	**1,971,828**	**2,660,568**	**3,658,637**
Non-Operating Expenses				
Depreciation & Amort.	3,313	6,625	6,625	6,625
Interest & Taxes	9,051	27,976	40,045	58,696
Total Non-Operating Expenses	**12,364**	**34,602**	**46,670**	**65,321**
Total Expenses	**749,848**	**2,006,430**	**2,707,238**	**3,723,958**
Total Operating Margin	**($146,433)**	**($141,331)**	**($37,587)**	**$189,092**
Operating Margin Percent	**-24.3%**	**-7.6%**	**-1.4%**	**4.8%**

PNW Hospice LLC Expense Assumptions

Category/Item		Assumptions (Forecasted Years 2023 - 2026)
Patient Days		
Estimated Patient Days	62.12	Unique patients served times ALOS of 62.12 in WA
Professional Fees		
Medical Director (contracted)		Based on medical director contract compensation and 0.2 FTEs in Year 0, 0.5 FTEs in Year 1, 0.7 FTEs in Year 2, and 1 FTE in Year 3
SNF Pass-through Professional Fees	$13.34	$13.34/patient day based on MHS Hospice Oct 2021 YTD average
Supplies		
Pharmaceutical Supplies	$1.36	$1.36/patient day based on MHS Hospice Oct 2021 YTD average
Medical Supplies	$2.24	$2.24/patient day based on MHS Hospice Oct 2021 YTD average
Office Supplies	$0.03	$0.03/patient day based on MHS Hospice Oct 2021 YTD average
Purchased Services		
PSI Pharmacy Prescriptions	$3.17	$3.17/patient day based on MHS Hospice Oct 2021 YTD average
System License and Maintenance Fee	$0.33	$0.33/patient day based on MHS Hospice Oct 2021 YTD average
Other Expenses		
Epic Charges		Costs include $21,250 License/Op fees for 12 users, $31,875 License/Op fees for 18 users per quarter, or $42,500 License/Op fees for 18 users per quarter
Building Lease Space		Lease expenses equal to $4,200.00 per month in 2023, $4,273.50 per month in 2024, $4,401.71 per month in 2025, and $4,533.76 in 2026
Equipment Lease & Rent Fees	$4.10	$4.10/patient day based on MHS Hospice Oct 2021 YTD average
Mileage/Tolls/Parking	$3.44	$3.44/patient day based on MHS Hospice Oct 2021 YTD average
Copier and Fax Line	$200.00	$200/month based on MHS Hospice Oct 2021 YTD average
Cell Phone	$53.33	$53.33/month per employee based on MHS Hospice Oct 2021 YTD average
Travel	$0.04	$0.04/patient day based on MHS Hospice Oct 2021 YTD average
Other Operating Costs (Incl. books & subscriptions, postage, & recruitment)	$2.11	$2.11/patient day based on MHS Hospice Oct 2021 YTD average
System Allocation	$22.23	$22.23/patient day based on MHS Hospice Oct 2021 YTD average
Depreciation & Amort.	$6,625.43	Capital expenses equal to about $66,254.31 depreciated over 10 years; equals about $6,625.43/year in depreciation costs
Taxes	1.5%	1.50% B&O taxes in WA (% of Net Revenue)

PNW Hospice LLC. Staffing Forecast 2023 - 2026
FTE Projections

FTE Per Position (Productive + Non-Productive)	Year 0 (2023 Q3 & Q4)	Year 1 (2024)	Year 2 (2025)	Year 3 (2026)
Administrator	0.50	1.00	1.00	1.00
Clinical Supervisor	0.50	1.00	1.50	1.50
Intake/Scheduling	0.50	1.00	1.00	2.00
Volunteer Coordinator	0.50	1.00	1.00	1.00
Registered Nurse	1.44	4.44	6.35	9.31
Physical Therapist (Contracted As Needed)				
Occupational Therapist (Contracted As Needed)				
Speech Language Pathologist (Contracted As Needed)				
Medical Social Worker	0.23	0.70	1.01	1.48
Chaplain	0.09	0.27	0.39	0.58
Hospice Aide	0.64	1.99	2.84	4.17
Total FTEs	**4.39**	**11.40**	**15.09**	**21.03**

Note: the number of FTEs were prorated over a partial year based on 2080 hours per year.
Medical director is a contracted position thus the compensation is reflected in professional fees.

Breakdown by Productive and Non-Productive:

FTE Per Position (Productive)	Year 0 (2023 Q3 & Q4)	Year 1 (2024)	Year 2 (2025)	Year 3 (2026)
Administrator	0.45	0.91	0.91	0.91
Clinical Supervisor	0.45	0.91	1.36	1.36
Intake/Scheduling	0.45	0.91	0.91	1.82
Volunteer Coordinator	0.45	0.91	0.91	0.91
Registered Nurse	1.30	4.03	5.77	8.46
Physical Therapist (Contracted As Needed)				
Occupational Therapist (Contracted As Needed)				
Speech Language Pathologist (Contracted As Needed)				
Medical Social Worker	0.21	0.64	0.91	1.34
Chaplain	0.08	0.25	0.36	0.52
Hospice Aide	0.58	1.81	2.58	3.79
Total FTEs	**3.99**	**10.36**	**13.72**	**19.11**

Note: the number of FTEs were prorated over a partial year based on 2080 hours per year.
Medical director is a contracted position thus the compensation is reflected in professional fees.

PNW Hospice LLC. Staffing Forecast 2023 - 2026
FTE Projections

FTE Per Position (Non-Productive)	Year 0 (2023 Q3 & Q4)	Year 1 (2024)	Year 2 (2025)	Year 3 (2026)
Administrator	0.05	0.09	0.09	0.09
Clinical Supervisor	0.05	0.09	0.14	0.14
Intake/Scheduling	0.05	0.09	0.09	0.18
Volunteer Coordinator	0.05	0.09	0.09	0.09
Registered Nurse	0.13	0.40	0.58	0.85
Physical Therapist (Contracted As Needed)				
Occupational Therapist (Contracted As Needed)				
Speech Language Pathologist (Contracted As Needed)				
Medical Social Worker	0.02	0.06	0.09	0.13
Chaplain	0.01	0.02	0.04	0.05
Hospice Aide	0.06	0.18	0.26	0.38
Total FTEs	**0.40**	**1.04**	**1.37**	**1.91**

Note: the number of FTEs were prorated over a partial year based on 2080 hours per year.
Medical director is a contracted position thus the compensation is reflected in professional fees.

PNW Hospice LLC. Staffing Forecast 2023 - 2026
Salary and Benefit Projections

Salary Per Position	Pay Rate (Annual)	Year 0 (2023 Q3 & Q4)	Year 1 (2024)	Year 2 (2025)	Year 3 (2026)
Administrator	$195,000	$97,500	$195,000	$195,000	$195,000
Clinical Supervisor	$115,000	$57,500	$115,000	$172,500	$172,500
Intake/Scheduling	$55,000	$27,500	$55,000	$55,000	$110,000
Volunteer Coordinator	$33,000	$16,500	$33,000	$33,000	$33,000
Registered Nurse	$107,000	$154,080	$475,080	$679,450	$996,170
Physical Therapist	Contrated As Needed				
Occupational Therapist	Contrated As Needed				
Speech Language Pathologist	Contrated As Needed				
Medical Social Worker	$81,000	$18,630	$56,700	$81,810	$119,880
Chaplain	$73,000	$6,570	$19,710	$28,470	$42,340
Home Health Aide	$52,000	$33,280	$103,480	$147,680	$216,840
Total Salaries		**$411,560**	**$1,052,970**	**$1,392,910**	**$1,885,730**

Benefits Per Position (23.7%)	Year 0 (2023 Q3 & Q4)	Year 1 (2024)	Year 2 (2025)	Year 3 (2026)
Administrator	$23,108	$46,215	$46,215	$46,215
Clinical Supervisor	$13,628	$27,255	$40,883	$40,883
Intake/Scheduling	$6,518	$13,035	$13,035	$26,070
Volunteer Coordinator	$3,911	$7,821	$7,821	$7,821
Registered Nurse	$36,517	$112,594	$161,030	$236,092
Physical Therapist				
Occupational Therapist				
Speech Language Pathologist				
Medical Social Worker	$4,415	$13,438	$19,389	$28,412
Chaplain	$1,557	$4,671	$6,747	$10,035
Home Health Aide	$7,887	$24,525	$35,000	$51,391
Total Benefits	**$97,540**	**$249,559**	**$330,120**	**$446,918**

Note: the Sal & Ben were prorated over a partial year based on 2080 hours per year. Medical director is a contracted position thus the compensation is reflected in professional fees.

PNW Hospice LLC. Cash Flow Pro Forma 2023 - 2026

	Year 0 (2023 Q3 & Q4)	Year 1 (2024)	Year 2 (2025)	Year 3 (2026)
Cash flows from Operating Activities:				
Net Income (Loss) from Operations	**(142,235)**	**(143,887)**	**(41,393)**	**185,053**
Adjustments to Reconcile Net Income to Cash Provided by Operations:				
Depreciation and Amortization	3,313	6,625	6,625	6,625
Change in Accounts Receivable	(46,933)	(25,598)	(31,284)	(48,354)
Change in Accounts Payable & Accrued Expenses	9,913	4,922	5,978	8,702
Change in Accrued Compensation	42,358	11,915	17,525	25,341
Total Adjustments	**8,651**	**(2,136)**	**(1,156)**	**(7,685)**
Net Cash Provided by Operations	**(133,584)**	**(146,023)**	**(42,549)**	**177,368**
Cash Flows from Investing Activities:				
Net Cash Provided by Investing Activities	-	-	-	-
Cash Flows from Financing Activities:				
Net Cash Provided by Financing Activities	-	-	-	-
Net Increase (Decrease) in Cash	**(133,584)**	**(146,023)**	**(42,549)**	**177,368**
Beginning Cash Balance	**250,000**	**116,416**	**(29,607)**	**(72,156)**
Cash balance at End of Year	**116,416**	**(29,607)**	**(72,156)**	**105,212**

PNW Hospice LLC. Balance Sheet Pro Forma 2023 - 2026

	Beginning of 2023 Q3	Year 0 (2023 Q3 & Q4)	Year 1 (2024)	Year 2 (2025)	Year 3 (2026)
ASSETS	**7/1/2023**	**12/31/2023**	**12/31/2024**	**12/31/2025**	**12/31/2026**
Current Assets					
Cash and Cash Equivalents	244,882	116,416	(29,607)	(72,156)	105,212
Accounts Receivable	0	46,933	72,531	103,815	152,169
Total Current Assets	244,882	163,349	42,924	31,659	257,381
Fixed Assets					
Long-term Assets		66,254	66,254	66,254	66,254
Accum. Depreciation		(3,313)	(9,938)	(16,564)	(23,189)
Land		0	0	0	0
Total Fixed Assets		62,942	56,316	49,691	43,065
Other Assets		0	0	0	0
Total Assets	**244,882**	**226,291**	**99,240**	**81,350**	**300,446**
LIABILITIES AND CAPITAL					
Current Liabilities					
Accounts Payable & Accrued Expenses		9,913	14,834	20,812	29,514
Accrued Compensation		42,358	54,273	71,798	97,139
Total Current Liabilities		52,271	69,107	92,609	126,653
Long-Term Liabilities		0	0	0	0
Total Liabilities	**244,882**	**52,271**	**69,107**	**92,609**	**126,653**
Capital		**174,020**	**30,133**	**(11,260)**	**173,793**
Total Liabilities & Capital	**244,882**	**226,291**	**99,240**	**81,350**	**300,446**

Note: "Capital" is equal to working capital less retained earnings. Both investments and dividends are equal to zero over the forecast period.

PNW Hospice LLC Startup Expenses

Pre-Operating Expenses (Q2 2023)	**Amount**
Epic Charges	
Epic hospice labor cost	118,800.00
License/Op fees (<12 users)	21,250.00
Cell Phones	14.65
Cell Phone Service	219.72
Copier Service Fee	150.00
Fax line	50.00
Recruitment and Training	3,000.00
Office supplies	200.00
Office Lease	12,600.00
Printing and Publications	375.00
Total Pre-Operating Expenses	**156,659.37**
Equipment Costs	**66,254.31**
Subtotal, Pre-Operating Expenses and Equipment	**222,913.68**
CON Application Fee	21,968.00
Total Startup Expenses	**244,881.68**

Exhibit 12

MultiCare Health System Audited Financial Statements

MULTICARE HEALTH SYSTEM

Consolidated Financial Statements

December 31, 2020 and 2019

(With Independent Auditors' Report Thereon)

KPMG LLP
Suite 2900
1918 Eighth Avenue
Seattle, WA 98101

Independent Auditors' Report

The Board of Directors
MultiCare Health System:

We have audited the accompanying consolidated financial statements of MultiCare Health System (a Washington nonprofit corporation), which comprise the consolidated balance sheets as of December 31, 2020 and 2019, and the related consolidated statements of operations and changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of MultiCare Health System as of December 31, 2020 and 2019, and the results of its operations and changes in net assets and its cash flows for the years then ended, in accordance with U.S. generally accepted accounting principles.

KPMG LLP

Seattle, Washington
March 24, 2021

MULTICARE HEALTH SYSTEM

Consolidated Balance Sheets

December 31, 2020 and 2019

(In thousands)

Assets		2020	2019
Current assets:			
Cash and cash equivalents	$	946,223	434,854
Accounts receivable		374,372	376,500
Supplies inventory		49,167	41,738
Other current assets, net		85,144	71,397
Total current assets		1,454,906	924,489
Donor restricted assets held for long-term purposes		88,900	70,783
Investments		1,970,458	1,797,483
Property, plant, and equipment, net		1,763,666	1,763,345
Right-of-use operating lease asset, net		137,763	144,140
Right-of-use financing lease asset, net		15,694	—
Other assets, net		502,459	384,004
Total assets	$	5,933,846	5,084,244
Liabilities and Net Assets			
Current liabilities:			
Accounts payable and accrued expenses	$	208,422	195,356
Accrued compensation and related liabilities		299,523	247,971
Accrued interest payable		18,649	15,168
Current portion of right-of-use operating lease liability		28,574	28,322
Current portion of right-of-use financing lease liability		2,836	—
Current portion of long-term debt		7,950	13,668
Total current liabilities		565,954	500,485
Interest rate swap liabilities		154,347	88,311
Right-of-use operating lease liability, net of current portion		114,288	120,345
Right-of-use financing lease liability, net of current portion		13,200	—
Long-term debt, net of current portion		1,618,849	1,276,973
Other liabilities, net		213,046	155,320
Total liabilities		2,679,684	2,141,434
Commitments and contingencies (note 15)			
Net assets:			
Without donor restrictions		3,111,401	2,819,420
With donor restrictions		142,761	123,390
Total net assets		3,254,162	2,942,810
Total liabilities and net assets	$	5,933,846	5,084,244

See accompanying notes to consolidated financial statements.

MULTICARE HEALTH SYSTEM

Consolidated Statements of Operations and Changes in Net Assets

Years ended December 31, 2020 and 2019

(In thousands)

	2020	2019
Revenues, gains, and other support without donor restrictions:		
Patient service revenue	$ 3,105,968	3,107,525
Other operating revenue	256,819	120,355
Net assets released from restrictions for operations	4,655	6,225
Total revenues, gains, and other support without donor restrictions	3,367,442	3,234,105
Expenses:		
Salaries and wages	1,616,021	1,548,101
Employee benefits	248,132	241,346
Supplies	520,378	501,688
Purchased services	298,256	271,114
Depreciation and amortization	168,188	165,670
Interest	45,970	46,585
Other	369,741	357,486
Total expenses	3,266,686	3,131,990
Excess of revenues over expenses from operations	100,756	102,115
Other income (loss):		
Investment income	272,266	255,460
Loss on interest rate swaps, net	(75,033)	(45,436)
Other (loss) income, net	(13,068)	869
Total other income, net	184,165	210,893
Excess of revenues over expenses	284,921	313,008
Other changes in net assets without donor restrictions:		
Changes in pension asset	2,513	13,276
Net assets released from restriction – capital acquisitions	4,327	9,689
Other	220	(7,550)
Increase in net assets without donor restrictions	291,981	328,423
Changes in net assets with donor restrictions:		
Contributions and other	21,425	20,032
Income on investments	2,482	1,116
Net assets released from restriction – capital acquisitions	(4,327)	(9,689)
Net assets released from restrictions for operations and other	(4,655)	(6,225)
Increase in assets held in trust by others	4,446	2,620
Increase in net assets with donor restrictions	19,371	7,854
Increase in net assets	311,352	336,277
Net assets, beginning of year	2,942,810	2,606,533
Net assets, end of year	$ 3,254,162	2,942,810

See accompanying notes to consolidated financial statements.

MULTICARE HEALTH SYSTEM

Consolidated Statements of Cash Flows

Years ended December 31, 2020 and 2019

(In thousands)

	2020	2019
Cash flows from operating activities:		
Increase in net assets	$ 311,352	336,277
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation and amortization	168,188	165,670
Amortization of bond premiums, discounts, and issuance costs	(2,494)	(2,728)
Net realized and unrealized gains on investments	(251,078)	(216,859)
Change in fair value of interest rate swap	67,298	42,620
(Gain) loss on disposal of assets, net	(90)	824
Gain on bond refinancing	—	(869)
Losses on joint ventures, net	4,709	8,002
Restricted contributions for long-term purposes	(12,188)	(2,795)
Changes in operating assets and liabilities:		
Accounts receivable	2,128	(659)
Supplies inventory and other current assets	(21,176)	(12,298)
Right-of-use lease asset	35,391	29,282
Other assets, net	(104,363)	(16,374)
Accounts payable and accrued expenses and accrued interest payable	16,547	(7,144)
Accrued compensation and related liabilities	51,552	26,117
Right-of-use lease liability	(33,111)	(24,756)
Other liabilities, net	57,479	27,675
Net cash provided by operating activities	290,144	351,985
Cash flows from investing activities:		
Purchase of property, plant, and equipment	(169,168)	(195,206)
Proceeds from disposal of property, plant, and equipment	997	1,157
Investments in joint ventures, net	(26,199)	(15,084)
Purchases of investments	(4,397,377)	(2,342,719)
Sales of investments	4,472,955	2,263,097
Change in donor trusts	(9,457)	(5,571)
Net cash used in investing activities	(128,249)	(294,326)
Cash flows from financing activities:		
Repayment of long-term debt	(20,796)	(12,009)
Proceeds from bond issuance	300,000	—
Proceeds from debt issuance	61,794	—
Payment of debt issue expenses	(2,346)	—
Principal payments on finance lease obligations	(1,366)	—
Restricted contributions for long-term purposes	12,188	2,795
Net cash provided by (used in) financing activities	349,474	(9,214)
Net change in cash and cash equivalents	511,369	48,445
Cash and cash equivalents, beginning of year	434,854	386,409
Cash and cash equivalents, end of year	$ 946,223	434,854
Supplemental disclosures of cash flow information:		
Cash paid during the year for interest, net of amount capitalized	$ 42,967	47,781
Noncash activities:		
Increase in deferred compensation plans	13,726	16,198
Increase (decrease) in accounts payable for purchases of property, plant, and equipment	349	(3,716)

See accompanying notes to consolidated financial statements.

