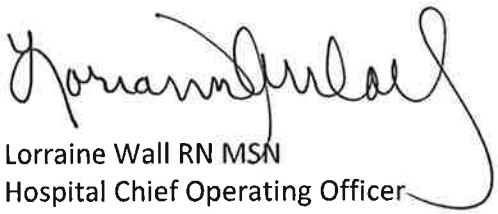
WASHINGTON STATE CERTIFICATE OF NEED PROGRAM
RCW 70.38 AND WAC 246-310

APPLICATION FOR CERTIFICATE OF NEED
HOSPICE PROJECTS
(excludes amendments)

Certificate of Need applications must be submitted with a fee in accordance with the instructions on page 2 of this form.

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

Signature and Title of Responsible Officer:	**Person To Whom Questions Regarding This Application Should Be Directed:**
 Lorraine Wall RN MSN Hospital Chief Operating Officer Olympic Medical Center **Date: December 28, 2018**	Lorraine Wall RN MSN Hospital Chief Operating Officer Olympic Medical Center **Telephone Number:** 360-417-7162
Legal Name of Applicant: Clallam County Public Hospital District #2 dba Olympic Medical Center **Address of Applicant:** Olympic Medical Center 939 Caroline Street Port Angeles WA 98362 **Telephone Number:**	**Type of Project (check all that apply):** [x] New Agency [ ] Existing Medicare Certified/Medicaid Eligible Agency Expanding into Different County [ ] Existing Licensed-Only Hospice Agency to Become Medicare Certified/Medicaid Eligible
Project Summary: Establishment of a new Medicare-certified hospice agency to serve residents of Clallam County, Washington **Estimated capital expenditure:** $ $136,300	

INSTRUCTIONS FOR SUBMISSION:

1. Mail an original and one copy of the completed application, with narrative portion to:

Department of Health
Certificate of Need Program
2725 Harrison Avenue, Suite 500
P O Box 47852
Olympia, Washington 98504-7852

The application must be accompanied by a check, payable to: ***Department of Health.*** This check is for the review fee as identified on the **enclosed fee schedule.**

2. COMPLETE THE FOLLOWING PRIOR TO SUBMISSION FOR REVIEW:

TOTAL AMOUNT OF FEE ACCOMPANYING THIS APPLICATION:

PROCESSING FEE: $21,968

APPLICANT NAME: Olympic Medical Center

DATE OF SUBMISSION: December 28, 2018 CHECK NUMBER: 385730

APPLICATION INFORMATION INSTRUCTIONS:

These application information requirements are to be used in preparing a Certificate of Need application. The information will be used to evaluate the conformance of the project with all applicable review criteria contained in RCW 70.38.115 and WAC 246-310-210, 220, 230, and 240.

- The application is to be submitted together with a completed, signed Certificate of Need application face sheet and the appropriate review and processing fee. Please send an original and one copy to:

  Department of Health
  Certificate of Need Program
  111 Israel Rd. S.E.
  Tumwater, WA 98501
  P O Box 47852
  Olympia, Washington 98504-7852

- Please note that a **Letter of Intent** must be submitted for all projects, within a minimum of 30 days and a maximum of 6 months, prior to submission of the application. If a Letter of Intent is not received prior to application submission, the department will consider the application the Letter of Intent and no further action will be taken until the end of the 30 day Letter of Intent period.

- Please make the narrative information complete and concise. Data sources are to be cited Extensive supporting data, that tends to interrupt the narrative, should be placed in the appendix.

- DO NOT bind the application.

- Please number **ALL** pages consecutively.

- All cost projections are to be in non-inflated dollars. Use the current year dollar value for all program data and projections. **DO NOT** inflate these dollar amounts.

- Capital expenditures should not include contingencies. Certificate of Need statutes and regulations allow a 12 percent or $50,000.00 *(whichever is greater)* margin before an amendment to an approved Certificate is required.

- All subsequent correspondence in relation to the application must be submitted with an original and one copy.

Please contact Facilities and Services Licensing, Department of Health, for information on licensure requirements.

Overview

Olympic Medical Center requests approval to establish a Medicare-certified hospice agency in Clallam County, Washington. Olympic Medical Center (OMC) is a public hospital district that operates a 67-bed acute care hospital and related services in Clallam County, Washington. OMC (Clallam County Public Hospital District No. 2) is a comprehensive health care provider for more than 70,000 residents of Clallam County. Locally-owned and operated since 1951, it is a sole community hospital and rural referral center as designated by Medicare. Located in Port Angeles, Washington, the hospital also serves residents of Sequim and surrounding North Olympic Peninsula communities of Clallam County and western Jefferson County.

The Department of Health has determined since 2015 that there is need for additional Medicare hospice capacity in Clallam County. The Department's Hospice Need Method forecasts this need when a county's hospice providers collectively fall below the state average of hospice utilization in light of the projected population of the county. OMC's application provides documentation that it currently serves many terminally-ill residents of Clallam County who could appropriately receive hospice care.

Olympic Medical Center currently operates Olympic Medical Home Health, a Medicare-certified home health agency that made 48,000 home visits in 2017 to homes throughout Clallam and western Jefferson counties. A successful application to establish Olympic Medical Hospice will result in an additional hospice option for OMC's many terminally-ill home health patients.

In light of the Department's current determination of need, this application emphasizes the manner in which OMC intends to develop and expand hospice services that will meet it. Clallam County residents have experienced limited access to Medicare hospice services. This application will discuss those current limitations and describe what OMC and its home health and hospice division will do to address those.

As Olympic Medical Center develops its hospice program, it has adopted four goals tailored to the unique needs and circumstances in the planning area:

- Goal 1: Recognize and seek opportunities for cooperative activities with key area providers including Forks Community Hospital, S'Klallam Tribal Health Clinic, North Olympic Healthcare Network, VIMO, and Volunteer Hospice of Clallam County.
- Goal 2: Actively address and overcome negative views of Medicare hospice held by many area providers and community members.
- Goal 3: Assure OMC's existing patients considering hospice are offered informed choice as required by CMS.
- Goal 4: Build toward inpatient hospice care for the many area residents who face terminal illness but have no local family or caregivers in their own homes.