(1) Nature of Organization and Summary of Significant Accounting Policies

(a) Organization Description

MultiCare Health System (MHS), a Washington nonprofit corporation, is an integrated healthcare delivery system providing inpatient, outpatient, and other healthcare services primarily to the residents of Pierce, South King and Spokane Counties and, with respect to pediatric care, much of the southwest Washington area. As of December 31, 2020, MHS is licensed to operate 1,992 inpatient hospital beds, including 120 beds associated with Wellfound Behavioral Health Hospital (Wellfound), a 50% owned joint venture located in Tacoma, Washington, which opened in May 2019. MHS currently operates eight acute care facilities (Tacoma General Hospital, Good Samaritan Hospital, Allenmore Hospital, Mary Bridge Children's Hospital, Auburn Medical Center, Covington Medical Center, Deaconess Hospital and Valley Hospital) and one behavioral health hospital (Navos).

As of December 31, 2020, MHS also operates eight outpatient surgical sites, five free-standing emergency departments, home health, hospice, and a network of urgent care, primary care and multispecialty clinics located throughout the MHS service areas.

The consolidated financial statements include the operations of these facilities and services as well as those of three wholly owned subsidiaries (Greater Lakes Mental Healthcare, Medis, Inc. and MultiCare Rehabilitation Specialists, P.C.), a wholly owned professional services organization supporting cardiovascular services at MHS (CHVI Professional Corp), a wholly owned accountable care organization (MultiCare Connected Care), and two fundraising foundations (Mary Bridge Children's Foundation and MultiCare Foundations, which is doing business as MultiCare Health Foundation, Good Samaritan Foundation, MultiCare South King Health Foundation, MultiCare Behavioral Health Foundation and MultiCare Inland Northwest Foundation).

In December 2020, MHS announced that it reached an agreement with an affiliate of LifePoint Health to acquire a majority ownership interest in Capital Medical Center in Olympia. The acquisition is subject to regulatory approval but is anticipated to close on or about March 31, 2021.

(b) Principles of Consolidation

The accompanying consolidated financial statements include the accounts of MHS after elimination of all significant intercompany accounts and transactions.

(c) Use of Estimates

The preparation of consolidated financial statements in conformity with U.S. generally accepted accounting principles (GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates and assumptions.

(d) Cash and Cash Equivalents

Cash and cash equivalents include certain investments in highly liquid instruments with maturities of three months or less at the date of purchase. Cash equivalents and investments that are held by

outside investment managers or restricted per contractual or regulatory requirements are classified as investments on the consolidated balance sheets.

(e) Accounts Receivable

Accounts receivable are primarily comprised of amounts due for healthcare services from patients and third-party payors and are recorded net of amounts for contractual adjustments and implicit price concessions.

(f) Supplies Inventory

Supplies inventory consists of pharmaceutical, medical-surgical, and other supplies generally used in the operations of MHS. Supplies inventory is stated at lower of cost or net realizable value using the average cost method, except for pharmacy, which uses the first-in, first-out (FIFO) method. Obsolete and unusable items are expensed at the time such determination is made.

(g) Donor Restricted Assets

The majority of the donor restricted assets are invested in MHS' investments and are stated at fair value or estimated fair value. Donor restricted assets that are held separately from MHS' investments include perpetual trusts and charitable remainder unitrusts, where MHS is the beneficiary but not the trustee, that are invested in mutual funds, fixed income securities, and equity securities. Those with readily determinable fair values are stated at fair value. Those investments for which quoted market prices are not readily determinable are carried at values provided by the respective investment managers or trustees, which management believes approximates fair value.

Charitable gift annuities, which are included in donor restricted assets, totaled $2,471 and $2,410 at December 31, 2020 and 2019, respectively. MHS has recorded a corresponding payable of $1,119 and $1,222 at December 31, 2020 and 2019, respectively, to pay for estimated future obligations to beneficiaries. The current portion of these obligations is included in accounts payable and accrued expenses and the long-term portions are included in other liabilities, net in the accompanying consolidated balance sheets. According to Washington State law, MHS, as a distinct legal entity holding charitable gift annuities, is required to maintain unrestricted net assets of at least $500, which MHS has done for each of the periods presented.

(h) Investments

MHS accounts for its investment portfolio as a trading portfolio, therefore, investments in fixed income securities, equity securities, and commingled trusts with a readily determinable fair value are recorded at fair value, which are determined based on quoted market prices or prices with observable inputs obtained from national securities exchanges or similar sources. Other investments, including limited partnerships, commingled real estate trust funds, limited liability partnerships, and hedge funds are carried at net asset value (NAV) provided by the respective investment managers, which management believes approximates fair value. Valuations provided by investment managers consider variables such as valuation and financial performance of underlying investments, quoted market prices for similar securities, recent sale prices of underlying investments, and other pertinent information. Management reviews the valuations provided by investment managers and believes that the carrying values of these financial instruments are reasonable estimates of fair value.

Realized gains and losses are recorded using the average cost method. Investment income or loss (including realized gains and losses on investments, change in unrealized gains or losses, interest, and dividends) is included in the excess of revenues over expenses unless the income or loss is restricted by donor or law.

(i) Property, Plant, and Equipment

Property, plant, and equipment are recorded at cost. Depreciation expense is computed using the straight-line method over the following estimated useful lives of the assets:

Buildings	25–50 years
Land improvements	8–20 years
Equipment	3–25 years

Maintenance and repairs are charged to operations as they occur. Expenditures that materially increase values, change capacities, or extend useful lives are capitalized. Gains upon sale or retirement of property, plant, and equipment are included in other operating revenue whereas losses are included in other expenses. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of constructing those assets.

MHS assesses potential impairments to its long-lived assets as well as its intangible assets, as described below, when there is evidence that events or changes in circumstances indicate that an impairment has been incurred. These changes can include a deterioration in operating performance, a reduction in reimbursement rates from government or third-party payors or a change in business strategy. An impairment charge is recognized when the sum of the expected future undiscounted net cash flows is less than the carrying amount of the asset. In 2020 and 2019, there were no impairment charges.

Gifts of long-lived assets such as land, buildings, or equipment are reported as support without donor restrictions, and are excluded from the excess of revenues over expenses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as support with donor restrictions. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

(j) Leases

Management reviews contracts in order to identify leases and properly classify leases as either operating or financing. MHS is a lessee of various equipment and facilities under noncancelable operating and financing leases. Operating and financing right-of-use (ROU) liabilities are recognized based on the net present value of lease payments over the lease term at the commencement date of the lease, and are reduced by payments made on each lease on the straight-line basis. Since most of the leases do not provide an implicit rate of return, MHS uses its incremental borrowing rate based on information available at the commencement date of the lease in determining the present value of lease

payments. Generally, MHS cannot determine the interest rate implicit in the lease because it does not have access to the lessor's estimated residual value or the amount of the lessor's deferred initial direct costs. Therefore, MHS generally uses its incremental borrowing rate as the discount rate for the lease. MHS' incremental borrowing rate for a lease is the rate of interest it would have to pay on a collateralized basis to borrow an amount equal to the lease payments using similar terms. Leases with an initial term of 12 months or less are not recorded on the balance sheet; rather, rent expense for these leases is recognized on a straight-line basis over the lease term, or when incurred if a month-to-month lease.

If a lease contains a renewal option at the commencement date and it is considered reasonably certain that the renewal option will be exercised by management to renew the lease, the renewal option payments are included in MHS' net minimum lease payments used to determine the right-of-use lease liabilities and related lease assets. All other renewal options are included in right-of-use lease liabilities and related lease assets when they are reasonably certain to be exercised.

All lease agreements generally require MHS to pay maintenance, repairs, property taxes and insurance costs, which are variable amounts based on actual costs incurred during each applicable period. Such costs are not included in the determination of the ROU lease liability or ROU lease asset. Variable lease cost also includes escalating rent payments that are not fixed at commencement but are based on an index that is determined in future periods over the lease term based on changes in the Consumer Price Index or other measure of cost inflation.

Variable lease payments associated with MHS' leases are recognized when the event, activity, or circumstance in the lease agreement on which those payments are assessed occurs. Variable lease payments are presented in other expenses in the consolidated statement of operations and changes in net assets.

MHS has elected the practical expedient to not separate lease components from nonlease components related to its real estate leases.

(k) Goodwill and Intangible Assets

Goodwill is an asset representing the future economic benefits arising from the difference in the fair value of the business acquired and the fair value of the identifiable and intangible net assets acquired in a business combination. Indefinite-lived intangible assets are assets that are not amortized because there is no foreseeable limit to cash flows generated from them. Goodwill and intangible assets is included in other assets, net in the accompanying consolidated balance sheets.

If it is more likely than not that goodwill is impaired, MHS records the amount that the carrying value exceeds the fair value as an impairment charge. Goodwill is not amortized and along with indefinite-lived intangible assets is evaluated at least annually for impairment. There were no impairment charges recognized during the years ended December 31, 2020 or 2019.

Amortizing intangible assets are comprised of certificates of need, license agreements, trade names and lease arrangements, which all have finite useful lives. Amortization expense is recorded on a

straight-line basis over the estimated useful life of the assets, which ranges from three to thirty years, associated with the nature of the intangible asset.

(l) Investment in Joint Ventures

MHS maintains ownership in certain joint ventures related to imaging, office buildings, behavioral health and other healthcare focused activities and accounts for these joint ventures under the equity method of accounting. As of December 31, 2020 and 2019, MHS held ownership interests in 21 and 15 joint ventures, respectively. Investment in joint ventures is included in other assets, net in the accompanying consolidated balance sheets. Losses on joint ventures for the years ended December 31, 2020 and 2019 were $4,709 and $8,002, respectively, primarily associated with the startup costs at Wellfound and are included in other operating revenue on the consolidated statements of operations and changes in net assets.

(m) Estimated Third-Party Payor Settlements

Medicare cost reports are filed annually by MHS with the Medicare intermediary and are subject to audit and adjustment prior to settlement. Estimates of net settlements due to Medicare were $3,456 and $3,562 as of December 31, 2020 and 2019, respectively, and have been recorded within accounts payable and accrued expenses in the accompanying consolidated balance sheets. Third-party settlements are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods, based upon the amount of the final settlements. Patient service revenue increased by $106 and $2,746 for 2020 and 2019, respectively, to reflect changes in the estimated Medicare settlements for prior years.

(n) Interest Rate Swaps

MHS maintains several interest rate swap agreements as a means of hedging its exposure to variable-based interest rates and fluctuations in cash flows as part of its overall interest rate risk management strategy. All MHS interest rate swaps are recorded at fair value. The accounting for changes in the fair value of these swaps depends on whether those had been designated as cash flow hedges. As of December 31, 2020 and 2019, none of MHS' interest rate swaps were designated as cash flow hedges and therefore, the changes in fair value are recognized and included in other income (loss) on the consolidated statements of operations and changes in net assets. These swaps have notional amounts totaling approximately $709,000 and expire starting in August 2027 through August 2049. The majority of the swaps have the economic effect of fixing the LIBOR-based variable interest rate on an equivalent amount of MHS' outstanding floating rate principal debt.

Under master netting provisions of the International Swap Dealers Association (ISDA) agreement with each of the counterparties, MHS is permitted to settle with the counterparties on a net basis. Due to the right of offset under these master netting provisions, MHS offsets the fair value of certain interest rate swap assets with swap liabilities on the consolidated balance sheets.

(o) Net Assets with Donor Restrictions

Gifts are reported as support with donor restrictions if they are received with donor stipulations that restrict the use of the donated assets to a specific time or purpose or have been restricted by donors and are maintained by MHS in perpetuity. When restricted funds to be used for operations are

expended for their restricted purposes or by the occurrence of the passage of time, these amounts are released from restrictions for operations and are classified as revenues, gains, and other support without donor restrictions. When restricted funds are expended for the acquisition of property, plant, and equipment, these amounts are recognized in net assets without donor restrictions as net assets released from restriction – capital acquisitions.

MHS applies the provisions of Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) Topic 820, *Fair Value Measurement*, related to using the present value technique to measure fair value of pledges receivable. In accordance with ASC Topic 820, MHS has applied the expected present value technique to pledges received after January 1, 2009 that adjusts for a risk premium to take into account the risks inherent in those expected cash flows. Pledges of financial support are recorded as pledges receivable when unconditional pledges are made and are stated at net realizable value. Pledges are reported net of an allowance for uncollectible pledges and pledges to be collected in future years are reflected at a discounted value using a weighted average discount rate. As of December 31, 2020, and 2019, MHS has recorded $14,160 and $8,024, respectively, of net pledge receivables, which are included in donor-restricted assets in the accompanying consolidated balance sheets. As of December 31, 2020, $5,436 of pledges are due in one year or less and $8,724 in two to seven years.

(p) Patient Service Revenue

Patient service revenue is reported at the amount that reflects the consideration to which MHS expects to receive in exchange for providing patient services. These amounts are due from patients, third-party payors, and others and include the variable consideration for retroactive adjustments to revenue due to final settlement of audits, reviews, and investigations. MHS bills the patient and third-party payors several days after the services are performed or when the patient is discharged from the facility, whichever is later.

(q) Hospital Safety Net Assessment

The State of Washington (the State) has a safety net assessment program involving Washington State hospitals to increase funding from other sources and obtain additional federal funds to support increased payments to providers for Medicaid services. In connection with this program, MHS recorded increases in patient service revenue of $83,884 and $84,831 for 2020 and 2019, respectively, and incurred assessments of $61,112 and $59,460 for 2020 and 2019, respectively, which were recorded in other operating expenses in the accompanying consolidated statements of operations and changes in net assets. MHS has outstanding receivables of $14,649 and $4,679 associated with this program as of December 31, 2020 and 2019, respectively, which are included with accounts receivable on the consolidated balance sheets.

(r) Uncompensated and Undercompensated Care

MHS provides a variety of uncompensated and undercompensated healthcare services to the communities it serves within the purview of its mission. Because MHS does not pursue collection of amounts determined to qualify as uncompensated care, MHS has determined that it has provided implicit price concessions to uninsured patients and patients with other uninsured balances. The implicit price concessions included in estimating the transaction price represent the difference between

amounts billed to patients and the amount MHS expects to receive based on its historical collections from these patients. Patients who meet the criteria of MHS' uncompensated care policy are eligible to receive these services without charge or at an amount less than MHS' established rates. Such amounts determined to qualify as charity care are not reported as revenue. The State provides guidelines for charity care provided by hospitals in the state. Hospitals are recommended to provide full charity care to patients who meet 100% of the federal poverty guidelines and a lesser amount to patients who meet up to 200% of the federal poverty guidelines. MHS provides full charity care to patients who meet 300% of the federal poverty guidelines and also provides uncompensated care on a sliding scale for patients whose income is between 301% and 500% of the federal poverty guidelines for true self-pay patients and patients with deductibles and coinsurance amounts. The estimated cost of charity care provided was approximately $51,000 and $58,000 in 2020 and 2019, respectively. The estimated cost of uncompensated and undercompensated services provided to patients covered under Medicaid in excess of payments received was approximately $218,443 and $203,000 in 2020 and 2019, respectively. These cost estimates are calculated based on the overall ratio of costs to charges for MHS.

(s) Other Operating Revenue

Other operating revenue includes revenue from cafeteria sales, retail pharmacy, laboratory revenue from community providers, medical office rental income, contributions without donor restrictions, grant revenue, contracted behavioral healthcare revenue and other miscellaneous revenue.

(t) Excess of Revenues over Expenses

The consolidated statements of operations and changes in net assets include excess of revenues over expenses. Changes in net assets without donor restrictions, which are excluded from the excess of revenues over expenses, primarily include changes in accrued pension asset, net assets released from restrictions for capital expenditures, and capital assets received.

(u) Federal Income Taxes

ASC Subtopic 740-10, *Income Taxes*, clarifies the accounting for uncertainty in income taxes recognized in MHS' consolidated financial statements. This topic also prescribes a recognition threshold and measurement standard for the financial statement recognition and measurement of an income tax position taken or expected to be taken in a tax return. Only tax positions that meet the "more-likely-than-not" recognition threshold at the effective date may be recognized or continue to be recognized upon adoption. In addition, this topic provides guidance on derecognition, classification, interest and penalties, accounting in interim periods, disclosure, and transition. Other than Medis, Inc., which is a taxable corporation, all of the other entities have obtained determination letters from the Internal Revenue Service that they are exempt from federal income taxes under Section 501(a) of the Internal Revenue Code as an organization described in 501(c)(3) of the Internal Revenue Code, except for tax on unrelated business income.

(v) Self-Insurance Reserves

MHS is self-insured with respect to professional and general liability, workers compensation and medical and other health benefits with excess insurance coverage over self-insured retention limits. MHS records insurance liabilities for these specific items by using third party actuarial calculations and certain assumptions and inputs such as MHS historical claims experience and the estimated amount of future claims that will be incurred.

(w) New and Pending Accounting Standards

In June 2016, FASB issued ASU 2016-13, *Financial Instruments – Credit Losses (Topic 326): Measurement of Credit Losses on Financial Instruments,* The amendments in this update require that financial assets are measured at amortized cost basis and presented at the net amount expected to be collected. This eliminates the probable initial recognition threshold in current GAAP and, instead, reflects an entity's current estimate of all expected credit losses and broadens the information that an entity must consider in developing its expected credit loss estimate for assets measured either collectively or individually. The provisions of this ASU are effective for MHS for the year beginning on January 1, 2021. MHS does not expect the adoption of this ASU to have a material effect on its consolidated financial statements.

In August 2018, FASB issued ASU 2018-13, *Fair Value Measurement (Topic 820): Disclosure Framework – Changes to the Disclosure Requirements for Fair Value Measurement.* The amendments in this update modify the disclosure requirements on fair value measurements in Topic 820, *Fair Value Measurement*, based on the concepts in the Concepts Statement, including the consideration of costs and benefits. The changes in this ASU remove certain disclosure requirements, modify certain disclosure requirements, and add two new disclosure requirements, as applicable. Most of these changes relate to Level 3 fair value measurements. The provisions of this ASU are effective for MHS for the year beginning on January 1, 2020. MHS has adopted this ASU, and it did not have a material effect on its consolidated financial statements.