I. APPLICANT DESCRIPTION:

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

The legal name of the applicant is Clallam County Public Hospital District #2 doing business as Olympic Medical Center.

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

Olympic Medical Center does not currently operate a hospice agency; therefore, the applicant is not an existing hospice facility.

Olympic Medical Center operates a Medicare-certified home health agency, with offices located near the main hospital campus, at 801 East Front Street, Port Angeles WA 98362.

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

The applicant is a Washington public hospital district.

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

The owning entity at completion of the project is the same as the applicant. Address:

Olympic Medical Center
939 Caroline Street
Port Angeles WA 98362

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

The operating entity at completion of the project will be the same as the applicant.

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

Please see Appendix B for an OMC organization chart showing the organization relationship to related parties.

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

1. Sequim Medical Plaza – 777 N. 5th Ave., Sequim 98362
2. Medical Services Building – 840 N. 5th Ave., Sequim 98362
3. Olympic Medical Cancer Center – 844 N. Fifth Ave., Sequim 98362
4. Medical Office Building – 907 Georgiana St., Port Angeles 98382
5. OMC Physical Therapy – 321 Chambers St., Port Angeles 98382
6. OMC Primary Care Clinic – 8th & Vine – 433 E. 8th St., Port Angeles 98382
7. Cherry St. Pediatric Clinic – 303 W. 8th St., Port Angeles 98383 (?)
8. OMC Imaging Center – 1102 Front St., Port Angeles 98382
9. Sequim Physical Therapy/Primary Care – 800 N. 5th Ave., Sequim 98362
10. OMC Radiology/Lab at Jamestown Health Clinic – 808 N. 5th Ave., Sequim 98362 (not owned by OMC)
11. OMC Lung Center – 1112 Caroline St., Port Angeles 98382

H. For existing facilities, identify the geographic primary service area.

The primary geographic service area of Olympic Medical Center is Clallam County, Washington.

I. Identify the facility licensure/accreditation status.

OMC is licensed as an acute care hospital and is accredited by DNV GL:

a) Licensure
OMC is licensed by the Washington Department of Health as an acute care hospital.

b) Accreditation
- DNV GL Accreditation
Olympic Medical Center
Port Angeles, WA 98362
Effective Date of Accreditation: 04/11/2017
Expiration Date of Accreditation: 04/11/2020
- ISO Certification
Effective Date of Certification: 8/25/2017
Expiration Date of Certification: 8/25/2020

The proposed hospice will be licensed as a Washington in-home services agency/hospice and will be Medicare-certified.

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

Yes, and the proposed hospice will be also be reimbursed under Titles XVIII and XIX of the Social Security Act.

K. Identify the medical director and provide his/her professional license number, and specialty represented.

A medical director for the proposed hospice will be identified upon receipt of a hospice Certificate of Need. The medical director job description and qualifications are provided at Appendix C.

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

Search and recruitment activities for an OMH medical director are under way.

Final selection and hiring of the medical director for the Clallam County Medicare-certified hospice will be undertaken upon receipt of a Certificate of Need.

The Medical Director will be a hospital employee. Please see Appendix C for a copy of the proposed medical director job description and position requirements.

Projected FTE for each year of the position and resulting annual compensation based on a full-time salary of $216,000:

OMH Medical Director, projected FTE and compensation:

Year	Projected FTE	Annual Compensation @ $216,000 Full Time Salary
2020	.2	$43,200
2021	.2	$43,200
2022	.3	$64,800

M. For existing facilities, please provide the following information for each county currently serving:

1. total number of unduplicated hospice patients served per year for the last three years;
2. average length of stay (days) per patient per year for the last three years;
3. median length of stay; and
4. average daily census per year for the last three years.

Olympic Medical Center does not operate an existing hospice facility.

II. PROJECT DESCRIPTION

Include the following elements in the project description. An amendment to a Certificate of Need is required for certain project modifications as described in WAC 246-310-100(1).

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

Name of the proposed hospice facility will be Olympic Medical Hospice.

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

Approval is sought for establishment of a Medicare-certified and Medicaid-approved hospice to serve the residents of Clallam County, Washington.

C. List new services or changes in services represented by this project. Please indicate which services would be provided directly by the agency and which services would be contracted.

The table below lists the scope of services comprising Medicare hospice and indicates which will be provided directly or will be contracted.

New Services	Medicare Hospice	Provided directly	Contracted
Nursing care	Required	x	
Medical social worker	Required	x	
Speech-language pathology services	Required	x	
Physical and occupational therapies	Required	x	
Dietary	Required		x
Pastoral care	Required		x
Home care aide	Required	x	
Interdisciplinary team	Required		
Case management	Required	x	
Medical Director	Required	x	
Medical appliances and supplies, including drugs and biologicals	Required	x	
Inpatient hospital care for procedures necessary for pain control and acute and chronic system management	Required	x	
Inpatient (nursing home) respite care to relieve home caregiver as necessary	Required	x	
24-hour continuous care in the home at critical periods	Required	x	
Bereavement service for the family for 13 months	Required	x	
Available to nursing home residents??	Yes	x	

The hospice interdisciplinary group must include, but is not limited to, individuals who are qualified and competent to practice in the following professional roles:

- A doctor of medicine or osteopathy (who is an employee or under contract with the hospice).
- A registered nurse.
- A social worker.
- A pastoral or other counselor.
- Physical therapy services, occupational therapy services, and speech-language pathology services must be available, and when provided, offered in a manner consistent with accepted standards of practice.
- Volunteers must provide day-to-day administrative and/or direct patient care services in an amount that, at a minimum, equals 5 percent of the total patient care hours of all paid hospice employees and contract staff. The hospice must maintain records on the use of volunteers for patient care and administrative services, including the type of services and time worked.

A hospice must be primarily engaged in providing the following care and services and must do so in a manner that is consistent with accepted standards of practice:

- Nursing services.
- Medical social services.
- Physician services.
- Counseling services, including spiritual counseling, dietary counseling, and bereavement counseling
- Hospice aide, volunteer, and homemaker services.
- Physical therapy, occupational therapy, and speech-language pathology services.
- Short-term inpatient care.
- Medical supplies (including drugs and biologicals) and medical appliances.

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

The proposed hospice will serve Clallam County patients requiring end-of-life care and support and, in particular, those who have elected to avail themselves of the Medicare hospice program or

Medicaid or private plans that are similar in organization, benefits, and payment arrangement.

E. List the equipment proposed for the project:
1. description of equipment proposed; and

Items	Estimated Expense
Furnishings	13,500.00
Telecommunications	2,500.00
Computers/Copiers/Printers	7,800.00
Total	**$23,800.00**

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

Not applicable. No equipment is being replaced.

F. Provide drawings of proposed project:
a. single line drawings, approximately to scale, of current locations which identify current department and services; and

Please see Appendix D for a single line drawing that shows the current configuration of the office space adjacent the proposed OMH offices.

b. single line drawings, approximately to scale, of proposed locations which identify proposed services and departments; and

Please see Appendix D for a single line drawing showing the proposed area of construction for the new OMH offices to be located in a one-story office building currently owned by Olympic Medical Center.

c. total net and gross square feet of project.

Office space for the proposed hospice is 600 net square feet. Net and gross area are the same for the proposed OMH office space.

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

Project Commencement

a) Patient care

Commencement of patient care by OMH is anticipated on January 1, 2020.

The care of the hospice patient does not take place in the hospital setting but in the patient's home. Since OMC's home health agency already cares for a large number of hospice-eligible patients, it is expected that the initial home visits by OMH staff will be made to those same terminally-ill patients in their homes who will have elected the Medicare hospice option.

b) Construction
OMC anticipates that project construction involving alterations to an existing office building owned by OMC will begin on receipt of a Certificate of Need or by January 1, 2020. If necessary to house minimal office functions needed to support the first month of hospice operation, temporary office space will be provided by the hospital.

Project Completion

a) Patient care
Based on WAC 246-310- 010(13) [1] initiation of hospice services will represent project completion on January 1, 2020.

b) Construction
Remodeling of existing office building space by OMC internal staff is anticipated to take one month.

Planning Horizon

The third full year of OMH operation will be 2022.

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

Olympic Medical Center's Strategic Plan, 2018-2020, provides substantial context for and support of its plan to initiate hospice services in 2020:

Of its key commitments, two relate to hospice care in particular:

> **We will support you – our patients** – in your choices. Through the Honoring Choices Pacific Northwest program, you have an opportunity to establish your preferences, so your family, loved ones and caregivers will know how you wish to be cared for if you are unable to communicate those wishes yourself. With this program comes our commitment to establishing end-of-life care options in addition to our life-saving capabilities.

[1] WAC 246-310- 010(13) provides the definition of "commencement" of the project.
"Commencement of the project" means whichever of the following occurs first: In the case of a construction project, giving notice to proceed with construction to a contractor for a construction project provided applicable permits have been applied for or obtained within. sixty days of the notice; beginning site preparation or development; excavating or starting the foundation for a construction project; or beginning alterations, modification, improvement, extension, or expansion of an existing building. In the case of other projects, initiating a health service." [underlining provided]

Ensure integration of services that focus on patient flow throughout our system for treatment and efficiencies.

Stated objectives of the OMC Strategic Plan that relate to establishment of a hospice include:

- *Continue "Honoring Choices Pacific Northwest" (an advanced care planning program) and implement an inpatient palliative care program with hospice beds by the end of 2018.*
- *Prevent unnecessary readmissions*
- *Further refine the home health experience for patients*
- *Invest in facilities and services in order to appropriately meet community need.*
- *Grow volume of services provided locally and mitigate threats to market share.*

Based on Department of Health's 2018 Hospice Need Method for Clallam County, OMC's new hospice will support its financial objectives by offering a needed service to many more area residents while covering the costs of care through reimbursement by the Medicare Hospice Program, Medicaid and private health insurers.

E. Provide documentation that the applicant has sufficient interest in the site or facility proposed. "Sufficient interest" shall mean any of the following:
   - clear legal title to the proposed site; or
   - a lease for at least one year with options to renew for not less than a total of three years; or
   - a legally enforceable agreement (i.e., draft detailed sales or lease agreement, executed sales or lease agreement with contingencies clause) to give such title or such lease in the event that a Certificate of Need is issued for the proposed project.

For documentation of OMC's ownership of the subject property, please see Appendix E.

III. PROJECT RATIONALE

Please address each county proposing to be served separately.

A. Need (WAC 246-310-210)

1. Identify and analyze the unmet hospice service needs and/or other problems toward which this project is directed.

a. identify the unmet hospice needs of the patient population in the proposed service area(s). The unmet patient need should not include physical plant and/or operating (service delivery) deficiencies; and

OMC has undertaken two analyses that demonstrate the scale of the current and projected shortfall in hospice care in the proposed service area. The two numerical analyses resulted in the following findings:

Method 1: Application of the Department of Health Hospice Need Methodology for forecasting need for additional hospice agencies in a planning area

First, the applicant calculated the projected Year 2020 need for additional hospice services in Clallam County as demonstrated through the Department of Health's current interpretation of the Hospice Need Methodology at WAC 246-310-290(7).

Calculating the eight required steps of the method with the Department's currently-posted results of its 2018 hospice provider survey showed the need for an additional Medicare-certified hospice agency in Clallam County.

WAC 246-310-290

Hospice services—Standards and need forecasting method.