In August 2018, FASB issued ASU 2018-15, *Intangibles – Goodwill and Other – Internal-Use Software (Subtopic 350-40): Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement That Is a Service Contract.* The amendments in this update align the requirements for

capitalizing implementation costs incurred in a hosting arrangement that is a service contract with the requirements for capitalizing implementation costs incurred to develop or obtain internal-use software (and hosting arrangements that include an internal-use software license). The guidance in Subtopic 350-40 is used to determine which implementation costs to capitalize as an asset related to the service contract and which costs to expense and is also used to determine the amortization period of the capitalized costs. The provisions of this ASU are effective for MHS for the year beginning on January 1, 2021. MHS does not expect the adoption of this ASU to have a material effect on its consolidated financial statements.

In April 2019, FASB issued ASU 2019-04, *Codification Improvements to Topic 326, Financial Instruments – Credit Losses, Topic 815, Derivatives and Hedging, and Topic 825, Financial Instruments.* The amendments in this update are divided into four separate topics that discuss the details of the improvement areas and the amendments made to the Codification for these improvement areas. Topics 1, 2 and 5 in this ASU relate specifically to ASU 2016-13, which is effective for MHS for the year beginning January 1, 2023. Topics 3 and 4 in this ASU have been evaluated and are not applicable to MHS. MHS does not expect the adoption of this ASU to have a material effect on its consolidated financial statements.

In March 2020, FASB issued ASU 2020-04, *Reference Rate Reform (Topic 848): Facilitation of the effects of Reference Rate Reform on Financial Reporting.* The amendments in this update provide practical expedients to contract modifications when it is being modified due to the replacement of a reference rate within the contract. The provisions of this ASU are effective immediately and will be available through December 31, 2022. Modifications completed after December 31, 2022 must use current guidance instead of the provisions in this ASU. MHS anticipates making contract modifications in 2021 and 2022 but does not expect the adoption of this ASU to have a material effect on its consolidated financial statements.

(2) Coronavirus (COVID-19) Impact

MHS, along with most other healthcare providers across the United States, has experienced operational challenges related to the outbreak of the COVID-19 pandemic. On February 29, 2020, the Governor of the State of Washington (the Governor) declared a state of emergency after the State of Washington reported its first known death from COVID-19. COVID-19 was declared a pandemic by the World Health Organization on March 11, 2020, and on March 13, 2020, the President of the United States declared a national emergency as a result of the pandemic. On March 23, 2020, the Governor implemented a stay at home order called "Stay Home, Stay Healthy." On March 27, 2020, the Coronavirus Aid, Relief, and Economic Security (CARES) Act was signed into law, which was aimed to direct economic assistance for American workers, families, and small businesses, and preserve jobs for American industries. The COVID-19 pandemic impacted all hospitals and physician offices throughout the health system.

On March 16, 2020, MHS canceled or postponed all nonemergent procedures as a precautionary measure to allow for the preservation of Personal Protective Equipment (PPE). Further, MHS set up temporary facilities and secured additional patient beds to accommodate the surge impacts that were projected in the early stages of the pandemic. On May 18, 2020, the Governor modified the restrictions on elective procedures for all medical and dental facilities. Based on this modification, MHS resumed all procedures within its facilities, while taking all appropriate social distancing precautions and usage of PPE for staff,

patients and visitors in accordance with national, state and local guidance. MHS ensured that sufficient PPE was maintained for surge capacity of at least 20% within the hospital facilities.

The CARES Act requires the amount of funding received to be validated, which requires management to quantify lost revenues and increased expenses associated with the pandemic for Provider Relief Funds (PRF). MHS has recognized revenue associated with the PRF funding according to the terms and conditions of the CARES Act, and as contribution revenue under FASB ASC 958-605. Contribution revenue attributable to PRF funding totaled $118,965 and is included within other operating revenue on the consolidated statements of operations and changes in net assets. Refunding of amounts received may be required by the CARES Act if a receiving entity is unable to quantify the financial losses intended to be covered by funding. MHS has determined that it is able to justify retaining all funding received in 2020 by the PRF and has not recorded any liabilities as of December 31, 2020 for potential repayment of PRF payments received.

In March 2020, MHS chose to support employees by protecting pay and benefits for those that were unable to work due to the cancellations/postponements of procedures. MHS protected the pay and benefits for those individuals through April 25, 2020. Approximately 50% of this cost has been recovered through the employee retention credits offered to employers as part of the CARES Act, which totaled $2,409. The CARES Act also allowed MHS to defer payment of the employer portion of the FICA taxes due to the federal government through December 31, 2020. Payment of these deferred taxes will occur with 50% paid by the end of 2021 and the other 50% by the end of 2022. The total amount of FICA taxes deferred in 2020 was $71,866, with the current portion of $35,933 recorded within accrued compensation and related liabilities, and the long-term portion of $35,933 recorded within other liabilities, net on the consolidated balance sheets. MHS considered whether to utilize the Medicare Advanced Payment Program (MAPP) when it was available to obtain additional cash flow but chose not to engage in this program.

MHS has filed applications and obtained reimbursement of additional expenses from the Federal Emergency Management Agency (FEMA) based on criteria due to the national emergency declaration made due to COVID-19. MHS submitted an expedited funding application with FEMA that covers the period from the start of the national disaster declaration to June 30, 2020. The expedited application allowed MHS to recover up to 50% of the total funding applied for on the application. However, based on FEMA guidelines for this expedited application, FEMA only reimbursed 75% of the recoverable amount. MHS continues to complete the final reconciliation of the expedited funding application to receive the remainder of the funding and will apply for additional funding pertaining to later periods until the national disaster declaration is no longer in effect.

The following table shows the funding that has been received to prepare and respond to COVID-19 and recognized as other operating revenue through December 31, 2020:

(Dollars in thousands)

Sources of external relief funding		Amount
CARES Act PRF funding	$	118,965
FEMA		4,214
Insurance Funds for Business Interruption		1,004
State of Washington Coronavirus Relief Fund		2,922
Total proceeds received and recognized in 2020	$	127,105

In January 2021, MHS received an additional $160,032 in CARES Act PRF funding. MHS continues to reconcile and analyze its lost revenue and increased expenses based on known reporting guidance.

The impact of COVID-19 has increased the uncertainty associated with management's assumptions and estimates made on these financial statements. The actual impact of COVID-19 on MHS's consolidated financial statements may differ significantly from the assumptions and estimates made for the year ended December 31, 2020.

(3) Revenue from Contracts with Customers

Revenue is recognized as performance obligations are satisfied. Performance obligations are determined based on the nature of the services provided by MHS and are recognized either over time or at a point in time. Revenue for performance obligations satisfied over time is recognized based on actual charges incurred through a point in time in relation to total actual charges incurred. MHS believes that this method provides a useful depiction of the provision of services over the term of the performance obligation based on the inputs needed to satisfy the obligation. Generally, performance obligations satisfied over time relate to patients in the hospitals or clinics receiving inpatient or outpatient services. MHS measures an inpatient performance obligation from time of admission to time of discharge and an outpatient performance obligation from the start of the outpatient service to the completion of the outpatient service. Revenue for performance obligations satisfied at a point in time are recognized when goods or services are provided to patients and customers.

MHS has elected to apply the optional exemption in ASC 606-10-50-14a as all of MHS' performance obligations related to contracts with a duration of less than one year. Under this exemption, MHS was not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period. Any unsatisfied or partially unsatisfied performance obligations are completed within days or weeks of the end of the year.

MHS determines the transaction price based on standard charges for goods and services provided, reduced by contractual adjustments provided to third-party payors, discounts provided to uninsured patients in accordance with MHS policy, and implicit price concessions provided to uninsured patients. MHS determines its estimates of contractual adjustments and discounts based on contractual agreements, discount policies and historical experience. MHS determines its estimate of implicit price concessions based on its historical collection experience with each class of patients.

Contractual agreements with third-party payors provide for payments at amounts less than MHS' established charges. A summary of the payment arrangements with major third-party payors is as follows:

- Medicare – Inpatient acute care services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge, which provides for reimbursement based on Medicare Severity Diagnosis-Related Groups (MS-DRGs). These rates vary according to a patient classification system that is based on clinical diagnosis, acuity, and expected use of hospital resources. The majority of Medicare outpatient services is reimbursed under a prospective payment methodology, the Ambulatory Payment Classification System (APCs), or fee schedules.
- Medicaid – Inpatient services rendered to Medicaid program beneficiaries are reimbursed under a prospective payment system similar to Medicare; however, Medicaid utilizes All Payor Refined Diagnosis-Related Groups (APR-DRGs) as opposed to Medicare's MS-DRGs. The majority of Medicaid outpatient services is reimbursed under a prospective payment methodology, the Enhanced Ambulatory Patient Groups (EAPG), or fee schedules.
- Other – MHS has entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to MHS under these agreements includes prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates and fee schedules.

Laws and regulations concerning government programs, including Medicare and Medicaid, are complex and subject to varying interpretation. As a result of investigations by governmental agencies, various healthcare organizations have received requests for information and notices regarding alleged noncompliance with those laws and regulations, which, in some instances, have resulted in organizations entering into significant settlement agreements with the government. Compliance with such laws and regulations may also be subject to future government exclusion from the related programs. There can be no assurance that regulatory or governmental authorities will not challenge MHS' compliance with these laws and regulations, and it is not possible to determine the impact, if any, that such claims or penalties would have upon MHS. In addition, the contracts with commercial payors also provide for retroactive audit and review of claims that can reduce the amount of revenue ultimately received.

Settlements with third-party payors for retroactive adjustments due to audits, reviews, or investigations are considered variable consideration and are included in the determination of the current estimated transaction price for providing patient care. These settlements are estimated based on the terms of the payment agreement with the payor, correspondence from the payor, and historical settlement activity, including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known, or as years are settled and no longer subject to such audits, reviews and investigations. Adjustments arising from a change in the transaction price were not significant in 2020 or 2019.

Generally, patients who are covered by third-party payors are responsible for related deductibles and co-insurance, which vary in amount. MHS also provides services to uninsured patients, and offers those uninsured patients a discount, either by policy or law, from standard charges. MHS estimates the transaction price for patients with deductibles and co-insurance from those who are uninsured based on

(Dollars in thousands)

historical experience and current market conditions. The initial estimate of the transaction price is determined by reducing the standard charges by any contractual adjustments, discounts, and implicit price concessions. Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to patient service revenue in the period of the change. Additional revenue due to changes in estimates of implicit price concessions, discounts, and contractual adjustments for prior years were not significant for 2020 or 2019. Subsequent changes that are determined to be the result of an adverse change in the patient's ability to pay and deemed uncollectable are recorded as bad debt expense.

Consistent with MHS' mission, care is provided to patients regardless of their ability to pay. MHS has determined that it has provided implicit price concessions to uninsured patients and patients with other uninsured balances. The implicit price concessions included in estimating the transaction price represent the difference between amounts billed to patients and the amount MHS expects to receive based on its collection experience with those patients. Patients who meet the criteria for charity care are provided care without charge or at amounts less than established rates. Such amounts determined to qualify as uncompensated care are not reported as revenue.

MHS has determined that the best depiction of its revenue is by its mix of payors as this shows the amount of revenue recognized from each portfolio. Patient service revenue disaggregated by payor for the years ended December 31, 2020 and 2019 are as follows:

		2020	2019
Payors:			
Medicare	$	847,084	833,070
Medicaid		497,785	479,340
Premera		445,238	458,091
Regence		306,588	326,247
Aetna		190,029	195,283
Kaiser Permanente		142,854	128,354
First Choice		112,142	116,867
Self-pay		16,246	15,963
Other		548,002	554,310
	$	3,105,968	3,107,525

MHS has elected to apply the practical expedient under ASC 340-40-25-4 and therefore, all incremental customer contract acquisition costs are expensed as incurred, as the amortization period of the asset that MHS would have otherwise recognized is one year or less in duration.

(Dollars in thousands)

(4) Concentration of Credit Risk

MHS grants credit without collateral to its patients, most of whom are residents of the communities it serves and are insured under third-party payor agreements. The mix of gross receivables from patients and third-party payors at December 31, 2020 and 2019 was as follows:

	2020	2019
Medicare	32 %	30 %
Medicaid	24	23
Premera	10	9
Self-pay	9	8
Regence	5	6
First Choice	1	2
Health Care Exchange	1	1
Other commercial insurance	18	21
	100 %	100 %

(5) Fair Value Measurements

(a) Fair Value Hierarchy

In accordance with ASC Topic 820, fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. ASC Topic 820 establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for similar assets or liabilities (Level 1 measurements) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are as follows:

- Level 1 inputs are quoted prices (unadjusted) in active markets for identical or similar assets or liabilities that MHS could access at the measurement date. Level 1 securities generally include investments in equity securities, mutual funds and certain fixed income securities.
- Level 2 inputs are inputs other than quoted prices included within Level 1 that are based upon observable market inputs for the asset or liability, either directly or indirectly. Level 2 securities generally include investments in fixed income securities (composed primarily of government, agency and corporate bonds), and interest rate swaps.
- Level 3 inputs are unobservable market inputs for the asset or liability. Level 3 securities include donor trusts where MHS is not the trustee.

The level in the fair value hierarchy within which a fair value measurement, in its entirety, falls is based on the lowest level input that is significant to the fair value measurement.

(Dollars in thousands)

ASC Subtopic 820-10 allows for the use of a practical expedient for the estimation of the fair value of investments in investment companies for which the investment does not have a readily determinable fair value. The practical expedient used by MHS is the Net Asset Value (NAV) per share, or its equivalent. In some instances, the NAV may not equal the fair value that would be calculated under fair value accounting standards. Valuations provided by investment managers consider variables such as the financial performance of underlying investments, recent sales prices of underlying investments and other pertinent information. In addition, actual market exchanges at year-end provide additional observable market inputs of the redemption price. MHS reviews valuations and assumptions provided by investment managers for reasonableness and believes that the carrying amounts of these financial instruments approximate the estimated of fair value of the instrument. Where investments are not presented at fair value, NAV is used as a practical expedient to approximate fair value.

The following tables present the placement in the fair value hierarchy of investment assets and liabilities that are measured at fair value on a recurring basis and investments valued at NAV at December 31, 2020 and 2019:

		Fair value measurements at reporting date using		
	December 31, 2020	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Assets:				
Trading securities:				
Mutual funds	$ 592,499	592,499	—	—
Equity securities	243,866	243,866	—	—
Fixed income bond funds	364,126	364,126	—	—
Fixed income governmental obligations	67,186	21,137	46,049	—
Fixed income other	95,268	—	95,268	—
Commingled trust fund – international equity	169,362	—	169,362	—
Donor trusts	30,807	—	—	30,807
Total assets at fair value	1,563,114	$ 1,221,628	310,679	30,807
Investment assets valued at NAV	456,274			
Total assets at fair value or NAV	$ 2,019,388			
Liabilities:				
Interest rate swaps	$ 154,347	—	154,347	—

(Continued)

(Dollars in thousands)

		Fair value measurements at reporting date using		
	December 31, 2019	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Assets:				
Trading securities:				
Mutual funds	$ 649,528	649,528	—	—
Equity securities	122,103	122,103	—	—
Fixed income bond funds	343,709	343,709	—	—
Fixed income governmental obligations	65,137	26,912	38,225	—
Fixed income other	84,106	—	84,106	—
Commingled trust fund – international equity	144,659	—	144,659	—
Interest rate swaps	1,263	—	1,263	—
Donor trusts	25,904	—	—	25,904
Total assets at fair value	1,436,409	1,142,252	268,253	25,904
Investment assets valued at NAV	403,840			
Total assets at fair value or NAV	$ 1,840,249			
Liabilities:				
Interest rate swaps	$ 88,311	—	88,311	—

(Continued)

(Dollars in thousands)

The following table presents information for investments where the NAV was used as a practical expedient to measure fair value at December 31, 2020 and 2019:

	NAV December 31, 2020	NAV December 31, 2019	Unfunded commitments	Redemption frequency	Redemption notice period
Hedge funds	$ 239,797	213,291	60	Quarterly	60 or 95 business days prior to valuation date
Common trust funds	205,844	175,882	N/A	Daily	1 business day prior to valuation date
Limited partnerships	10,633	14,667	1,800	N/A	N/A
Total investments valued at NAV	$ 456,274	403,840	1,860		

Hedge funds include investments in hedge fund-of-funds products with certain investment managers. The fair values of the investments in this category have been estimated using the NAV per share of the investment.

Common trust funds include investments in a collective or common trust account that invests funds in an underlying fund or set of funds. The trust account seeks an investment return that approximates the performance of an index as defined by each common trust fund. The fair value of the investments in this category are estimated using the NAV per share of the fund that is derived from the underlying investments in the trust fund.

Limited partnerships include investments in private equity and venture capital funds in both developed and emerging markets with approximately 35% invested in private equity in developed markets, 20% in venture capital in developed markets, and 45% in private equity and venture capital in emerging markets. The fair values of the investments in this category have been estimated using the NAV of MHS' ownership interest in partners' capital. These assets can never be redeemed with the partnerships. Instead, the nature of the investment in this category is that distributions are received through the liquidation of the underlying assets of the partnership.

(b) Interest Rate Swaps

The interest rate swaps are recorded at estimated fair value by using certain observable market inputs that participants would use from closing prices for similar assets. In addition, other valuation techniques and market inputs are used that help determine the fair values of these swaps, which include certain valuation models, current interest rates, forward yield curves, implied volatility and credit default swap pricing.

At December 31, 2020 and 2019, these interest rate swaps did not qualify as cash flow hedges and therefore, any changes in the fair value of these swaps are recorded as a gain or loss in the consolidated statements of operations and changes in net assets.

(Dollars in thousands)

The fair value of the interest rate swaps liability is included in interest rate swap liabilities on the consolidated balance sheets, and the fair value of the interest rate swap asset is included in other assets, net on the consolidated balance sheets. The fair value losses of these interest rate swaps for the years ended December 31, 2020 and 2019 were $67,298 and $42,620, respectively, and are included in loss on interest rate swaps in other (loss) income, net in the consolidated statements of operations and changes in net assets. Also included in the loss on interest rate swaps is the loss on net cash settlement amounts associated with the swaps of $7,735 and $2,816, respectively, for the years ended December 31, 2020 and 2019, respectively.