(8) Need projection. The following steps will be used to project the need for hospice services.
(a) Step 1. Calculate the following two statewide predicted hospice use rates using department of health survey and vital statistics death data:
(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.
(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 the age of sixty-five by the average number of past three years statewide total deaths under sixty-five.
(b) Step 2. Calculate the average number of total resident deaths over the last three years for each planning area by age cohort.
(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.
(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 use rate to determine the potential volume of hospice use by the projected population by the two age cohorts identified in Step 1, (a)(i) and (ii) of this subsection using OFM data.
(e) Step 5. Combine the two age cohorts. Subtract the most recent three-year average 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.

(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.
(g) Step 7. Divide the unmet patient days from Step 6 by 365 to determine the unmet need ADC.
(h) Step 8. Determine the number of hospice agencies in the planning areas that could support the unmet need with an ADC of thirty-five.

The unmet need for 2020 was determined to be an ADC (average daily census) of 74 over the calendar year. This projection of unmet hospice need is a clear indication that the existing Medicare hospice provider in Clallam County has not kept pace with the overall rate of hospice utilization in Washington. (See Appendix F for calculations.)

Method 2: Comparison of hospice penetration in Clallam County with the average in Washington.

Exhibit 1
Deaths by Age Cohort
Washington State Total & Clallam County, 2017

PLACE	Age under 65	Age 65 +
WA State Total	14,113	42,918
Clallam County	180	842

Data Source:
WA State Center for Health Statistics: 2017 death data

Exhibit 2
Washington State Hospice Utilization Compared with Clallam County Utilization, 2017, with estimate of "Underserved" Clallam Patients, 2017

	WA Statewide Use Rate (1)	Clallam County actual admissions (2)	Expected admissions per WA avg.	Clallam County Use Rate (3)	# of Clallam County Patients Underserved (4)
Patients Under 65	28.5%	14	51	8%	37
Patients 65+	60.9%	143	513	19%	370
Clallam Totals		**157**	**564**	15%	**407**

Notes to Exhibit 2:

(1) 2015-2017 avg. statewide admissions per DOH survey divided by 2015-2017 avg. deaths

(2) Number of hospice admissions, Clallam County, 2017

(3) Hospice admissions as % of deaths, Clallam County, 2017

(4) Additional Clallam County patients that would have been served If 2017 Clallam County residents used hospice care as often as the state average

Exhibit 2 shows that, if Clallam County's population experienced the average hospice market penetration of all Washington counties, 407 more terminally-ill persons and their families in Clallam County would have received Medicare-type hospice care in 2017.

Using a conservative average length of stay (ALOS) of 60 days, the 407 underserved patients shown in Exhibit 2 above would have represented an average daily census (ADC) of 67 hospice patients in 2017. Adopting the Department's assumption that an ADC of 35 is required for financial feasibility, this analysis further demonstrates the need for an additional hospice agency to address the unmet needs of Clallam County residents.

Need for personal choice
Each family in Clallam County that wishes to consider hospice care has currently only one choice of Medicare-certified hospice provider. Certainly, when making an end-of-life decision so intimate, so personal and values-laden, it is preferable for there to be at least two hospices from which to choose.

Need for a flexible approach to the provision of chemotherapy and radiation therapy for palliative care purposes
Palliative treatments, such as chemotherapy and radiation therapy, are what many providers classify as "uncovered services". These palliative treatments are intended to shrink tumors to relieve pain or other symptoms. Many hospices do not admit patients on expensive therapies. OMH is prepared to provide for these therapies as well as infusion therapy, ventilators, liquid oxygen and others as necessary to palliate the symptoms of terminal illness when these palliative treatments do not change the six months or less prognosis.

Need for broader outreach and provision of bereavement support
OMC believes that providing bereavement support services only to the families of hospice patients is too limiting. With the specialized skills of the spiritual counselor and social work members of its team, OMH can reach out to a broader range of the community.

Need for outreach and information services that will increase understanding of hospice among community members and the professional health care community.
OMH will develop an array of educational and informational tools to successfully bring the hospice benefit to more eligible patients in Clallam County. OMH outreach plans include the hospital's program of Honoring Choices educational seminars focusing on

end-of-life issues for Clallam County professionals who work with end-of-life patients.

In addition to having an extensive education program, hospice team will tailor communication with the attending physician according to the wishes of that physician.

b. identify the negative impact and consequences of unmet hospice needs and deficiencies.

The negative impact and consequences of unmet hospice needs are best described by listing the benefits of hospice that were not available to those 407 Clallam County residents whose hospice needs were not met:

Longer lives
Hospice care prolongs the lives of those who choose it compared with those who don't. Terminal patients live from 20 days to more than 2 months longer in hospice, according to studies from 2004 through 2010 noted by the National Hospice and Palliative Care Organization.

Reduced out of pocket expense for patients and their families
Prescription medications are one of the biggest areas of cost savings for hospice patients. Hospice covers the cost of all medications for pain and comfort management related to the terminal illness. Rental costs of durable medical equipment -- hospital beds, wheelchairs, walkers, wound dressings and catheters -- are included as part of the paid-by-hospice coverage. Without hospice, the patient would need to pay for this equipment or would need to pay a Medicare rental copayment after submitting a doctor's approval for the equipment.

Personalized and coordinated care plan
End-of-life care can be overwhelming, with a patient often seeing multiple health care professionals. Hospice provides each patient a doctor, nurse, home health aide and social worker, who coordinate the patient's daily care. Other provided health care professionals include a dietitian, and physical, occupational and speech therapists

Hospice care available at home
Being in hospice care may allow seniors to stay in their own homes versus going into long-term care or assisted living. Nearly 90% of people over 65 want to stay in their home for as long as possible, according a 2011 survey by the AARP Public Policy Institute.

Hospice care also can be provided to those in a nursing home or assisted living facility, though the cost of nursing homes or assisted living facilities is not covered by hospice. A 2010 study of cancer patients in hospice by the Mount Sinai School of Medicine found that continuous hospice use leads to a reduction of hospital-based services, including fewer emergency and urgent care visits, and a greater likelihood that a patient will die at home, not in a hospital.

There are respite options for caregivers

Hospice care provides free respite options for caregivers in 2 ways: Respite volunteers can provide patient-sitting services. If the caregiver needs a break for a short time (a few hours at most), they can do so without having to pay. Hospice also provides a longer-term respite care option -- up to 5 consecutive days for the patient in a hospice-approved nursing facility.

Social work and bereavement support

Hospice care also includes a social worker on the hospice team. The social worker can help patients and families find additional care and caregiver support services through local and federal programs. They can also help with finalizing burial plans. In conjunction with a spiritual counselor, social workers may also address the emotional needs of the patient and the family regarding the patient's eventual death. The patient and the family decide whether to use these services. Hospice care doesn't end when the patient dies. Bereavement support for up to 1 year after the patient's death is available to immediate family members.

Coordination of care

Coordinating multiple caregivers and providers is difficult for the healthiest person. For the family or terminally person without access to a Medicare-certified hospice, lack of coordination can create an insurmountable barrier to safe and effective care.

The need to control pain appropriately and address bereavement issues early are two aspects of caring for the terminal patient that many family members would despair of. But under the direction of the Medicare hospice interdisciplinary team, these are required aspects of care included in every patient’s plan of care.

Yes, with lots of work and personal funds, one could assemble a team like the Medicare certified hospice team. But this service already exists within the Medicare program and all Medicare patients are eligible for it.

Reduced re-hospitalization

Hospice care reduces re-hospitalization. A study of terminally ill residents in nursing homes showed that residents enrolled in hospice are much less likely to be hospitalized in the final 30 days of life than those not enrolled in hospice (24% vs. 44%).

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

Hospice services will be provided to patients age 14 and greater who require end-of-life care; Medicare hospice patients are those terminally ill patients with a life expectancy of 6 months or less.

A large number of these patients will be end-stage cancer patients. The remainder of the patients will have terminal conditions related to a variety of diagnoses. The majority of patients will be over age 75. The percentage breakdown of patients by diagnostic group is provided in response to Question 5 below.

Patients receiving in-home care will include not only those still living in their own private homes but also those who are residents of nursing homes, adult family homes and assisted living facilities.

The proposed hospice will provide care to patients regardless of the source or availability of payment for care.

Care will be provided to all patients regardless of culture, language, or sensory disability. Where needed, interpretive services and assistive communication methods and technologies will be used.

For terminally-ill persons who are homeless, OMH staff will make efforts to find housing/shelter for those individuals where they can be provided appropriate end of life care.

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

Olympic Medical Hospice is not an existing facility. It will be a program of Olympic Medical Center whose patient origin data is provided in the table below:

Inpatient Origin by Zip code
Olympic Medical Center, 2017

Zip code	Discharges	Percent	Area
98382	1,718	37.3%	Sequim
98362	1,623	35.2%	Port Angeles
98363	807	17.5%	Port Angeles
98331	99	2.1%	Forks
98357	82	1.8%	Neah Bay
98324	59	1.3%	Carlsborg
98350	23	0.5%	LaPush
98326	16	0.3%	Clallam Bay
98305	11	0.2%	Beaver
98343	8	0.2%	Joyce
98381	7	0.2%	Sekiu
	4,453	**96.6%**	**Clallam County Total**
	29	**0.6%**	**Jefferson County**
	85	**1.8%**	**Other Washington Counties**
	45	**1.0%**	**Other States**
	4,612	**100.0%**	**TOTAL**

Source: CHARS

4. Please provide utilization forecasts for the following, for each county proposing to serve:

   a. total number of unduplicated hospice patients served per year for the first three years;
   b. average length of stay (days) per patient per year for the first three years;
   c. median length of stay; and
   c. average daily census per year for the first three years.

Olympic Medical Hospice Utilization Forecast

	2020	2021	2022
Unduplicated patients	108	210	304
Average L.O.S.	60	60	60
Median L.O.S.	20	20	20
ADC	17.8	34.5	50.0

5. Please provide a forecasted breakdown of patient diagnoses.

   The table below shows the national average published by the National Hospice and Palliative Care Organization.

Diagnosis	Percent
Cancer	28
Heart/Cardiac/Circulatory	19
Dementia	16
Lung/Respiratory	11
Stroke/Coma	9
Other	17
Total	**100%**

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

DOH Clallam County Need Projection & Methodology

Please see Appendix F for the Department of Health's calculations of forecasted Clallam County hospice need for 2020. This document is the current version posted on the Department's web site at the time of this application's submission. This most recently published version of the method conclusively shows the need for an additional hospice agency to be established in Clallam County.

WAC 246-310-290

Hospice services—Standards and need forecasting method.

(8) Need projection. The following steps will be used to project the need for hospice services.
(a) Step 1. Calculate the following two statewide predicted hospice use rates using department of health survey and vital statistics death data:
(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.
(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 the age of sixty-five by the average number of past three years statewide total deaths under sixty-five.
(b) Step 2. Calculate the average number of total resident deaths over the last three years for each planning area by age cohort.
(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.
(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 use rate to determine the potential volume of hospice use by the projected population by the two age cohorts identified in Step 1, (a)(i) and (ii) of this subsection using OFM data.
(e) Step 5. Combine the two age cohorts. Subtract the most recent three-year average 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.
(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.
(g) Step 7. Divide the unmet patient days from Step 6 by 365 to determine the unmet need ADC.
(h) Step 8. Determine the number of hospice agencies in the planning areas that could support the unmet need with an ADC of thirty-five.