The following table represents both the fair value and settlement value for the interest rate swap assets and liabilities as of December 31, 2020 and 2019 as follows:

	Asset derivatives					
	2020			2019		
	Balance Sheet Location	Fair value	Settlement value	Balance Sheet Location	Fair value	Settlement value
Derivative instruments:						
Interest rate swaps	Other assets	—	—	Other assets	1,263	1,438

	Liability derivatives					
	2020			2019		
	Balance Sheet Location	Fair value	Settlement value	Balance Sheet Location	Fair value	Settlement value
Derivative instruments:						
Interest rate swaps	Interest rates swap liabilities	154,347	159,666	Interest rates swap liabilities	88,311	94,899

(Continued)

(Dollars in thousands)

(6) Donor Restricted Assets and Investments

A summary of donor restricted assets and investments at 2020 and 2019 is as follows:

	December 31, 2020		
	Donor restricted assets	Investments	Total
Mutual funds	$ 5,400	587,099	592,499
Equity securities	2,222	241,644	243,866
Fixed income securities	4,799	521,781	526,580
Commingled trust fund – international equity	1,543	167,819	169,362
Hedge funds	2,185	237,612	239,797
Common trust funds	1,876	203,968	205,844
Limited partnerships	98	10,535	10,633
Donor trusts	30,807	—	30,807
Pledge receivables, net and other	39,970	—	39,970
Total	$ 88,900	1,970,458	2,059,358

	December 31, 2019		
	Donor restricted assets	Investments	Total
Mutual funds	$ 5,588	643,940	649,528
Equity securities	1,050	121,053	122,103
Fixed income securities	4,241	488,711	492,952
Commingled trust fund – international equity	1,245	143,414	144,659
Hedge funds	1,836	211,455	213,291
Common trust funds	1,513	174,369	175,882
Limited partnerships	126	14,541	14,667
Donor trusts	25,904	—	25,904
Pledge receivables, net and other	29,280	—	29,280
Total	$ 70,783	1,797,483	1,868,266

Fixed income securities include mutual funds, corporate bonds, mortgage-backed securities, asset-backed securities, U.S. government obligations, and state government obligations.

(Dollars in thousands)

(7) Liquidity and Availability of Financial Assets

MHS actively monitors the availability of resources required to meet its operating obligations and other contractual commitments, while also striving to maximize investment returns of its available funds. To help meet its general obligations, MHS can also access the credit markets as a means of producing liquidity, if needed. MHS draws income, appreciation and distributions from its endowment fund up to 5% of the endowment average account value annually, as applicable donor restrictions are met, as another way of providing liquidity. For purposes of analyzing resources available to meet general expenditures over a twelve-month period, MHS considers all expenditures related to its ongoing activities to provide integrated healthcare delivery as well as the conduct of services undertaken to support these activities to be general expenditures.

At December 31, 2020 and 2019, MHS' financial resources are as follows:

		2020	2019
Cash and cash equivalents	$	946,223	434,854
Accounts receivable		374,372	376,500
Other current assets, net		85,144	71,397
Donor restricted assets		88,900	70,783
Investments		1,970,458	1,797,483
		3,465,097	2,751,017
Less prepaid assets included in other current assets, net		(37,612)	(35,222)
Less donor restricted assets		(88,900)	(70,783)
Less investments with redemption limitations of greater than one year		(10,633)	(14,667)
Total financial assets available for general expenditures	$	3,327,952	2,630,345

In addition to financial assets available to meet general expenditures over the next twelve months, MHS operates mostly using revenues, gains and other support without donor restrictions and anticipates collecting sufficient revenues to cover general expenditures.

(Dollars in thousands)

(8) Property, Plant, and Equipment, Net

A summary of property, plant, and equipment at December 31, 2020 and 2019 is as follows:

		2020	2019
Land and land improvements	$	131,993	131,635
Buildings		2,202,449	2,094,270
Equipment		1,115,316	1,020,402
		3,449,758	3,246,307
Less accumulated depreciation		(1,751,452)	(1,585,761)
		1,698,306	1,660,546
Construction in progress		65,360	102,799
Property, plant, and equipment, net	$	1,763,666	1,763,345

Depreciation expense charged to operations for the years ended December 31, 2020 and 2019 amounted to $166,517 and $163,826, respectively. Depreciation and amortization expense for the years ended December 31, 2020 and 2019 was $168,188 and $165,670, respectively.

(9) Other Assets, Net

Other assets are as follows at December 31, 2020 and 2019:

		2020	2019
Investment in joint ventures	$	64,534	45,575
Deferred compensation plan assets held in trust (note 11)		85,320	71,594
Accrued pension asset (note 11)		45,590	45,420
Self-insured retention receivables, net of current portion (notes 12 and 13)		23,435	22,383
Interest rate swaps (note 5(b))		—	1,263
Goodwill and other intangibles		167,083	168,284
Net investment in lease (note 16(b))		23,200	25,798
Loans receivable		75,606	1,160
Other		17,691	2,527
Other assets, net	$	502,459	384,004

Deferred compensation plan assets held in trust are participant-managed investments consisting of equity and fixed income mutual funds with prices quoted in active markets.

(Dollars in thousands)

In December 2020, MHS funded $75,000 into an escrow account as part of a loan based on a credit agreement executed with Astria Health. The loan bears a fixed interest rate of 9.5% with payments due at June 30 and December 31 of each year. In January 2021, the final promissory note documents were executed and funds were disbursed at that time. The loan matures in January 2024.

(10) Other Liabilities, Net

Other liabilities are as follows at December 31, 2020 and 2019:

		2020	2019
Professional liability, net of current portion (note 12)	$	73,822	67,204
Deferred compensation liability (note 11)		85,320	71,594
Workers' compensation liability, net of current portion (note 13)		14,166	12,943
Deferred FICA liability (note 2)		35,933	—
Other		3,805	3,579
Other liabilities, net	$	213,046	155,320

(11) Retirement Plans

(a) Defined Benefit Pension Plan

MHS operates one qualified defined benefit pension plan (the Plan) covering eligible employees. The Plan was closed to new employees effective after July 31, 2002. The benefits are based on years of service and the employee's highest five consecutive years of compensation. MHS contributions to the Plan vary from year to year, but the minimum contribution required by law has been provided in each year. Effective December 31, 2016, participants no longer accrue pension benefits under the Plan.

(Dollars in thousands)

The following tables set forth the changes in projected benefit obligations, changes in fair value of plan assets, and components of net periodic benefit costs for the Plan, which has measurement dates of December 31, 2020 and 2019:

		2020	2019
Change in projected benefit obligation:			
Projected benefit obligations at beginning of year	$	639,993	576,605
Service cost		670	1,230
Interest cost		22,963	25,779
Actuarial loss		85,184	71,704
Expected administrative expenses		(670)	—
Benefits paid		(32,854)	(35,325)
Projected benefit obligations at end of year	$	715,286	639,993
Change in fair value of plan assets:			
Fair value of plan assets at beginning of year	$	685,413	604,690
Actual gain on plan assets		108,966	116,048
Actual administrative expenses		(649)	—
Benefits paid		(32,854)	(35,325)
Fair value of plan assets at end of year	$	760,876	685,413
Funded status recognized in consolidated balance sheets consist of:			
Asset for pension benefits	$	45,590	45,420
Amount recognized in net assets without donor restrictions:			
Net loss		115,669	118,182

	2020	2019
Weighted average assumptions used to determine benefit obligations as of December 31:		
Discount rate	2.70 %	3.70 %
Expected return on plan assets	4.50	5.00

The expected return on plan assets assumption is based upon an analysis of historical long-term returns for various investment categories as measured by appropriate indices. These indices are weighted based upon the extent to which plan assets are invested in the particular categories in arriving at MHS' determination of a composite expected return. An actuary reviews the assumptions annually for reasonableness.

(Dollars in thousands)

The components of net periodic benefit cost are as follows during the years ended December 31, 2020 and 2019:

		2020	2019
Components of net periodic benefit cost:			
Service cost	$	670	1,230
Interest cost		22,963	25,779
Expected return on plan assets		(31,730)	(36,593)
Amortization of net actuarial loss		10,441	5,524
	$	2,344	(4,060)

The accumulated benefit obligation for the Plan was $715,286 and $639,993 at December 31, 2020 and 2019, respectively.

(i) Cash Flows – Contributions

MHS expects to make contributions to the Plan totaling approximately $650 in 2021.

(ii) Estimated Future Benefit Payments

The following benefits payments, which reflect expected future service, as appropriate, are expected to be paid as follows:

		Pension benefits
2021	$	38,071
2022		40,010
2023		40,044
2024		39,850
2025		40,770
2026–2030		195,246

(Dollars in thousands)

(iii) Plan Assets

The following tables set forth by level, within the fair value hierarchy, the Plans' investments at fair value:

		Fair value measurements at reporting date using		
	December 31, 2020	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Assets:				
Cash and cash equivalents	$ 12,053	12,053	—	—
Trading securities:				
Mutual funds	106,439	106,439	—	—
Fixed income bond funds	105,998	105,998	—	—
Fixed income governmental obligations	312,189	270,336	41,853	—
Fixed income other	211,950	—	211,950	—
Commingled trust fund – international equity	22,485	—	22,485	—
	771,114	$ 494,826	276,288	—
Broker receivables	40,662			
Broker payables	(164,621)			
Total assets at fair value	647,155			
Investments valued at NAV	113,721			
Total assets at fair value or NAV	$ 760,876			

(Dollars in thousands)

		Fair value measurements at reporting date using		
	December 31, 2019	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Assets:				
Cash and cash equivalents	$ 15,320	15,320	—	—
Trading securities:				
Mutual funds	89,996	89,996	—	—
Equity securities	267	267	—	—
Fixed income bond funds	115,559	115,559	—	—
Fixed income governmental obligations	267,627	211,270	56,357	—
Fixed income other	184,525	—	184,525	—
Commingled trust fund – international equity	22,286	—	22,286	—
	695,580	$ 432,412	263,168	—
Broker receivables	56,641			
Broker payables	(171,268)			
Total assets at fair value	580,953			
Investments valued at NAV	104,460			
Total assets at fair value or NAV	$ 685,413			

There were no significant transfers into or out of Level 1 or Level 2 financial instruments during the years ended December 31, 2020 and 2019.

(Dollars in thousands)

The following table presents information for investments where the NAV was used as a practical expedient to measure fair value at December 31, 2020 and 2019:

	Fair value at December 31, 2020	Fair value at December 31, 2019	Unfunded commitments	Redemption frequency (if currently eligible)	Redemption notice period
Commingled trust funds:					
Real estate	$ 22,426	22,333	N/A	Quarterly	45 days
Absolute return funds	85,603	74,741	N/A	Monthly	5 business days prior to valuation date
Limited partnerships	5,692	7,386	850	N/A	N/A
Total investments valued at NAV	$ 113,721	104,460	850		

Real estate is a real estate commingled trust that invests in U.S. commercial real estate. The fund owns real estate assets in the U.S. office, industrial, residential, and retail sectors.

Absolute return fund investments consist primarily of listed equity, equity-related and debt securities, including exchange-traded funds, other securities and other pooled investment vehicles. These investments use derivatives or other instruments for both investment and hedging purposes and may take long and/or short positions, and the derivative investments may include but are not restricted to futures, options, swaps, and forward currency contracts.

Limited partnerships include investments in private equity and venture capital in both developed and emerging markets with approximately 35% invested in private equity in developed markets, 20% in venture capital in developed markets, and 45% in private equity and venture capital in emerging markets. The fair values of the investments in this category have been estimated using the NAV of MHS' ownership interest in partners' capital. These assets can never be redeemed with the partnerships. Instead, the nature of the investment in this category is that distributions are received through the liquidation of the underlying assets of the partnership.

(Dollars in thousands)

The defined benefit plan weighted average asset allocations at December 31, 2020 and 2019 by asset category are as follows:

	2020	2019
Asset category:		
Domestic equities	10 %	7 %
International equities	7	7
Emerging markets	1	1
Fixed income securities	78	79
Alternative investments	1	1
Real estate	3	3
Global asset allocation	—	2
	100 %	100 %

(iv) Investment Objectives

The target asset allocations for each asset class are set based on the achieved funding levels for the Plan and are summarized below:

	2020	2019
Asset category:		
Domestic equities	9 %	8 %
International equities	8	6
Emerging markets	—	1
Fixed income securities	80	80
Real estate	3	3
Global asset allocation	—	2
	100 %	100 %

(v) Investment Categories

Equities

The strategic role of domestic equities is to provide higher expected market returns (along with international equities) of the major asset classes; maintain a diversified exposure within the U.S. stock market using multimanager portfolio strategies; and achieve returns in excess of passive indices using active investment managers and strategies.

The strategic role of international equities is to provide higher expected market return premiums (along with domestic equities) of the major asset classes and diversify the Plans' overall equity exposure by investing in non-U.S. stocks that are less than fully correlated to domestic equities with similar return expectations; to maintain a diversified exposure within the international stock

market through the use of multimanager portfolio strategies; and achieve returns in excess of passive indices through the use of active investment managers and strategies.

The strategic role of emerging markets is to diversify the portfolio relative to domestic equities and fixed income investments and to specifically include equity investment in selected global markets and may also include currency hedging for defensive purposes.

Fixed Income

The strategic role of fixed income securities is to diversify the Plan's equity exposure by investing in fixed income securities that exhibit a low correlation to equities and lower volatility; maintain a diversified exposure within the U.S. fixed income market using multimanager portfolio strategies; and achieve returns in excess of passive indices through the use of active investment managers and strategies. It also provides effective diversification against equities and a stable level of cash flow.

Alternative Investments

The strategic role of alternative investments is for diversification relative to equities and fixed income investments, to add absolute return using hedging strategies, and to achieve significant expected return premiums over longer holding periods. Alternative investments include investments in hedge funds and private equities and are under the supervision and control of investment managers. Hedge funds include investments in a variety of instruments including stocks, bonds, commodities, and a variety of derivative instruments. Private equities consist primarily of equity investments made in companies that are not quoted on a public stock market, which can include U.S. and non-U.S. venture capital, leveraged buyouts, and mezzanine financing.

Real Estate

The strategic role of real estate is to diversify the Plan's portfolio relative to equities and fixed income investments to include a component of real property investment through a commingled fund structure and providing higher returns than benchmark investments of a similar class. Real estate investments may also include publicly and privately traded real estate investment trusts as well as direct investment through properties and mortgages.

Global Asset Allocation

The strategic role of global asset allocation is to add value through broad diversification among traditional asset classes and tactical allocation shifts. Global asset allocation includes investments in diversified multi-asset funds to achieve returns above other broad diversified benchmarks.

(b) Defined Contribution Plans

MHS currently maintains three defined contribution plans including the MHS 401(a) Retirement Account Plan (RAP), the MHS 403(b) Employee Savings Plan, and the MHS 401(k) Plan. Most employees assigned to work at Deaconess Hospital, Valley Hospital and Rockwood Clinic are eligible for participation in the MHS 401(k) Plan, which is funded by both MHS and employee contributions. The MHS 403(b) Employee Savings Plan is 100% funded by employee contributions and the RAP is 100% funded by MHS contributions.

MHS' funding for the defined contribution plans is based on certain percentages of the employees' base pay and/or a percentage of their deferred contributions. Employer contributions to the defined-contribution plans for 2020 and 2019 were approximately $49,550 and $47,200, respectively, which were included with employee benefits in the accompanying consolidated statements of operations and changes in net assets.

(c) Other

In addition to the defined benefit and defined contribution plans as described above, MHS also maintains several deferred compensation arrangements for the benefit of eligible employees. Substantially all amounts that are deferred under these arrangements are held in trust until such time as these funds become payable to the participating employees.

(12) Professional Liability

MHS maintains a self-insurance program for professional liability with excess coverage over self-insured retention limits provided by commercial insurance carriers. MHS has recorded a liability as of December 31, 2020 and 2019, which comprises estimated deductibles and retentions for known claims at year-end and a liability for incurred but not reported claims based on an actuarially determined estimate.

At December 31, 2020 and 2019, the estimated gross professional liability (including current and long-term portions) was $97,997 and $85,634, respectively. The current portion is included in accounts payable and accrued expenses and the remainder is included in other liabilities, net. MHS has recorded a receivable for amounts to be received from the excess insurance carriers for their portion of the claims (including current and long-term portions) of $32,450 and $30,026 as of December 31, 2020 and 2019, respectively. The current amount is included in other current assets, net and the remainder is included in other assets, net in the accompanying consolidated balance sheets.

(13) Workers' Compensation and Employee Health Benefit Programs

MHS maintains a self-insurance program for workers' compensation with excess coverage over self-insured retention limits provided by commercial insurance carriers. MHS has recorded a liability based on an actuarial estimate of future claims payments. At December 31, 2020 and 2019, the estimated net liability based on future claims cost totaled $17,726 and $16,127, respectively. The gross liabilities (including both current and long-term portions) total $21,083 and $19,135 as of December 31, 2020 and 2019, respectively. The long-term amounts are included in other liabilities, net and the current portions are included in accounts payable and accrued expenses in the accompanying consolidated balance sheets. These liabilities are secured by a letter of credit with the State of Washington. MHS has recorded a receivable for amounts to be received from excess insurance carriers of $3,357 and $3,008 as of

(Dollars in thousands)

December 31, 2020 and 2019, respectively, which is included with other current assets, net and other assets, net for the respective estimated current and long-term portions.

MHS maintains a self-insurance program for employee medical and dental insurance. Employees can elect to be included in the self-insurance plan as a part of their fringe benefit package. Premiums deducted from employees' wages are used in paying a portion of members' medical claims. The estimated liability for claims in 2020 and 2019 was $10,129 and $12,083, respectively. These amounts are included in accrued compensation and related liabilities in the accompanying consolidated balance sheets.

(14) Long-Term Debt

Long-term debt consists of the following at December 31, 2020 and 2019:

	2020	2019
2020 Taxable bonds	$ 300,000	—
2020 OCED financing	60,889	—
2019 Term loan	35,255	35,255
WHCFA Revenue bonds, 2017 Series A and B	321,705	325,020
WHCFA Revenue bonds, 2017 Series C, D, and E	191,010	191,010
2017 Term loans	130,170	130,170
WHCFA Revenue bonds, 2015 Series A and B	352,315	356,365
WHCFA Revenue bonds, 2012 Series A	60,000	60,000
WHCFA Revenue bonds, 2009 Series A and B	98,130	98,130
Other	22,313	34,839
	1,571,787	1,230,789
Adjusted for:		
Current portion	(7,950)	(13,668)
Bond premiums, discounts, and debt issuance costs	55,012	59,852
Long-term debt, net of current portion	$ 1,618,849	1,276,973

(a) 2020 Taxable Bonds

In July 2020, MHS issued $300,000 of taxable 2020 series bonds. These bonds were issued as fixed rate bonds that bear interest of 2.803%. The principal of $300,000 is due in 2051, with interest only payments made semiannually in February and August of each year.

(b) 2020 OCED Financing

In June 2020, MHS finalized a sale-leaseback transaction for three completed off-campus emergency departments (OCED) and one OCED still in progress of being constructed with total cash proceeds received of $61,794. Due to the specific terms of the agreement, the lease qualified as a financing type lease. The agreement did not meet the criteria for sale-leaseback accounting treatment and instead, is considered a financing liability. The agreement bears an implicit interest rate of 4.64%. Annual principal payments range from $1,803 in 2021 to $4,461 in 2039 with a final principal payment of $96 in 2041.

(c) 2019 Term Loan

In August 2019, MHS entered into a fixed rate term loan agreement with JPMorgan Chase Bank, N.A., with an interest rate of 1.89%. The principal balance of $35,255 is due in 2022.

(d) Washington Health Care Facility Authority (WHCFA) Revenue Bonds 2017 Series A and B

In November 2017, MHS issued $333,970 of 2017 Series A and B bonds. These bonds were issued as fixed rate bonds that bear interest ranging from 3.0% to 5.0%. Annual principal payments range from $3,315 in 2020 to $62,410 in 2047.

(e) WHCFA Revenue Bonds 2017 Series C, D, and E

In November 2017, MHS entered into a $111,010 variable rate private placement agreement (Series C and D) with JPMorgan Chase Bank, National Association and an $80,000 variable rate private placement agreement (Series E) with Wells Fargo Municipal Capital Strategies, LLC. Annual principal payments range from $390 in 2043 to $55,505 in 2049. The interest rates, which were between 0.56% and 1.98% at December 31, 2020, reset monthly and are based on 70% of the one-month U.S. LIBOR plus a spread.

(f) 2017 Term Loans

In November 2017, MHS entered into two $65,085 variable rate term loan agreements with Wells Fargo Bank, N.A. The principal balance of $130,170 is due in 2047. The interest rates, which were between 0.84% and 2.55% at December 31, 2020, reset monthly and are based on the one-month U.S. LIBOR plus a spread.

(g) WHCFA Revenue Bonds 2015 Series A and B

In April 2015, MHS issued $373,390 of 2015 Series A and B bonds. Series A and B bonds were issued as fixed rate bonds that bear interest ranging from 2.0% to 5.0%. Annual principal payments range from $4,050 in 2020 to $24,085 in 2034 with a final payment of $8,860 due in 2045.

(h) WHCFA Revenue Bonds 2012 Series A

In November 2012, MHS issued $60,000 of 2012 Series A bonds. 2012 Series A bonds were issued as fixed rate bonds that bear interest ranging from 3.8% to 4.1%. Annual principal payments range from $5,190 in 2040 to $22,085 in 2045 with a final payment of $19,715 due in 2046.

(i) WHCFA Revenue Bonds 2010 Series A

In January 2010, MHS issued $100,150 of 2010 Series A bonds. In August 2019, the 2010 bonds were refinanced with the proceeds from the 2019 Term Loan as described below. This refinancing resulted in a gain of $869 that is recognized in other (loss) income, net in the consolidated statements of operations and changes in net assets.

(j) WHCFA Revenue Bonds 2009 Series A and B

In May 2009, MHS issued the 2009 Series A and B bonds as variable rate demand bonds for $50,000 each. The bonds were backed by an irrecoverable letter of credit equal to the aggregate principal and interest of the bonds. In July 2012, the 2009 Series A and B bonds were converted to $98,130 of fixed rate bonds that bear interest ranging from 4.4% to 5.0%. Annual principal payments range from $3,690 in 2040 to $38,890 in 2044.

(k) Other

The other debt listed is primarily made up of debt held by Navos. In April 2020, MHS paid $11,488 of Navos' debt outstanding to third-party creditors. Of the outstanding debt at December 31, 2020, $16,092 is associated with certain buildings and other capital assets operated by Navos and is subject to provisions whereby the debt will be forgiven upon compliance with those provisions. These provisions state that Navos maintains the assets that were built or purchased with these notes and maintains their usage when the promissory note was signed for the length specified. If these provisions are not met, the note must be repaid based on the terms of the agreement. The forgivable debt is subject to a forgiveness provision in years 2028 through 2068.

(l) 2020 Line of Credit

In April 2020, MHS secured a $200,000 line of credit through JPMorgan Chase Bank, N.A. The term of the line of credit is for 12 months and bears interest at a variable rate based upon the Central Bank Floating Rate. No draws have occurred as of December 31, 2020.

Revenue bonds issued by MHS through WHCFA are subject to applicable bond indenture agreements, which require that MHS satisfy certain measures of financial performance as long as the bonds are outstanding. These measures include a minimum debt service coverage ratio and a condition that the bonds are secured by a gross receivables pledge. Based on management's assessment of these requirements, MHS is in compliance with these covenants at December 31, 2020 and 2019.

Each fixed-rate revenue bond requires semiannual interest payments on February 15 and August 15 of each year until maturity. These bonds are subject to early redemption by MHS on or after certain specific dates and at certain specific redemption prices as outlined in each bond agreement.

(Dollars in thousands)

Principal maturities on long-term debt are as follows:

Year ending December 31:	
2021	$ 7,950
2022	45,390
2023	20,616
2024	21,641
2025	22,716
Thereafter	1,453,474
	$ 1,571,787

A summary of interest costs is as follows during the years ended December 31, 2020 and 2019:

	2020	2019
Interest cost:		
Charged to operations	$ 48,464	49,313
Amortization of bond premiums, discounts, and issuance costs	(2,494)	(2,728)
Capitalized	478	1,231
	$ 46,448	47,816

(15) Commitments and Contingencies

Approximately 48% of MHS employees were covered under collective bargaining agreements as of December 31, 2020. These employees provide nursing, nursing support, pharmacy, imaging, lab, inpatient and outpatient therapies, housekeeping, food, laundry, maintenance, and inventory/distribution services to MHS. Collective bargaining agreements have various expiration dates extending through March 2023.

(16) Leases

(a) Lessee

MHS leases various equipment and facilities under noncancelable operating and finance leases. Lease terms for noncancelable operating leases range from 1 to 18 years, and existing leases have expiration dates through 2036. Lease terms for finance leases range from 3 to 21 years, and existing leases have expiration dates through 2040.

(Dollars in thousands)

The components of lease cost for the years ended December 31, 2020 and 2019 were as follows:

		2020	2019
Operating lease cost	$	37,232	36,532
Finance lease cost:			
Amortization of right-of-use assets		1,550	—
Interest on lease liabilities		388	—
Total finance lease cost		1,938	—
Short term lease cost		1,644	344
Variable lease cost		7,242	7,141
Sublease income		(1,049)	(4,518)
Total lease cost	$	47,007	39,499

Other information related to leases as of December 31, 2020 and 2019 was as follows:

	2020	2019
Weighted average remaining lease term (years)		
Operating leases	6.7	6.8
Finance leases	7.7	N/A
Weighted average discount rate		
Operating leases	4.0 %	4.0 %
Finance leases	4.4	N/A
Operating cash flows from operating leases	(36,707)	(35,619)
Operating cash flows from finance leases	(388)	—
Financing cash flows from finance leases	(1,366)	—
Right-of-use assets obtained in exchange for new operating lease liabilities	19,850	40,717
Right-of-use assets obtained in exchange for new finance lease liabilities	16,739	—

(Continued)

(Dollars in thousands)

Maturities of lease liabilities under noncancelable leases as of December 31, 2020 are as follows:

		Operating Leases	Finance Leases	Total
For year ended December 31:				
2021	$	33,673	3,482	37,155
2022		26,333	3,482	29,815
2023		22,904	3,321	26,225
2024		18,102	3,096	21,198
2025		16,258	1,719	17,977
Thereafter		45,847	3,840	49,687
Total undiscounted lease payments		163,117	18,940	182,057
Less present value discount		(20,255)	(2,904)	(23,159)
Total lease liabilities	$	142,862	16,036	158,898

(b) Lessor

MHS leases a building to the Alliance for South Sound Health, which does business under the name Wellfound Behavioral Health Hospital (Wellfound). Wellfound is a related party owned 50 percent by MHS. The leased building is owned solely by MHS, and is the only asset that MHS leases out as a lessor. The lease has a 20 year initial lease term, with four 5 year extension options. Due to the related party nature of the lease, MHS considers it reasonably certain that Wellfound will exercise its four lease renewal options, and as such, treats the lease as a 40 year lease. There is no purchase option stated in the lease contract. MHS has determined that the lease is a sales-type financing lease, since the expected lease term spans a major portion of the useful life of the building. At December 31, 2020, MHS' other assets, net include a net investment in lease of $23,200.

Revenue from leases for the years ended December 31, 2020 and 2019 is as follows:

		2020	2019
Interest income on net investment in finance leases	$	1,136	812
Variable lease income		28	25
Total lease income	$	1,164	837

(Dollars in thousands)

Future lease payments receivable as of December 31, 2020 are as follows:

Year ended December 31:		
2021	$	1,246
2022		1,246
2023		1,246
2024		1,246
2025		1,246
Thereafter		43,495
Total lease payments to be received		49,725
Less: unearned interest income		(26,525)
Net investment in lease	$	23,200

(17) Net Assets with Donor Restrictions

Net assets with donor restrictions are available for the following specified purposes at December 31, 2020 and 2019:

		2020	2019
Healthcare services	$	52,151	49,866
Endowment funds, perpetual trusts and related receivables		71,651	64,273
Purchase of property, plant and equipment		16,234	6,377
Indigent care		1,533	1,634
Health education		1,192	1,240
Total net assets with donor restrictions	$	142,761	123,390

(18) Endowment Funds

MHS' endowments consist of over 100 individual funds established for a variety of purposes. They include both endowment funds with donor restrictions and funds designated without donor restrictions by the board of directors of its foundations to function as endowments (board-designated endowments). Net assets associated with endowment funds, including board-designated endowment funds, are classified and reported based on the existence or absence of donor-imposed restrictions and nature of restrictions, if any.

(Dollars in thousands)

The following tables present MHS' endowment net asset composition as well as associated changes therein:

	Board designated without donor restrictions	Funds with donor restrictions	Total
Endowment net assets, December 31, 2019	$ 2,673	39,700	42,373
Investment return:			
Investment income	39	493	532
Net appreciation – realized and unrealized	153	1,989	2,142
Total investment return	192	2,482	2,674
Contributions	—	443	443
Appropriation of endowment assets for expenditure	(40)	(201)	(241)
Endowment net assets, December 31, 2020	$ 2,825	42,424	45,249

	Board designated without donor restrictions	Funds with donor restrictions	Total
Endowment net assets, December 31, 2018	$ 2,923	38,140	41,063
Investment return:			
Investment income	62	782	844
Net appreciation – realized and unrealized	27	334	361
Total investment return	89	1,116	1,205
Contributions	—	1,990	1,990
Appropriation of endowment assets for expenditure	(339)	(1,546)	(1,885)
Endowment net assets, December 31, 2019	$ 2,673	39,700	42,373

Perpetual trusts that are held and managed by third party trustees are recorded as net assets with donor restrictions on the consolidated balance sheets; however, they are not included as endowment net assets with donor restrictions in the above presentation. Those perpetual trusts totaled $28,290 and $23,445, respectively, as of December 31, 2020 and 2019. Also excluded from the presentation of endowment net assets with donor restrictions above are pledge receivables and other totaling $937 and $1,128, respectively, as of December 31, 2020 and 2019.

(a) Funds with Deficiencies

From time to time, the fair value of assets associated with individual donor restricted endowment funds may fall below the level of the original gifts and the amounts of subsequent donations accumulated at the funds. In accordance with generally accepted accounting principles, deficiencies of this nature are reported in net assets with donor restrictions. There were no funds with deficiencies in 2020 or 2019.

(b) Investment Policy – Including Return Objectives and Strategies to Achieve Objectives

The endowment assets are invested in an investment portfolio, which include those assets of donor restricted funds that MHS must hold in perpetuity as well as all other foundation-related investment assets. MHS has adopted an investment policy for the foundation investments that intends to provide income to support the spending policy while seeking to maintain the purchasing power of the endowment assets. To satisfy its long-term rate of return objectives, MHS relies on a total return strategy in which investment returns are achieved through both capital appreciation and interest and dividend income. MHS uses a diversified asset allocation to achieve its long-term return objectives within prudent risk constraints. There are some donor restricted funds that are held separately from MHS' pooled investments. These endowments are invested by donors in manners to provide funding for specific purposes as determined by donors.

(c) Spending Policy

In order to provide a stable and consistent level of funding for programs and services supported by the endowments, the foundations have determined that an annual spending rate of 5% of the endowment's average account value is prudent. In establishing the spending policies, the MHS foundations considered among other things, the expected total return on its endowments, effect of inflation, duration of the endowments to achieve its objective of maintaining the purchasing power of the endowment assets held in perpetuity, as well as to provide additional growth through new gifts and investment returns.

(Dollars in thousands)

(19) Functional Expenses

MHS provides inpatient and outpatient services, physician services, home health services, and fund-raising activities. Certain categories of expenses are attributable to programs and support services. These included salaries and wages, depreciation and amortization and other expenses. Costs are allocated based on cost allocation methods depending on the allocable expense, including square footage, time utilization and percentage of gross charges. Expenses related to providing these services are as follows for the years ended December 31, 2020 and 2019:

	2020				
	Program services			Support services	
	Hospitals and related services	Clinics and urgent care centers	Retail and other services	Corporate and support services	Total
Salaries and wages	$ 969,456	392,470	51,225	202,870	1,616,021
Employee benefits	119,926	66,759	11,931	49,516	248,132
Supplies	416,964	34,712	54,952	13,750	520,378
Purchased services	98,027	25,874	18,409	155,946	298,256
Depreciation and amortization	110,868	17,914	1,921	37,485	168,188
Interest	41,004	3,936	—	1,030	45,970
Other	226,092	49,321	25,724	68,604	369,741
	$ 1,982,337	590,986	164,162	529,201	3,266,686

	2019				
	Program services			Support services	
	Hospitals and related services	Clinics and urgent care centers	Retail and other services	Corporate and support services	Total
Salaries and wages	$ 918,459	407,097	47,490	175,055	1,548,101
Employee benefits	120,308	69,120	11,259	40,659	241,346
Supplies	424,852	35,609	36,278	4,949	501,688
Purchased services	109,060	34,682	12,763	114,609	271,114
Depreciation and amortization	106,384	20,090	1,425	37,771	165,670
Interest	46,226	2,859	—	(2,500)	46,585
Other	217,900	44,851	16,565	78,170	357,486
	$ 1,943,189	614,308	125,780	448,713	3,131,990

(20) Litigation and Regulatory Environment

The healthcare industry is subject to numerous laws and regulations from federal, state, and local governments. These laws and regulations include, but are not limited to, matters such as licensure, accreditation, government healthcare program participating requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Government agencies are actively conducting investigations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in the imposition of significant fines and penalties, significant repayments for patient services previously billed, and/or expulsion from government healthcare programs. Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

MHS is also involved in litigation arising in the normal course of business. After consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect to MHS' financial position.

(21) Subsequent Events

MHS has evaluated the subsequent events through March 24, 2021, the date at which the consolidated financial statements were issued and has included all necessary adjustments and disclosures.

Exhibit 13

MHS Hospice Conditions, Corrections, and Approval Documents

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Office of Investigation & Inspections
Post Office Box 47874
Olympia, Washington 98504-7874

August 8, 2018

Kit Hughes RN, MHA, Interim Director
MultiCare Home Health, Hospice and Palliative Care
3901 South Fife Street MS: 3901-1-1-HH
PO BOX 5200
Tacoma, WA. (98415 -0200

Dear Ms. Hughes,

Surveyors from the Washington State Department of Health (DOH) conducted a Medicare recertification survey at MultiCare Home Health, Hospice and Palliative Care on 06/11/18 to 6/18/18. During the survey, DOH surveyors determined that MultiCare Home Health, Hospice and Palliative Care did not meet the following Condition of Participation (COP) for Medicare hospice:

42 CFR §418.54 CoP; Initial and comprehensive assessment of the patient

On 08/07/18, the DOH surveyor conducted an onsite post-survey revisit. This revisit confirmed that the health deficiencies cited during the recent recertification survey have been corrected, and that the Condition(s) of Participation listed above has been met. We have recommended that the 90-day termination process be stopped.

Please contact me with any questions at 360-236-4665 or sarah.benson@doh.wa.gov. You may also contact Robin Bucknell, In-Home Services Survey Manager, at 360-236-4697 or robin.bucknell@doh.wa.gov.