OMH Volume Projection Assumptions and Methodology

Assumptions

The basis for projected volumes at OMC Hospice:

- OMC Home Health currently has a very high percent of home health patients with terminal illnesses. A portion of these patients will begin to select the Medicare hospice option.
- As OMH becomes available to OMC inpatients and OMP outpatients with terminal illnesses, a portion of these patients will begin considering the Medicare hospice option and select OMH.
- OMH will receive referrals from Clallam County providers whose terminally-ill patients wish to consider hospice care. These include major area providers such as Forks Community Hospital, S'Klallam Tribal Healthcare, North Olympic Healthcare Network, Volunteers in Medicine of the Olympics, and others.
- Clallam County residents facing terminal diagnoses and being discharged from Puget Sound regional referral hospitals will be referred to OMH.

Methodology

Projection of OMH-specific hospice workload through 2022 relies on two categories of patients:

- Existing OMC home health patients
- Hospice referrals from physicians and community

and involves four steps:

1. Develop three numerical input assumptions
2. Calculate a baseline projection of OMH patients
3. Project a 2022 hospice volume for OMH based on increased Clallam County market share toward the statewide average.
4. Translate referrals to OMH into projected ADC, 2020-2022.

Step 1: Develop three numerical inputs to Steps 2-3:

1(a) Estimate Assured Hospice admissions through 2022

The table below shows the Assured Hospice admissions in Clallam County, 2000-2017. (Based on comparison to other more detailed data available the 2013 value appears to be an error.) By trending volumes 2010-2018, it appears a reasonable projection of Assured Hospice Clallam County admissions through 2022 is 140 admissions per year.

Assured-LHC	
Year	**Admissions**
2000	0
2001	0
2002	4
2003	77
2004	65
2005	71
2006	86
2007	95
2008	110
2010	108
2011	143
2012	147
2013	*281*
2014	179
2015	116
2016	116
2017	157

1(b) Calculate an "all age" hospice use rate for Clallam County

The DOH 2018 Hospice Need Method provides three-year average historical deaths and three-year average hospice admissions for Clallam County. These are provided for two age cohorts. By adding the figures for the two age cohorts, one can find the Clallam County totals for each. Then, dividing the average admissions, 130, by the average Clallam deaths, 971, results in a three-year average "all age" use rate of 13.4%. (This "all-age rate" is required in order to use the recent OFM all-age death projections for Clallam County, 2020-2025.)

1(c) Estimate conversion of OMC home health patients to OMH admissions

As a result of Clallam County community and provider reluctance to use Medicare hospice, OMC's home health agency serves an unusually large number of terminally ill patients. Based on its nurses' chart reviews, OMC's home health agency is providing skilled terminal care services to about 100 patients at any given time.

OMC discharge planners and home health staff estimate that patients with terminal illness will be more likely to choose Medicare hospice if more choices are presented to them. The average home health

episode of care is 60 days, so it will take 2-3 months at start up before this group of OMC's home health patients starts selecting the hospice option and choosing OMH as their Medicare hospice.

For historic reasons of community and provider preference, the change will be gradual and only half of hospice-eligible patients receiving home health services are projected to elect hospice by year 3. The table below shows the 2020-2022 estimated conversion of OMC terminally-ill OMC home health patients who will elect hospice rather than home health. Assuming a quarterly turnover in home health patients and 100 hospice-eligible patients per quarter, the table applies increasing annual conversion rates of 20%, 33% and 50%. Thus, the annual number of OMC home health patients that will move into OMH or elect OMH instead of home health is shown in the right-hand column as "Annual OMH Admissions.

Conversion of OMC Home Health patients to OMH Hospice 2020-2022

	HHA Terminal Patients per Quarter	% electing OMH	HHA referrals/qtr.	Annual OMH admissions*
2020	100	20%	20	60
2021	100	33%	33	132
2022	100	50%	50	200

*three quarters of 2020 only

Step 2: Demonstrate baseline Clallam County unmet need for hospice admissions using WA statewide all age use rate and subtracting Assured Hospice admissions

The table below applies the current "all age" hospice use rate, 52.7%, to the Clallam County three-year average of Clallam County deaths. This results in Column C's showing 511.7 Clallam County residents would be using hospice if the county's use rate mirrored that of the state as a whole. Assuming Assured Hospice serves 140 of those patients, it leaves a current number of underserved persons at 371.7.

	A	B	C	D	E	F	G	H
Current use:	**2018 Hospice All Age Use Rate**	**Estimated Clallam Deaths**	**Estimated need (A x B)**	**Estimated Assured ADMS**	**OMH ADMS from HHA**	**OMH ADMS from MD's & community**	**All Clallam County ADMS**	**Unmet need ADMS**
Statewide	52.70%	971	511.7	140	0	0	140	371.7

Step 3: Project OMH admissions, 2020-2022, using OFM death projections and increasing hospice use rate for Clallam County

The table below is driven by the assumption that Clallam County hospice use rates will increase to 24%, 35% and 45%, shown at Column A. These are applied to OFM projected annual deaths of 1038 per year, at Column B. The result, at Column G, projects Clallam hospice admissions per year that will result when availability of, and education about, OMH services start pushing the Clallam use rate higher each year through 2022.

Column C shows the expected hospice admissions were Clallam County hospice use reach the higher statewide rate of 52.7%. Clallam County's use rate is not expected to achieve this current WA statewide average by 2022.

Columns D-G show three sources and projected volumes of Clallam hospice patients from each, 2020-2022:

Column D - Assured Hospice (from Step 1a),
Column E - projected OMC home health patients using OMH (from Step 1b), and
Column F - estimated direct referrals to OMH from providers and Clallam community (the net of Columns G minus D and E) .

Column H shows for each year, the Clallam patients still not receiving the hospice care they would receive if the county's use rate were to reach the statewide "all-age" use rate of 52.7%

	A	B	C	D	E	F	G	H
Year	**Projected Clallam Use Rate**	**Projected Clallam Deaths**	**Total Need @ 52.7%**	**Estimated Assured ADMS**	**OMH referrals from home health**	**OMH referrals from providers & community**	**Total Clallam County admissions @ Col A %**	**Remaining Unmet Need**
2020	24%	1038	547	140	60	48	248	299
2021	35%	1038	547	140	132	78	363	184
2022	45%	1038	547	140	200	104	467	80

Step 4: Calculate OMH total admissions, patient days and ADC

The table below completes the projection method by combining the two sources of OMH patients, Columns A + B, for total OMH admissions at Column C. By applying a conservative average of 60ALOS, this translates at Column E to ADC's of 17.8, 34.5 and 50.0 for OMH in the three full years of 2020-2022.

	A	B	C	D	E
Year	**OMH ADMS from home health**	**OMH ADMS from physicians & community**	**Total OMH Admissions (A + B)**	**Pt Days @ 60 ALOS (C X 60)**	**OMH ADC (D÷365)**
2020	60	48	108	6,480	17.8
2021	132	78	210	12,600	34.5
2022	200	104	304	18,240	50.0

Conclusion:
The commencement of OMH patient care is projected for January 2020. Over the 36 months from January 2020 through December 2022, OMC conservatively projects the new hospice will have reached an ADC of 50 for the year 2022.

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

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

      Currently, Assured Hospice is the only licensed and Medicare-certified hospice provider in Clallam County.

      Assured Hospice's service to Clallam County is not recently established but is not achieving the average hospice penetration rate of the hospices across the state of Washington. Calculation of the Department of Health's Hospice Need Methodology indicates that the reach of its services to county residents has neither met nor kept pace with the population growth, aging, and resulting end-of-life needs of the county's residents.

      The Department of Health's 2018 calculation of forecasted Clallam County utilization is provided at Appendix F.

      1. Step 5 of the method documents substantially more forecasted utilization than the "capacity" of the existing hospice. For 2020, for example, the forecasted Clallam County hospice need at Step 5 totals 575 admissions annually at Washington's statewide average use rates.

      2. This need of 575 contrasts with the existing Assured Hospice "current capacity" of 130 in Clallam County, also shown in

Appendix F as part of the Department of Health's Survey Results, Hospice Numeric Need Methodology, released October 2018.

3. This leaves 446 (575 minus 130) persons with an unmet need according to the DOH hospice need method's calculation of 2020 need. This translates into a 2020 projected 78% shortfall in hospice availability in Clallam County. (446 ÷ 575 = 78%)

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

As discussed above and documented in the Department of Health's own 2018 calculation of 2020 Clallam County hospice need, existing services are not sufficiently available. This question is therefore not applicable.

Definitions of "capacity" and "hospice agency" at WAC 246-310-290, "Hospice services—Standards and need forecasting method" make clear that the capacity of the existing hospice provider in Clallam County is not sufficient to address the unmet need calculated by the Department of Health.

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

As documented in the Department of Health's own 2018 calculation of 2020 Clallam County hospice need, the proposed project is not an unnecessary duplication of services because it will respond to an unmet need of 74 average daily patients per day in 2020.

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

In response to Questions 8 and 9:

- Please see Appendices G, H, and I for copies of Olympic Medical Center policies and Olympic Medical Hospice draft policies relating to admissions, charity care and patient referral policy.

- OMH will develop policies tailored to the end of life needs of Patients with Special Communications Needs (including hearing disabilities, language & cultural requirements)

- When OMH is referred terminally ill persons who are homeless or have unstable housing situations, the medical social worker will connect with local resources to locate housing options specific to their needs.

- As documented by the Department of Health's own hospice need methodology, at least 445 Clallam County patients will go without needed hospice care in 2020. These are individuals made vulnerable by virtue of their end-of-life status and are precisely the patients that hospice is designed to serve.

- OMH will reach out to minority communities in Clallam County – local tribes and the Spanish-speaking community in particular - to build culturally-competent services to meet their specific needs in hospice care.

- Nationally, the majority of hospice patients are very elderly women. Additional Medicare hospice care in Clallam County will help address the needs of this group. And, compared to the average population, the group of elderly persons – especially women – who are living on fixed incomes have a higher percentage of low-income persons among them.

- In offering of bereavement services, Olympic Medical Hospice will be addressing needs of the family and loved ones of its current and former hospice patients. These individuals have special needs in light of their loss and grieving status.

- Olympic Medical Hospice will develop relationships with veterans' groups and providers of their medical care in tailoring its hospice services to the needs of this large and growing population in the service area.

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

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

Please see Appendices G, H, and I.

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

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

Not applicable

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

Not applicable

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

Not applicable

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

WAC 246-310-990(2) defines "total capital expenditure" to mean the total project costs to be capitalized according to generally accepted accounting principles. These costs include, but are not limited to, the following: legal fees; feasibility studies; site development; soil survey and investigation; consulting fees; interest expenses during construction; temporary relocation; architect and engineering fees; construction, renovation, or alteration; total costs of leases of capital assets; labor; materials; fixed or movable equipment; sales taxes; equipment delivery; and equipment installation.

1. Provide the proposed capital expenditures for the project. These expenditures should be broken out in detail and account for at least the following:

- Land acquisition;
- Site survey, tests, inspections;
- Construction contract;
- Financial feasibility studies, architectural fees/engineering fees/consulting fees;
- Fixed equipment (not in construction contract);
- Movable equipment;
- Freight and delivery charges;
- Sales tax;
- Cost of tuning up and trial runs;
- Reconditioning costs (in case of used asset);
- Cost of title investigations, legal fees, brokerage commissions;
- Other activities essential to the acquisition, improvement, expansion, or replacement of plant and equipment due to the project; and
- Financing costs, including interim interest expense, reserve account, interest expense, and other financing costs.

Please see Appendix J for a list of proposed capital expenditures supporting the project.

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

   - Estimated furnishings and equipment costs are based on OMC historical purchases of similar items.

   - Estimated cost of altering existing office building space for use by hospice staff is based on OMC in-house construction estimate that relied on prior similar project costs and familiarity with materials costs.