Sincerely,

Sarah Benson BSN, RN - IHS Surveyor
Survey Team Leader
Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	501508	A. BUILDING _____ B. WING _____	06/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULTICARE HOSPICE	3901 SOUTH FIFE STREET TACOMA, WA 98409

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 000	INITIAL COMMENTS MEDICARE RECERTIFICATION SURVEY The Washington State Department of Health (DOH) in accordance with Medicare Conditions of Participation set forth in 42 CFR 418, conducted this health and safety survey. Onsite dates: 06/11/18 - 06/15/18 and 06/18/18 Examination number: X2018-415 The survey was conducted by: Sarah Benson, BSN Jada Lynn, BSN DOH staff found the facility not in compliance with the following Conditions of Participation: §42CFR 418.54 Initial and comprehensive assessment of the patient. The cumulative effect of these failures is the inability of the Hospice Agency to ensure the comprehensive assessment, drug review, bereavement assessment are completed to meet the patient's individualized end of life needs. (Reference: TAG L-0523, L-0530, L-0531, L-0533)	L 000	1. A written PLAN OF CORRECTION is required for each deficiency listed on the Statement of Deficiencies. 2. EACH plan of correction statement must include the following: The regulation number and/or the tag number; HOW the deficiency will be corrected; WHO is responsible for making the correction; WHAT will be done to prevent reoccurrence and how you will monitor for continued compliance; and WHEN the correction will be completed. 3. Your PLANS OF CORRECTION must be returned within 10 calendar days from the date you receive the Statement of Deficiencies. Your Plans of Correction must be postmarked by July 11, 2018 4. Return the ORIGINAL REPORT with the required signatures	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lynn Sieckmann	Vice President, Clinical Continuum	7/6/18

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	501508	A. BUILDING _____ B. WING 0938-0391	06/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULTICARE HOSPICE	3901 SOUTH FIFE STREET TACOMA, WA 98409

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 520	INITIAL & COMPREHENSIVE ASSESSMENT OF PATIENT CFR(s): 418.54 This CONDITION is not met as evidenced by: §42CFR 418.54 Initial and comprehensive assessment of the patient. Based on review of patient records, policies and procedures and staff interviews, it was determined that the Hospice Agency failed to complete the comprehensive assessment no later than 5 calendar days after election of hospice care (L523). The Hospice Agency failed to ensure review of actual or potential drug interactions was documented per agency policy (L530). The Hospice Agency failed to ensure initial bereavement risk assessments were completed (L531). The Hospice Agency failed to ensure the comprehensive assessment was updated no less frequently than every 15 days (L533). The cumulative effect of these systemic practices resulted in the agency's failure to ensure patients' individualized end of life needs would be met. (Reference: TAG L-0523, L-0530, L-0531, L-0533)	L 520	Please see each individual plan of correction below for L523, L530, L531 and L533. In addition, the attached Exhibit A as an easy to read plan of correction as well.	
L 523	TIMEFRAME FOR COMPLETION OF ASSESSMENT CFR(s): 418.54(b) The hospice interdisciplinary group, in consultation with the individual's attending physician (if any), must complete the comprehensive assessment no later than 5 calendar days after the election of hospice care in accordance with §418.24.	L 523		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	501508	A. BUILDING _____ B. WING _____	06/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULTICARE HOSPICE	3901 SOUTH FIFE STREET TACOMA, WA 98409

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 523	Continued From page 2 This STANDARD is not met as evidenced by: Based on review of patient records and interview with agency staff, the agency failed to ensure the initial comprehensive assessment visits were completed within 5 days of admission by its Chaplains staff for 2 of 20 patients in the survey sample (Patients #4 and #9). Failure of the agency to not ensure all members of the interdisciplinary team complete their individual assessments places patients at risk of physical and/or psychological harm when there is delay of identification of their care needs. Findings included: 1. The surveyor reviewed patient records on 06/13/18 - 06/15/18 and 06/18/18 and noted the following: Patient #4 was admitted for hospice services on 01/10/18 with the diagnosis PEHO Syndrome (PEHO syndrome is a rare neurodegenerative condition, which usually begins within the first few weeks of life. The condition takes its name from the following features: (P) progressive encephalopathy (Disease, damage, or malfunction of the brain with), (E) edema, (H) hypsarrhythmia (disorganized, chaotic pattern of brain waves that occurs in children with infantile spasms) and (O) optic atrophy) and aspiration pneumonia. The Chaplin completed the first visit and comprehensive assessment on 01/24/18, 14 days after admission. There was no documentation explaining the delay in completion of the comprehensive assessment.	L 523	Education occurred the week of July 2, 2018 with Chaplain staff regarding proper documentation within the 5-day time requirement. The education included the requirement to document refused or the request to reschedule visits. The Nurse Reviewer will be provided a list of daily admissions for audit completion beginning July 3, 2018. Audits will occur for all new patients to ensure compliance with documentation within the 5-day time requirement. The Nurse Reviewer, in collaboration with Hospice Supervisor will track and report team assessments completed on day 3 for newly admitted patients and notify remaining staff of needed documentation. The Interim Director and Vice President are ultimately responsible for the plan of correction and ongoing overall compliance.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	501508	A. BUILDING _____ B. WING 0938-0391	06/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULTICARE HOSPICE	3901 SOUTH FIFE STREET TACOMA, WA 98409

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 523	Continued From page 3 Patient #9 was admitted for hospice services on 05/01/18 with the diagnoses of congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD). The Chaplin completed the first visit and comprehensive assessment on 05/14/18, 13 days after admission. There was no documentation explaining the delay in completion of the comprehensive assessment. 2. The surveyor interviewed Staff J on 06/14/18 at 2:30pm. Staff J stated Patient #4 had been in the Palliative care service prior to admission to hospice. The Chaplin had cared for Patient #4 during the Palliative care admission and had seen the patient one month prior to the hospice admission. The Nurse Reviewer was unable to located documentation explaining the delay in completion of the comprehensive assessment. 3. The surveyor interviewed Staff H on 06/15/18 at 3:00pm. Staff H was unable to locate documentation explaining the delay in completion of the comprehensive assessment for Patient #9. The agency Director and Administrator acknowledged these findings on 06/18/18.	L 523	See page 3 for L 523	
L 530	CONTENT OF COMPREHENSIVE ASSESSMENT CFR(s): 418.54(c)(6) [The comprehensive assessment must take into consideration the following factors:] (6) Drug profile. A review of all of the patient's prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following:	L 530	See page 5 for L 530	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES OMB

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L 530	Continued From page 4 (i) Effectiveness of drug therapy (ii) Drug side effects (iii) Actual or potential drug interactions (iv) Duplicate drug therapy (v) Drug therapy currently associated with laboratory monitoring. This STANDARD is not met as evidenced by: Based on policy review, record review and interview, the Agency failed to ensure comprehensive review and reconciliation of medications with drug to drug interactions for 8 of 20 patients (Patient's #3, 5, 6, 7, 8, 9, 10, and 14). This failure potentially places patients at risk for harm due to adverse drug interactions. Background: 1. Adverse drug interactions may occur when "two or more drugs are taken concurrently, they may influence one another in a manner that results in either an enhanced or diminished intensity of effect produced by any of the drugs taken alone." (www.ncbi.nlm.gov, accessed 06/20/18). 2. A Hospice Comfort Kit includes a "prescribed set of medications that are kept in a patient's home should a medical crisis strikes." Its aim is to provide pain and symptom relief when medication management is needed quickly. (www.verywellhealth.com, accessed 06/20/18). 3. Giving a drug only on an "as needed" basis, is identified as "prn". Findings include:	L 530	The after-hours nursing staff are currently performing admission record reviews daily. The admission nursing staff and after-hours nursing staff will be re-trained to ensure understanding of responsibility related to expected record completion and chart reviews. Each group will be provided a guiding document to ensure completion of required tasks. The after-hours nursing staff will notify both the admitting nurse and the Nurse Reviewer when medication reconciliation is not completed. In addition, Case Managers will be educated and held accountable to review, document and communicate to the provider any major drug interactions for all patients receiving ongoing services. The admission chart review expectations, audits and follow-up will be a required part of the standard work for the after-hours nursing staff and the Nurse Reviewer. All gaps in medication reconciliation for new patients will be reported by the Nurse Reviewer to the Supervisor. For ongoing patients on service, documentation of medication reconciliation and major drug interactions will also be reviewed during the Interdisciplinary Team Meeting (IDT) which occurs on every patient no more than every 15 days. Education to after-hours nursing staff occurred on or before July 6, 2018. Expectations will be communicated at all IDT meetings the week of July 2 and July 9, 2018. The Interim Director and Vice President are ultimately responsible for the plan of correction and ongoing overall compliance.	

L 530 Nurse Auditor will track and report non-compliance for newly admitted patients to Supervisor daily. Supervisors will review weekly random patient records presented at IDT to ensure ongoing compliance.

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L 530	Continued From page 5 On 06/14/18, a review of Agency policy entitled Medication Management (last revised on 07/17) states "the patient's medications will be... reviewed and reconciled for accuracy, potential allergies, drug/drug and food/drug interactions ...". "The EHR medications are reviewed for changes at every visit by disciplines within their scope of practice." Furthermore, in the same policy under Primary Admissions, it states: "1) All medications, at the time of entry or change, are checked in the EHR (electronic health record) for drug and food interactions." ... 4) The clinician will review the Medication Interaction Report, and will begin instructing the patient and caregivers in potential food or drug interactions. The review, initial medication teaching and patient/designee response will be documented in the EHR. The physician will be notified of potential food/drug, drug/drug interactions and contraindications. Staff will document Provider response. a) The clinician will include the "Major" drug/drug interactions in their order to the provider for their prompt review and response. b) The clinician will teach to "Major" food/drug interactions at the initial visit or as soon as the interaction is identified, and document patient/designee response to teaching. On 06/14/18 and 06/15/18, record reviews of medication reconciliation occurred for the following patients: 1. Patient #3 had an initial start date of 09/11/17. The EHR indicated there were 2 Major potential drug/drug interactions.	L 530	See page 5 for L 530	

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L 530	Continued From page 6 a) Haldol, ordered 03/30/18, to be given prn for agitation or other (restlessness, or nausea/vomiting). This is a standard Hospice Kit medication. b) Trazadone, ordered 02/02/18, given routinely at bedtime for sleep. c) Lorazepam, ordered 09/12/17, given prn for anxiety or agitation, and d) Olanzapine, ordered 03/24/18, given twice daily for mood instability. Haldol and Trazadone have major drug interactions and Lorazepam and Olanzapine have major interactions. Although Haldol and Lorazepam are only ordered on a prn basis, there is still the potential for adverse reactions if given together. There was no documentation in the clinical record these potentially adverse interactions were noted by the clinician, or if the provider was notified, or any response obtained from the provider. 2. Patient #5 had an initial start date of 12/07/17. The EHR indicated there were 2 Major potential drug/drug interactions. a) Haldol, ordered 12/07/18, to be given prn for agitation or other (restlessness, or nausea/vomiting). This is a standard Hospice Kit medication. b) Trazadone, ordered 11/06/18, given routinely at bedtime for sleep. c) Spironolactone, ordered 12/21/17, given daily for fluid retention, and d) Lisinopril, ordered 01/31/18, given daily for heart failure. Haldol and Trazadone have major drug interactions. Although Haldol is only ordered on a prn basis, there is still the potential for adverse reactions if given together. Spironolactone and Lisinopril have major drug	L 530	See page 5 for L 530	

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L 530	Continued From page 7 interactions, and were being given concurrently. There was no documentation in the clinical record these potentially adverse interactions were noted by the clinician or if the provider was notified, or any response documented from the provider. 3. Patient #6 had an initial start date of 04/04/18. The EHR indicated there was 1 Major potential drug/drug interactions. a) Haldol, ordered 12/07/18, to be given prn for agitation or other (restlessness, or nausea/vomiting). This is a standard Hospice Kit medication. b) Trazadone, ordered 04/06/18, given routinely at bedtime for sleep. Haldol and Trazadone have major drug interactions. Although Haldol is only ordered on a prn basis, there is still the potential for adverse reactions when given together. There was no documentation in the clinical record these potentially adverse interactions were noted by the clinician or if the provider was notified, or any response documented from the provider. 4. Patient #7 had an initial start date of 11/03/17. The EHR indicated there was 1 Major potential drug/drug interactions. a) Haldol, ordered 11/03/17, to be given prn for agitation or other (restlessness, or nausea/vomiting). This is a standard Hospice Kit medication. b) Ondansetron, ordered 11/06/17, given as needed for nausea and vomiting. Haldol and Ondansetron have major drug interactions. Both drugs are only ordered on a prn basis, there is still the potential for adverse reactions if given together. There was no documentation in the clinical record these potentially adverse interactions were noted	L 530	See page 5 for L 530	

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L 530	Continued From page 8 by the clinician or if the provider was notified, or any response documented from the provider. 5. Patient #8 had an initial start date of 02/09/18. The EHR indicated there was 2 major potential drug/drug interactions. a) Haldol, ordered 02/09/18, to be given prn for agitation or other (restlessness, or nausea/vomiting), and b) Ondansetron, ordered 02/06/18, given prn for nausea and vomiting, or c) Compazine, ordered 02/09/18, given prn for nausea and vomiting. Haldol and Ondansetron have major drug interactions. Both drugs are only ordered on a prn basis, there is still the potential for adverse reactions if given together. Haldol and Compazine have major drug interactions. Both drugs are only ordered on a prn basis, there is still the potential for adverse reactions if given together. These drugs are all part of the Hospice Comfort Kit in the patient's home. There was no documentation in the clinical record these potentially adverse interactions were noted by the clinician or if the provider was notified, or any response documented from the provider. 6. Patient #9 had an initial start date of 05/01/18. The EHR indicated there was 1 Major potential drug/drug interactions. a) Haldol, ordered 05/01/18, to be given prn for agitation or other (restlessness, or nausea/vomiting). This is a standard Hospice Kit medication. b) Seroquel, ordered 06/01/18, given daily for mood disorders. Haldol and Seroquel have major drug interactions. Although Haldol is only ordered on a	L 530	See page 5 for L 530	

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L 530	Continued From page 9 prn basis, there is still the potential for adverse reactions together. There was no documentation in the clinical record these potentially adverse interactions were noted by the clinician or if the provider was notified, or any response documented from the provider. 7. Patient #10 had an initial start date of 04/06/18. The EHR indicated there was 1 Major potential drug/drug interactions. a) Haldol, ordered 04/07/18, to be given prn for agitation or other (restlessness, or nausea/vomiting). This is a standard Hospice Kit medication. b) Citalopram, ordered 04/06/18, given daily for mood disorders. Haldol and Citalopram have major drug interactions. Although Haldol is only ordered on a prn basis, there is still the potential for adverse reactions together. There was no documentation in the clinical record these potentially adverse interactions were noted by the clinician or if the provider was notified, or any response documented from the provider. 8. Patient #14 had an initial start date of 04/15/17. The EHR indicated there was 3 Major potential drug/drug interactions. a) Haldol, ordered 04/15/17, to be given prn for agitation or other (restlessness, or nausea/vomiting). This is a standard Hospice Kit medication, and b) Ondansetron, ordered 05/10/17, given prn for nausea and vomiting. Haldol and Ondansetron have major drug interactions. Both drugs are only ordered on a prn basis, there is still the potential for adverse reactions if given together. c) Amiodarone, ordered 05/10/17, given daily for	L 530	See page 5 for L 530	

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L 530	Continued From page 10 cardiac conditions, and d) Ondansetron, ordered 05/10/17, given prn for nausea and vomiting. Amiodarone and Ondansetron have major drug interactions. Although Ondansetron is only ordered on a prn basis, there is still the potential for adverse reactions together.e) Morphine Sulfate, ordered 04/15/17, given prn for pain control or shortness of breath, and f) Clopidogrel, ordered 09/22/15, daily for heart disease. Morphine Sulfate and Clopidogrel have major drug interactions. Although Morphine Sulfate is only ordered on a prn basis, there is still the potential for adverse reactions together. There was no documentation in the clinical record these potentially adverse interactions were noted by the clinician or if the provider was notified, or any response documented from the provider. On 06/15/18 at 02:30 pm, Staff H was interviewed about the lack of documentation regarding medication reconciliation. Staff H acknowledged these findings and stated "the likelihood of any significant interactions were very low, and if I were notified of these drug interactions, I would probably not order any changes. But the staff are not following our policy and procedures, and these steps should all be documented." The agency Director and Administrator acknowledged these findings on 06/18/18.	L 530	See page 5 for L 530	
L 531	CONTENT OF COMPREHENSIVE ASSESSMENT CFR(s): 418.54(c)(7) [The comprehensive assessment must take into consideration the following factors:]	L 531	See page 12 for L 531	

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L 531	Continued From page 11 (7) Bereavement. An initial bereavement assessment of the needs of the patient's family and other individuals focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the patient's death. Information gathered from the initial bereavement assessment must be incorporated into the plan of care and considered in the bereavement plan of care. This STANDARD is not met as evidenced by: Based on record review and interview, the Agency failed to ensure bereavement risk assessments were completed as part of the initial comprehensive assessment for 2 of 20 patients (Patient's #9 and #17). This failure has the potential to delay or overlook the needs of the patient's family and others in their ability to cope with the patient's death. Findings include: 1. The surveyor reviewed patient records on 06/13/18 - 06/15/18 and 06/18/18 and noted the following: Patient #9 was admitted on 05/01/18. Documentation of the initial bereavement risk assessment was not present in the patient record. There was no documentation to explain the absence of the bereavement risk assessment. Patient #17 was admitted on 03/10/18. Documentation of the initial bereavement risk assessment was not present in the patient record. There was no documentation to explain	L 531	The after-hours nursing staff are currently performing admission record reviews daily. The admission nursing staff and after-hours nursing staff will be re-trained to ensure understanding of responsibility related to expected record completion and chart reviews. The after-hours nursing staff will notify both the admitting nurse and the Nurse Reviewer when bereavement risk assessment is not completed. In addition, Bereavement staff will notify Supervisor of missing assessments as a secondary audit. The admission chart review expectations, audits and follow-up will be a required part of the standard work for the after-hours nursing staff and the Nurse Reviewer. All gaps in bereavement risk assessments for new patients will be reported by the Nurse Reviewer to the Supervisor. The Nurse Auditor will track and report non-compliance for newly admitted patients to Supervisor daily. Supervisors will review weekly random patient records to ensure ongoing compliance. Education to after-hours nursing staff occurred on or before July 6, 2018. Expectations will be communicated at all IDT meetings the week of July 2 and July 11, 2018. The Interim Director and Vice President are ultimately responsible for the plan of correction and ongoing overall compliance.	

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L 531	Continued From page 12 the absence of the bereavement risk assessment. 2. The surveyor interviewed Staff H on 06/15/18 at 3:00pm. Staff H was unable to locate documentation explaining the absence of the bereavement risk assessment. The agency Director and Administrator acknowledged these findings on 06/18/18.	L 531	See page 12 for L 531	
L 533	UPDATE OF COMPREHENSIVE ASSESSMENT CFR(s): 418.54(d) The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days. This STANDARD is not met as evidenced by: Based on record review, policy review and interview the facility failed to ensure that the comprehensive assessment was updated by the hospice interdisciplinary group (IDG) every 15 days for 11 of 20 patients (Patient's #1, 2, 3, 4, 5, 8, 9, 10, 11, 12, and 14). Failure to review and/or update the comprehensive assessment as needed or no later than 15 days, may lead to patients not	L 533	See page 14 for L 533	

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L 533	Continued From page 13 receiving the care and services in a timely, planned manner that could affect their comfort at the end of life. Reference: The agency calls the interdisciplinary group (IDG) the interdisciplinary team (IDT). Findings include: 1. The surveyor reviewed patient records on 06/13/18 - 06/15/18 and 06/18/18 and noted the following: Patient #1 was admitted on 03/15/18. The surveyor reviewed IDT documentation from 05/08/18 - 06/15/18. The patient record contained documentation of 2 IDT meetings. The first IDT occurred on 05/08/18 and the second documented IDT was on 06/05/18. There was 28 days between the IDT meetings. Patient #2 was admitted on 04/20/18. The surveyor reviewed IDT documentation from 04/20/18 - 06/15/18. The patient record contained documentation of 2 IDT meetings. The first IDT occurred on 05/07/18 and the second documented IDT was on 06/05/18. There was 29 days between these IDT meetings. Patient #3 was admitted on 09/12/17. The surveyor reviewed IDT documentation from 04/10/18 to 06/15/18. The patient record contained documentation of 2 IDT meetings. The first IDT occurred on 04/25/18 and the second documented IDT was on 05/30/18. There was 35 days between the IDT meetings. Patient #4 was admitted on 01/10/18. The	L 533	Re-education and communication of documentation expectation occurred to all responsible disciplines accountable to IDT the weeks of July 2 and July 9, 2018. The Supervisors will retain a list of all active patients to ensure that each patient is reviewed within the 15-day requirement. In addition, the Supervisor or Nurse Reviewer will audit records for documentation completion. Updates to the comprehensive assessment will be documented by the IDT group within 24 hours of when the patient was discussed at IDT. The documentation expectations will be a required part of the standard work for the RN Case Managers. When an RN Case Manager cannot be present for a scheduled IDT, they are expected to report off to their Supervisor who will present the case on their behalf to ensure all patients are reviewed within the required timeline. All gaps in documentation will be reported to the Supervisor weekly. Weekly, Supervisors will review random patient records presented at IDT to ensure ongoing compliance with documentation. The Interim Director and Vice President are ultimately responsible for the plan of correction and ongoing overall compliance.	

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L 533	Continued From page 14 surveyor reviewed IDT documentation from 04/10/18 to 06/15/18. The patient record contained documentation of 2 IDT meetings. The first IDT occurred on 04/25/18 and the second documented IDT was on 05/24/18. There was 29 days between the IDT meetings. Patient #5 was admitted on 12/07/17. The surveyor reviewed IDT documentation from 12/07/17 to 06/12/18. The patient record contained documentation of 2 IDT meetings. The first IDT occurred on 12/14/17 and the second documented IDT was on 01/04/18. There was 21 days between the IDT meetings. The record also contained documentation for an IDG meeting on 05/15/18 with no further documentation of IDT as of 06/18/18. Patient #8 was admitted on 02/09/18. The surveyor reviewed IDT documentation from 02/09/18 to 06/15/18. The patient record contained documentation of 2 IDT meetings. The first IDT occurred on 02/09/18 and the second documented IDT was on 04/04/18. There was 54 days between the IDT meetings. Patient #9 was admitted on 05/01/18. The surveyor reviewed IDT documentation from 04/10/18 to 06/15/18. The first IDT occurred on 05/02/18 and the second documented IDT was on 06/01/18. There was 30 days between the IDT meetings. Patient #10 was admitted on 04/06/18. The surveyor reviewed IDT documentation from 04/06/18 to 06/14/18. The last IDT meeting documented was on 05/15/18; with no further documentation of IDT meetings as of 06/18/18.	L 533	See page 14 for L 533	

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MULTICARE HOSPICE	3901 SOUTH FIFE STREET TACOMA, WA 98409

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 533	Continued From page 15 Patient #11 was admitted on 05/25/18. The surveyor reviewed IDT documentation from 05/25/18 to 06/15/18. The first IDT occurred on 05/25/18 and the second documented IDT was on 06/13/18. There was 19 days between the IDT meetings. Patient #12 was admitted on 05/09/18. The surveyor reviewed IDT documentation from 05/09/18 to 06/15/18. The first IDT occurred on 05/09/18 and the second documented IDT was on 05/31/18. There was 22 days between the IDT meetings. Patient #14 was admitted on 04/15/18. The surveyor reviewed IDT documentation from 04/15/18 to 06/15/18. The patient record contained documentation of IDT reviews, the first that occurred on 05/17/18. This was 38 days after 04/15/18 admission date. 2. The surveyor reviewed the agency policy on home health and hospice interdisciplinary team meetings (IDT). The policy states the IDT meets no less than every other week and that patient discussion, decisions and changes in the care plan are documented in the electronic health record. 3. The surveyor interviewed Staff J on 06/14/18 at 1:30pm. The surveyor asked if there was another location in the patient record that the IDG might be located. The Staff J stated, "The Case Manager was the team member responsible to document the IDG and that if the Case Manager was not at the IDG the documentation may have fallen through the cracks, so 2 or 3 months ago, they started having the Social Worker cover when the Case Manager was away."	L 533	See page 14 for L 533	

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L 533	Continued From page 16 4. The surveyor interviewed Staff H on 06/16/18 at 2:00pm. Staff H was unable to locate the missing documentation and acknowledged documentation of assessment updates from the IDG's are missing. The agency Director and Administrator acknowledged these findings on 06/18/18.	L 533	See page 14 for L 533	
L 538	IDG, CARE PLANNING, COORDINATION OF SERVICES CFR(s): 418.56 The plan of care must specify the hospice care and services necessary to meet the patient and family-specific needs identified in the comprehensive assessment as such needs relate to the terminal illness and related conditions. This STANDARD is not met as evidenced by: Based on policy review, record review and interview, the Agency failed to document ordered volunteer and comfort services on the Plan of Care (POC) for 7 of 20 sample patients, (Patient's #13, 14, 15, 16, 17, 18, and 19). Failure to identify and document these patient-specific non-skilled services on the POC has the potential to misrepresent the true status/condition of the patient. Background: 1. An agency policy entitled: Hospice: Volunteer Policy (page 3, #8), Volunteer Scope of Practice states, "Volunteer Services may provide non-skilled direct patient care as necessary to relieve the care giver for respite purposes" such	L 538	See page 18 for L 538	

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L 538	Continued From page 17 as providing stand-by assistance with transfers, giving fluids and assisting with feeding the patient, performing light household chores, or preparing meals. Volunteers may also provide companionship services for the patient. Another section of this policy entitled Referrals for Volunteer Services (Page 2, #5 (b) states "If a volunteer is desired, a member of that patient's care team completes the Volunteer Referral/Plan of Care form and submits it to a Volunteer Coordinator." Then (c), "The Volunteer Coordinator makes note of the assignment in the patient's chart, adding the appropriate documentation to the patient's Plan of care." 2. Comfort Services may include, but are not limited to, massage, aromatherapy, pet therapy, music therapy, etc. Any member (medical provider, RN, Social Worker, pastoral or other counselor) of the Interdisciplinary team (IDT) may make a referral and order for these services based upon information from the comprehensive assessment. Findings include: During 06/14/18 and 06/15/18, surveyors reviewed Plans of Care (POC's) for Patients #13, 14, 15, 16, 17, 18 and 19. 1. Patient #13 was admitted on 05/01/18. On 05/02/18, a referral was made for Comfort Services. Aromatherapy for this patient occurred on 05/04/18 and a massage visit occurred on 05/24/18. These therapies were not documented on the POC or patient response noted in the IDT meeting notes of 05/16/18 or 06/13/18.	L 538	Services for volunteer and comfort services are discussed during the admission process and reviewed during the IDT. The after-hours nursing staff are currently preforming admission record reviews daily. The admission nursing staff and after-hours nursing staff will be re-trained to ensure understanding of responsibility related to expected record completion and chart reviews. Each group will be provided a guiding document to ensure completion of required tasks. The after-hours nursing staff will notify both the admitting nurse and the Nurse Reviewer when documentation is not completed. The Supervisors will retain a list of all active patients to ensure that each patient is reviewed within the 15-day requirement. In addition, the Supervisor or Nurse Reviewer will audit records for documentation completion. The electronic charting template (EPIC) will be revised to include option for the volunteer and comfort therapy to be an entry option for the RN to include on the patient's plan of care. Audit processes will ensure ongoing compliance. The Nurse Auditor will track and report non-compliance for newly admitted patients to the Supervisor daily. Supervisors will review weekly random patient records presented at IDT to ensure ongoing compliance. Expectations will be communicated at all IDT meetings the week of July 09, 2018. Audits will begin the week of July 9, 2018.	

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	501508	A. BUILDING _____ B. WING 0938-0391	06/18/2018

DEPARTMENT OF HEALTH AND HUMAN SERVICES
APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES OME

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L 538	Continued From page 18 On 05/31/18, the Social Worker (MSW) made a referral for Volunteer Services for this patient and received a volunteer visit on 06/08/18. The volunteer did document the visit in a designated are of the Electronic Medical Record, however, there was no documentation within the POC or IDT meeting notes of 06/13/18 for this service or the effectiveness or outcome for the patient. 2. Patient #14 was admitted on 04/15/17 and died on 05/31/17. A Comfort Services visit occurred on 04/18/17. The practitioner did document the visit in a designated area of the Electronic Medical Record, however, there was no documentation within the POC or IDT meeting notes of 05/17/17 and 05/31/17 for this service or the effectiveness or outcome for the patient. 3. Patient #15 was admitted on 02/28/18 and died on 03/08/18. A Comfort Services referral was made on 02/28/18, but was not incorporated within the POC of 02/28/18, nor did the IDT notes of 02/28/18 reflect discussion of patient response to this service. 4. Patient #16 was admitted on 11/07/17. The patient received comfort therapy services on 11/14/17, 01/02/18, and 03/15/18. There was no documentation of these services on the POC or corresponding IDT notes of 11/15/17, 01/10/18, or 03/21/18 reflecting discussion of patient response to this service. 5. Patient #17 was admitted on 03/10/17. The patient received comfort therapy services on 01/02/18. There was no documentation of these services on the POC or corresponding IDT notes of 01/10/18 or 01/20/18 reflecting discussion of patient response to this service.	L 538	See page 18 for L 538	

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L 538	Continued From page 19 6. Patient #18 was admitted on 04/21/18. The patient received comfort therapy services on 05/02/18 and 05/17/18. There was no documentation of these services on the POC or corresponding IDT notes of 05/30/18 reflecting discussion of patient response to this service. 7. Patient #19 was admitted on 08/01/17. The patient received comfort therapy services on 08/08/17. There was no documentation of these services on the POC or corresponding IDT notes of 08/24/17 or 09/07/17 reflecting discussion of patient response to this service. On 06/18/18, Staff I and Staff H reviewed these records and agreed with these findings. On 06/18/18 at 1:00 pm, the Clinical Supervisor stated it was the policy of the Hospice that all services are documented on the POC, and all services are reviewed at the IDT meetings for as long as the service is being utilized by the patient. The agency Director and Administrator acknowledged these findings on 06/18/18.	L 538	See page 18 for L 538	
L 543	PLAN OF CARE CFR(s): 418.56(b) All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs if any of them so desire.	L 543	See page 21 for L 543	

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L 543	Continued From page 20 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to follow the plan of care for 3 of 20 patients (Patient's #2, #7 and #17). Failure to follow the plan of care placed patients and family members at risk of not receiving the care and services ordered. Findings include: 1. The surveyor reviewed patient records on 06/13/18 - 06/15/18 and 06/18/18 and noted the following: Patient #2 was admitted on 04/20/18. The Hospice Aide (HA) orders were for 1 time a week for 13 weeks beginning 04/24/18. There was no documentation of the HA visit for the week of 06/03/18- 06/09/18. There is no documentation concerning the missed visit. There is 1 missed visit. Patient #7 was admitted on 11/3/17. The patient record contains documentation of a Chaplin visit on 05/29/18. There was no order in the patient record for the Chaplin to visit Patient #7. Patient #17 was admitted on 03/10/17. The Social Worker orders were for 2 times per month for 2 months with 4 prn for caregiver support and community resources. The Social Worker made one visit on 05/17/18. There were no further visits recorded for May and no visits recorded up to 06/14/18. There is no documentation explaining the missed visit. 2. The surveyor interviewed Staff H on 06/15/18 at 2:00pm. Staff H was unable to locate	L 543	Education occurred the week of July 2, 2018 with staff regarding proper documentation when scheduled visits are missed. The scheduling department will run weekly missed visit reports and notify staff and supervisors of missing documentation. Weekly reports will be sent to the Supervisors to monitor ongoing compliance as standard work. Expectations were communicated to all staff the week of July 2 and July 09, 2018. Missed visit report tracking began the week of July 2, 2018. The Interim Director and Vice President are ultimately responsible for the plan of correction and ongoing overall compliance.	

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L 543	Continued From page 21 documentation explaining the late visits and was unable to locate an order for the Chaplin visit. The agency Director and Administrator acknowledged these findings on 06/18/18.	L 543	See page 21 for L 543	
L 711	INPATIENT CARE PROVIDED UNDER ARRANGEMENTS CFR(s): 418.108(c)(1) If the hospice has an arrangement with a facility to provide for short-term inpatient care, the arrangement is described in a written agreement, coordinated by the hospice and at a minimum specifies- (1) That the hospice supplies the inpatient provider a copy of the patient's plan of care and specifies the inpatient services to be furnished; This STANDARD is not met as evidenced by: Based on policy review, record review and interview, the Hospice failed to ensure 1 of 1 (Patient #18) sample patient residing in a Skilled Nursing Facility (SNF) had a Hospice Plan of Care (POC) available to SNF staff. This failure has the potential to negatively impact patient needs due to lack of understanding of the hospice process for a specific patient. Findings include: 1. On 06/14/18, the Hospice policy entitled Coordination of Care with Facility Staff (last revised 01/2016) and the Hospice Services Agreement (initiated 11/2016) were reviewed.	L 711	See page 23 for L 711	

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L 711	Continued From page 22 a) On 11/09/16, the Hospice entered into an Agreement with SNF A to deliver services to Patient #18. b) The Agreement stipulates that the Hospice "shall furnish Facility with a copy of the Hospice POC within 24 hours of 1) its completion or 2) Hospice patient's admission to facility, whichever is later." c) The Hospice Policy states on page 1, "A. On the initial hospice visit, the plan of care will be developed and coordinated with facility personnel." d) Also, the policy states "A contact note will be made in the facility chart by each discipline for each visit to the resident." 2. On 06/12/18, the surveyor made a visit to SNF A to see Patient #18, along with Staff E, RN. After the patient visit, the surveyor and Staff E went to the nurse's station at 01:30 pm to coordinate with the Facility charge nurse regarding care and patient status. a) The Facility has a Hospice binder for each individual patient receiving Hospice care. b) The surveyor noted the visit entries by hospice disciplines, however noted there was no POC within the binder as required. c) The Facility charge nurse was asked if the POC could be in a different location. The charge nurse looked to see if it had been scanned into the electronic medical record (EMR). The POC was also absent from the EMR. d) The POC was not able to be located in the nursing station or in the patient's Facility clinical record. e) At 02:00 pm, Staff E stated they knew it was Hospice policy to send the POC within the first 24 hours after POC development, but could not	L 711	The Case Management staff are responsible for ensuring compliance regarding documentation that the plan of care was provided to the SNF and providing the SNF with an updated plan of care post IDT. Supervisors will audit SNF patient records presented at the weekly IDT to validate proper documentation. The Liaison Team will conduct random audits of SNFs to validate presence of updated plan of care. Expectations will be communicated at all IDT meetings the week of July 2 and July 09, 2018. Audits will begin the week of July 9, 2018. The Interim Director and Vice President are ultimately responsible for the plan of correction and ongoing overall compliance.	

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L 711	Continued From page 23 explain the absence. The agency Director and Administrator acknowledged these findings on 06/18/18.	L 711	See page 23 for L 711	
L 715	INPATIENT CARE PROVIDED UNDER ARRANGEMENTS CFR(s): 418.108(c)(5) [If the hospice has an arrangement with a facility to provide for short-term inpatient care, the arrangement is described in a written agreement, coordinated by the hospice and at a minimum specifies-] (5) That the hospice retains responsibility for ensuring that the training of personnel who will be providing the patient's care in the inpatient facility has been provided and that a description of the training and the names of those giving the training is documented; This STANDARD is not met as evidenced by: Based on policy review, record review and interview, the Hospice failed to ensure Skilled Nursing Facility (SNF) staff were educated to the Hospice philosophy and method of care for 1 of 1 Hospice patient (Patient #18) who resided in SNF A. This failure has the potential to negatively impact patient needs due to lack of understanding of the hospice process for a specific patient. Findings include: 1. On 06/14/18, the Hospice contract entitled Hospice Services Agreement and the Hospice policy entitled Coordination of Care with Facility	L 715	See page 25 for L 715	

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L 715	Continued From page 24 Staff (last revised 01/2016) were reviewed. a) On 11/09/16 the Hospice entered into an Agreement with SNF A to deliver services to Patient #18. b) The Hospice Agreement stipulates that the "hospice shall assure that Facility staff furnishing care to Hospice Residents who are under Hospice's care are educated in the Hospice philosophy, including policies and procedures regarding methods of comfort, pain control, symptom management as well as principles about death and dying, individual response to death, patient rights, appropriate forms, and applicable record keeping requirements." c) The Hospice policy entitled Coordination of Care with Facility Staff stated on page 2, there will be "ongoing education by the hospice staff to facility staff concerning hospice philosophy and interventions and other care or end-of-life matters." 2. On 06/14/18, a document entitled 'Multicare Hospice & Home Health Community Education Tracking Tool' for 2016, 2017, and 2018, (through June 2018) was received from the interim Hospice Director. a) The document listed the agencies presented to; what topic was covered; the presenter's name; date and time of presentation; and the number of attendee's. b) SNF A was not documented as present in any of the 3 documents. 3. On 06/12/18, the surveyor made a visit to SNF A to see Patient #18, along with Staff E, RN. During an interview at 01:00 pm with the Skilled Nursing Facility (SNF) Employee at SNF A, the	L 715	Hospice will provide training on the Hospice Philosophy and method of care for patients receiving care at an inpatient facility. Validation that the facility has been educated will be reviewed upon patient admission or when an existing patient transfer to a facility. If a facility is listed as not having received the education, the Hospice Liaison will provide it as soon as possible and convenient to the facility. The Liaison Team will conduct random audits of facilities to validate that the education completed. Expectations and education to all involved staff occurred the week of July 09, 2018. The Interim Director and Vice President are ultimately responsible for the plan of correction and ongoing overall compliance.	

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L 715	Continued From page 25 surveyor inquired about staff education regarding the Hospice process. a) The SNF Employee K was not aware of any education being provided either individually or as a group to Facility staff. b) On 06/12/18 at 02:30 pm, the surveyor interviewed Skilled Nursing Facility (SNF) Employee L, a caregiver for SNF A. SNF Employee L was caring for Patient #18 that evening. When asked about receiving any training in Hospice philosophy while caring for Patient #18, SNF Employee L stated no training had occurred in the Facility to their knowledge. The agency Director and Administrator acknowledged these findings on 06/18/18.	L 715	See page 25 for L 715	

Medicare Hospice Recertification Plan of Correction Exhibit A

June 6, 2018

CoP/ Tag	Prefix Tag	Regulation/ Topic	Deficiencies	***HOW*** **the deficiency will be corrected**	***WHO*** **is responsible for making the correction**	***WHAT*** **will be done to prevent reoccurrence**	***HOW*** **you will monitor for continued compliance**	***WHEN*** **the correction will be completed**
42 CFR 418.54	**L520**	**Initial and Comprehensive Assessment of Patients** This CONDITION is not met as evidenced by: §42CFR 418.54 Initial and comprehensive assessment of the patient.	Based on review of patient records, policies and procedures and staff interviews, it was determined that the Hospice Agency failed to complete the comprehensive assessment no later than 5 calendar days after election of hospice care (L523). The Hospice Agency failed to ensure review of actual or potential drug interactions was documented per agency policy (L530). The Hospice Agency failed to ensure initial bereavement risk assessments were completed (L531). The Hospice Agency failed to ensure the comprehensive assessment was updated no less frequently than every 15 days (L533). The cumulative effect of these systemic practices resulted in the agency's failure to ensure patients' individualized end of life needs would be met.	Please see each individual plan of correction below for L523, L530, L531 and L533	Kit Hughes, Interim Director; Lynn Siedenstrang, Vice President	Please see each individual plan of correction below for L523, L530, L531 and L533	Please see each individual plan of correction below for L523, L530, L531 and L533	Please see each individual plan of correction below for L523, L530, L531 and L533
418.54(b)	**L523**	**TIMEFRAME FOR COMPLETION OF ASSESSMENT** The hospice interdisciplinary group, in consultation with the individual's attending physician (if any), must complete the comprehensive assessment no later than 5 calendar days after the election of hospice care in accordance with §418.24.	This STANDARD is not met as evidenced by: Based on review of patient records and interview with agency staff, the agency failed to ensure the initial comprehensive assessment visits were completed within 5 days of admission by its Chaplains staff for 2 of 20 patients in the survey sample (Patients #4 and #9).	Education occurred the week of July 2, 2018 with Chaplain staff regarding proper documentation within the 5 day time requirement. The education included the requirement to document refused or request to reschedule visits. The Nurse Reviewer will be provided a list of daily admissions for audit completion beginning July 3, 2018.	Kit Hughes, Interim Director; Lynn Siedenstrang, Vice President	Education occurred with staff on documentation expectations. Audits will occur for 100% of all new patients to ensure compliance with documentation within the 5 day time requirement.	Nurse Reviewer, in collaboration with Hospice Supervisor will track and report team assessments completed on day 3 for 100% of all newly admitted patients and notify remaining staff of needed documentation. This new audit process at day 3 will continue as a permanent process on all new admissions.	Education to staff occurred the week of July 2, 2018.
418.54 (c) (6)	**L530**	**CONTENT OF COMPREHENSIVE ASSESSMENT** [The comprehensive assessment must take into consideration the following factors:] (6) Drug profile. A review of all of the patient's prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following: (i) Effectiveness of drug therapy (ii) Drug side effects (iii) Actual or potential drug interactions (iv) Duplicate drug therapy (v) Drug therapy currently associated with laboratory monitoring.	This STANDARD is not met as evidenced by: Based on policy review, record review and interview, the Agency failed to ensure comprehensive review and reconciliation of medications with drug to drug interactions for 8 of 20 patients (Patient's #3, 5, 6, 7, 8, 9, 10, and 14). This failure potentially places patients at risk for harm due to adverse drug interactions.	The after-hours nursing staff are currently performing admission record reviews daily. The admission nursing staff and after-hours nursing staff will be re-trained to ensure understanding of responsibility related to expected record completion and chart reviews. Each group will be provided a guiding document to ensure completion of required tasks. The after-hours nursing staff will notify both the admitting nurse and the Nurse Reviewer when medication reconciliation is not completed. In addition, Case Managers will be educated and held accountable to review, document and communicate to the provider any major drug interactions for all patients receiving ongoing services.	Kit Hughes, Interim Director; Lynn Siedenstrang, Vice President	The admission chart review expectations, audits and follow-up will be a required part of the standard work for the after-hours nursing staff and the Nurse Reviewer. All gaps in medication reconciliation for new patients will be reported by the Nurse Reviewer to the Supervisor. For ongoing patients on service, documentation of medication reconciliation and major drug interactions will also be reviewed during the Interdisciplinary Team Meeting (IDT) which occurs on every patient no more than every 15 days.	After hours nursing staff will audit and report drug to drug interactions for 100% of all newly admitted patients to Supervisor daily. After hours auditor will report to admitting RN and Supervisor any non-compliance with medication reconciliation. This audit process will continue as a permanent process on 100% of all new admissions. Weekly, Supervisors will randomly review patient records presented at IDT to ensure ongoing compliance.	Education to after-hours nursing staff occurred on or before July 6, 2018. Expectations will be communicated at all IDT meetings the week of July 2 and July 9, 2018.

Medicare Hospice Recertification Plan of Correction Exhibit A

June 6, 2018

CoP/ Tag	Prefix Tag	Regulation/ Topic	Deficiencies	*HOW* the deficiency will be corrected	*WHO* is responsible for making the correction	*WHAT* will be done to prevent reoccurrence	*HOW* you will monitor for continued compliance	*WHEN* the correction will be completed
418.5 (c) (7)	**L531**	**CONTENT OF COMPREHENSIVE ASSESSMENT** [The comprehensive assessment must take into consideration the following factors:] (7) Bereavement. An initial bereavement assessment of the needs of the patient's family and other individuals focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the patient's death. Information gathered from the initial bereavement assessment must be incorporated into the plan of care and considered in the bereavement plan of care.	This STANDARD is not met as evidenced by: Based on record review and interview, the Agency failed to ensure bereavement risk assessments were completed as part of the initial comprehensive assessment for 2 of 20 patients (Patient's #9 and #17). This failure has the potential to delay or overlook the needs of the patient's family and others in their ability to cope with the patient's death.	The after-hours nursing staff are currently performing admission record reviews daily. The admission nursing staff and after-hours nursing staff will be re-trained to ensure understanding of responsibility related to expected record completion and chart reviews. The after-hours nursing staff will notify both the admitting nurse and the Nurse Reviewer when bereavement risk assessment is not completed. In addition, Bereavement staff will notify Supervisor of missing assessments as a secondary audit.	Kit Hughes, Interim Director; Lynn Siedenstrang, Vice President	The admission chart review expectations, audits and follow-up for 100% of all new admission will be a required part of the standard work for the after-hours nursing staff and the Nurse Reviewer. All gaps in bereavement risk assessments for new patients will be reported by the Nurse Reviewer to the Supervisor.	Nurse Auditor will track and report non-compliance for newly admitted patients to Supervisor daily. Supervisors will review weekly random patient records to ensure ongoing compliance. This audit will remain as a permanent process on 100% of new admissions.	Education to after-hours nursing staff occurred on or before July 6, 2018. Expectations will be communicated at all IDT meetings the week of July 2 and July 11, 2018.
418.54 (d)	**L533**	**UPDATE OF COMPREHENSIVE ASSESSMENT** The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days.	This STANDARD is not met as evidenced by: Based on record review, policy review and interview the facility failed to ensure that the comprehensive assessment was updated by the hospice interdisciplinary group (IDG) every 15 days for 11 of 20 patients (Patient's #1, 2, 3, 4, 5, 8, 9, 10, 11, 12, and 14). Failure to review and/or update the comprehensive assessment as needed or no later than 15 days, may lead to patients not receiving the care and services in a timely, planned manner that could affect their comfort at the end of life.	Re-education and communication of documentation expectation occurred to all responsible disciplines accountable to IDT the weeks of July 2 and July 9, 2018. The Supervisors will retain a list of all active patients to ensure that each patient is reviewed within the 15 day requirement. In addition, the Supervisor or Nurse Reviewer will audit records for documentation completion.	Kit Hughes, Interim Director; Lynn Siedenstrang, Vice President	Updates to the comprehensive assessment will be documented by the IDT group within 24 hours of when the patient was discussed at IDT. The documentation expectations will be a required part of the standard work for the RN Case Managers. When an RN Case Manager cannot be present for a scheduled IDT, they are expected to report off to their Supervisor who will present the case on their behalf to ensure all patients are reviewed within the required timeline. All gaps in documentation will be reported to the Supervisor weekly	After-hours nursing staff will conduct IDT note audits beginning week of 7/23/18 to ensure compliance with the less than 15 day requirement to update the comprehensive assessment. This review will be done on 100% of patients for each case manager. Once sustained compliance is achieved for 3 consecutive months, random audits will occur to validate ongoing compliance.	Expectations will be communicated at all IDT meetings the week of July 2 and July 09, 2018.

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418.56	**L538**	**IDG,CARE PLANNING,COORDINATION OF SERVICES** The plan of care must specify the hospice care and services necessary to meet the patient and family-specific needs identified in the comprehensive assessment as such needs relate to the terminal illness and related conditions.	This STANDARD is not met as evidenced by: Based on policy review, record review and interview, the Agency failed to document ordered volunteer and comfort services on the Plan of Care (POC) for 7 of 20 sample patients, (Patient's #13, 14, 15, 16, 17, 18, and 19). Failure to identify and document these patient-specific non-skilled services on the POC has the potential to misrepresent the true status/condition of the patient.	Services for volunteer and comfort services are discussed during the admission process and reviewed during the IDT. The after-hours nursing staff are currently preforming admission record reviews daily. The admission nursing staff and after-hours nursing staff will be re-trained to ensure understanding of responsibility related to expected record completion and chart reviews. Each group will be provided a guiding document to ensure completion of required tasks. The after-hours nursing staff will notify both the admitting nurse and the Nurse Reviewer when documentation is not completed. The Supervisors will retain a list of all active patients to ensure that each patient is reviewed within the 15 day requirement. In addition, the Supervisor or Nurse Reviewer will audit records for documentation completion.	Kit Hughes, Interim Director; Lynn Siedenstrang, Vice President	The electronic charting template (EPIC) has been revised to include option for the volunteer and comfort therapy to be an entry option for the RN to include on the patient's plan of care. Review of volunteer and comfort care services on the plan of care has been added to the audit review tool used by the after hours nurse auditors. The after hours nurse auditors will report non compliance to the Nurse Reviewer and Supervisor on 100% of new admissions as a permanent process. Audit processes will ensure ongoing compliance.	The Nurse Auditor will audit 100% of all new admissions and report non-compliance for newly admitted patients. Weekly, Supervisors will randomly review patient records presented at IDT to ensure ongoing compliance.	Expectations will be communicated at all IDT meetings the week of July 09, 2018. Audits will begin the week of July 9, 2018.
418.56 (b)	**L543**	**PLAN OF CARE** All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs if any of them so desire.	This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to follow the plan of care for 3 of 20 patients (Patient's #2, #7 and #17). Failure to follow the plan of care placed patients and family members at risk of not receiving the care and services ordered.	Education occurred the week of July 2, 2018 with staff regarding proper documentation when scheduled visits are missed. The scheduling department will run weekly missed visit reports and notify staff and supervisors of missing documentation.	Kit Hughes, Interim Director; Lynn Siedenstrang, Vice President	The scheduling department will run weekly reports for the Supervisors to monitor ongoing compliance.	Weekly reports will be sent to the Supervisors to monitor ongoing compliance as a permanent process on 100% of patients actively on service.	Expectations will be communicated to all staff the week of July 2 and July 09, 2018. Missed visit report tracking began the week of July 2, 2018.
418.108 (c) (1)	**L711**	**INPATIENT CARE PROVIDED UNDER ARRANGEMENTS** If the hospice has an arrangement with a facility to provide for short-term inpatient care, the arrangement is described in a written agreement, coordinated by the hospice and at a minimum specifies- (1) That the hospice supplies the inpatient provider a copy of the patient's plan of care and specifies the inpatient services to be furnished;	This STANDARD is not met as evidenced by: Based on policy review, record review and interview, the Hospice failed to ensure 1 of 1 (Patient #18) sample patient residing in a Skilled Nursing Facility (SNF) had a Hospice Plan of Care (POC) available to SNF staff.	Education occurred the week of July 2 and July 9, 2018 with Case Management staff at the IDT meetings regarding required documentation that plan of care was provided to SNF and providing SNF updated plan of care post IDT. Supervisors will audit SNF patient records to validate proper documentation of delivery of plan of care.	Kit Hughes, Interim Director; Lynn Siedenstrang, Vice President	Case Managers will provide a written plan of care to the facility following admission to Hospice services. Plan of care will be kept current with any updates following IDT meetings, with case manager delivering updating copy at next visit following IDT.	Weekly, Supervisors will review random patient records presented at IDT to ensure ongoing compliance with documentation. Supervisors will conduct two random weekly audits in collaboration with the liaison staff to validate presence of the updated plan of care in the facility. This will continue as a permanent process.	Expectations will be communicated at all IDT meetings the week of July 2 and July 09, 2018. Audits will begin the week of July 9, 2018.

Medicare Hospice Recertification Plan of Correction Exhibit A

June 6, 2018

CoP/ Tag	Prefix Tag	Regulation/ Topic	Deficiencies	***HOW*** **the deficiency will be corrected**	***WHO*** **is responsible for making the correction**	***WHAT*** **will be done to prevent reoccurrence**	***HOW*** **you will monitor for continued compliance**	***WHEN*** **the correction will be completed**
418.108 (c) (5)	**L715**	**INPATIENT CARE PROVIDED UNDER ARRANGEMENTS** [If the hospice has an arrangement with a facility to provide for short-term inpatient care, the arrangement is described in a written agreement, coordinated by the hospice and at a minimum specifies-] (5) That the hospice retains responsibility for ensuring that the training of personnel who will be providing the patient's care in the inpatient facility has been provided and that a description of the training and the names of those giving the training is documented;	This STANDARD is not met as evidenced by: Based on policy review, record review and interview, the Hospice failed to ensure Skilled Nursing Facility (SNF) staff were educated to the Hospice philosophy and method of care for 1 of 1 Hospice patient (Patient #18) who resided in SNF A. This failure has the potential to negatively impact patient needs due to lack of understanding of the hospice process for a specific patient.	Education occurred the week of July 9, 2018 with Supervisors and Liaison staff regarding the requirement for Hospice provided education to facilities. Hospice will provide training on the Hospice Philosophy and method of care for patients receiving care at an inpatient facility.	Kit Hughes, Interim Director; Lynn Siedenstrang, Vice President	Validation that the facility has been educated will be reviewed upon patient admission for 100% of all new clients or when an existing patient transfer to a facility. If a facility is listed as not having received the education, the Hospice Liaison will provide it as soon as possible and convenient to the facility.	Effective 7//23/18, the Liaison team is conducting 100% review of education provision in all facilities where patients currently on service reside. Going forward Liaison Team will be notified of 100% of new admissions for patients residing in a facility. Access Supervisor will ensure the Hospice Philosophy and Method of Care education is completed in the first week of service. This will be a permanent process.	Expectations will be communicated to all involved staff the week of July 09, 2018.

December 21, 2020

William "Bill" G. Robertson
President and CEO
MultiCare Health System
3901 S. Fife Street
Tacoma, WA 98403

Joint Commission ID #: 360248
Program: Home Care Accreditation
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed : 12/15/2020

Dear Mr. Robertson:

The Joint Commission is pleased to grant your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

Comprehensive Accreditation Manual for Home Care

This accreditation cycle is effective beginning October 3, 2020 and is customarily valid for up to 36 months. Please note, The Joint Commission reserves the right to shorten the duration of the cycle.

Should you wish to promote your accreditation decision, please view the information listed under the 'Publicity Kit' link located on your secure extranet site, The Joint Commission Connect.

The Joint Commission will update your accreditation decision on Quality Check®.

Congratulations on your achievement.

Sincerely,

Mark G. Pelletier, RN, MS
Chief Operating Officer and Chief Nurse Executive
Division of Accreditation and Certification Operations

Final Accreditation Report

MultiCare Health System
3901 S. Fife Street
Tacoma, WA 98403

Organization Identification Number: 360248
60-day Evidence of Standards Compliance Submitted: 12/15/2020

ESC Programs Reviewed
Home Care

The Joint Commission
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The Joint Commission
Executive Summary

Program	Submit Date	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Home Care	12/15/2020	No Requirements for Improvement	None	None

The Joint Commission
Requirements for Improvement Summary

Program: Home Care

Standard	Level of Compliance
IC.02.01.01	Compliant
MM.03.01.01	Compliant
NPSG.03.06.01	Compliant
NPSG.09.02.01	Compliant
PC.01.03.01	Compliant
PC.02.01.01	Compliant
PC.02.01.03	Compliant

The Joint Commission

Appendix

Standard and EP Text

Program: Home Care

Standard	EP	Standard Text	EP Text
IC.02.01.01	2	The organization implements the infection prevention and control activities it has planned.	The organization uses standard precautions, * including the use of personal protective equipment, to reduce the risk of infection. (See also EC.02.02.01, EP 4) Note: Standard precautions are infection prevention and control measures to protect against possible exposure to infectious agents. These precautions are general and applicable to all patients. Footnote *: For further information regarding standard precautions, refer to the website of the Centers for Disease Control and Prevention (CDC) at https://www.cdc.gov/hicpac/recommendations/core-practices.html (Infection Control in Healthcare Settings).
MM.03.01.01	2	The organization safely stores medications.	For organizations that store medications at their site(s): The organization stores medications according to the manufacturers' recommendations or, in the absence of such recommendations, according to a pharmacist's instructions. (See also MC.03.08.05, EP 1) Note: This element of performance is also applicable to sample medications.
NPSG.03.06.01	3	Maintain and communicate accurate patient medication information.	Compare the medication information the patient is currently taking with the medications ordered for the patient in order to identify and resolve discrepancies. Note: Discrepancies include omissions, duplications, contraindications, unclear information, and changes. A qualified individual, identified by the organization, does the comparison. (See also HR.01.06.01, EP 1)
NPSG.03.06.01	4	Maintain and communicate accurate patient medication information.	Provide the patient (or family as needed) with written information on the medications the patient should be taking when he or she leaves the organization’s care (for example, name, dose, route, frequency, purpose).
NPSG.09.02.01	1	Reduce the risk of falls.	Assess the patient’s risk for falls.
PC.01.03.01	5	The organization plans the patient’s care.	The written plan of care is based on the patient’s goals and the time frames, settings, and services required to meet those goals.
PC.02.01.01	2	The organization provides care, treatment, or services for each patient.	Staff provide care, treatment, or services in accordance with professional standards of practice, law, and regulation. For home health agencies that elect to use The Joint Commission deemed status option: All home health services must also be provided in accordance with current clinical practice guidelines.

The Joint Commission

Standard	EP	Standard Text	EP Text
PC.02.01.03	1	The organization provides care, treatment, or services in accordance with orders or prescriptions, as required by law and regulation.	Prior to providing care, the organization obtains or renews orders (verbal or written) from a licensed independent practitioner in accordance with professional standards of practice and law and regulation.