3. Document the project impact on (a) capital costs; and (b) operating costs and charges for health services

   Studies of the cost-effectiveness of hospice, both federally and privately sponsored, provide strong evidence that hospice is a cost-efficient approach to care for the terminally ill.

   An early study for CMS concluded that during the first three years of the hospice benefit, Medicare saved $1.26 for every $1.00 spent on hospice care. The study found that much of these savings accrue over the last month of life, which is due in large part to the substitution of home care days for inpatient days during this period.

   Additional research on hospice supports the premise that cost savings associated with hospice care are frequently unrealized because terminally ill Medicare patients often delay entering hospice care until they are within just a few weeks or days of dying, suggesting that more savings and more appropriate treatment could be achieved through earlier enrollment.

   An example of hospice cost efficiency can be seen in the RN staffing required for a terminally-ill person in a hospital ICU vs. that same person who may wish to die at home. While the ICU requires one or two RNs per patient for three shifts per day, the hospice nurse typically has ten in-home patients under his or her care on a given day.

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

   Please see Appendix J.

Revenue

Hospice agency	yyyy	yyyy	yyyy
Medicare			
Medicare Managed Care			
Medicaid			
Healthy Options [BHP]			
Private Pay			
Third Party Insurance			
Other [CHAMPUS, Veterans, etc.]			
Non-operating Revenue [United Way, etc.]			
Deductions from Revenue:			
(Charity)			
(Provision for Bad Debt)			
(Contractual Allowances)			

Expenses Hospice agency	yyyy	yyyy	yyyy
Advertising			
Allocated Costs			
B & O Taxes			
Depreciation and Amortization			
Dues and Subscriptions			
Education and Training			
Employee Benefits			
Equipment Rental			
Information Technology/Computers			
Insurance			
Interest			
Legal and Professional			
Licenses and Fees			
Medical Supplies			
Payroll Taxes			
Postage			
Purchased Services (utilities, other)			
Rental/Lease			
Repairs and Maintenance			
Salaries and Wages (DNS, RN, OT, clerical, etc.)			
Supplies			
Telephone/Pagers			
Travel (patient care, other)			

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

   All project costs for initiation of Medicare hospice agency will be covered by available OMC funds. No financing costs will be incurred.

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

   Please see Appendix K for a letter from OMC Chief Financial Officer Darryl Wolfe stating OMC's commitment to funding all project capital costs and cashflow requirements.

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

   There will be no financing costs for the proposed project. Accordingly, no analysis evaluating the alternatives is provided.

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

   Please see attached at Appendix J.

9. Provide a capital expenditure budget through the project completion and for three years following completion of the project.

   Please see attached at Appendix J.

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

    The table below indicates the estimated percentage payer mix for the proposed project. The percentages are not expected to change over time.

    Please note that OMC Hospice's proforma revenue and expense include a "charity care" line item. For accounting reasons, these amounts are not reflected in the table below.

OMC Hospice Projected Payer Mix Percent

Payer	Percent
Medicare & Medicare Managed Care	90%
Medicaid	5%
Commercial, TriCare, private etc.	5%
Total	**100%**

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

Please see Appendix M, attached.

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

    See attached as Appendix M.

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

    See attached as Appendix M.

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

    Olympic Medical Center is not an existing provider of hospice services.

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

    Charges for Medicare-certified hospice are set nationally by Medicare; these are based on fixed rates per day depending on the local cost of labor, the hospice patient's setting of care each day and the patient's current length of stay. Of the fixed rates, only one is based on a visit by a specific discipline: Based on a CMS-published rates for 2019 hospice payment, the hourly rate for Continuous Home Care by an RN is $43.01.

    No other costs nor charges per visit are calculated by Medicare-certified hospices. If the Department of Health prefers a certain methodology of allocating indirect expenses to types of patient visits and can provide that methodology to the applicant, such calculations can be undertaken.

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

    Please see Appendix J for a Staffing Assumptions that provide FTE's, salaries and wages by job title/discipline for the first three full years of operation.

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

    OMC has identified the costs of initial development and startup of the OMC Hospice. Sufficient working capital will be provided by the hospital to cover the costs of operation until Medicare reimbursement is received.

Please see Appendix K for a letter from Darryl Wolfe, OMC Chief Financial Officer, committing sufficient funds to the working capital required.

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

1. Please provide the current and projected number of employees for the proposed project, using the following:

	Current FTE		Year 1		Year 2		Year 3	
Staff	FTE	Contracted	FTE	Contracted	FTE	Contracted	FTE	Contracted
RN								
LPN								
Hospice Aide								
NURSING TOTAL								
Admin								
Medical Director								
DNS								
Business/Clerical								
ADMIN. TOTAL								
PT								
OT								
Speech Therapist								
Med Social Work								
Pastoral / Other Counselor								
Volunteers								
Other (specify):								
ALL OTHERS TOTAL								
TOTAL STAFFING								

OMC Hospice has no current employees.
Please see Appendix J for the information requested in the table above.

2. Please provide your staff to patient ratio.

Type of Staff	Staff / Patient Ratio
Skilled Nursing (RN & LPN)	1:10
Physical Therapist	As needed
Occupational Therapist	As needed
Medical Social Worker	1:35
Speech Therapist	As needed
Home Health / Hospice Aide	1:10
Spiritual counselor	Contracted per visit
Total	

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

   These ratios correspond to national averages as published by the National Hospice and Palliative Care Organization.

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

   Based on OMC's successful staffing of its existing home health agency, OMC expects no problems with availability of qualified health manpower and management personnel.

   To support its ongoing recruitment of required staff, OMC provides a strong compensation and benefits package. And, to augment recruitment for hospice staff, OMC plans to offer specialized training and credentialing in hospice care through programs such as UW's Cambia Center and the online hospice training capabilities of NHPCO and others such as California State University.

5. Please identify the number of providers and specialties represented on the interdisciplinary team.

   The most recent Medicare Hospice Conditions of Participation state:

   The interdisciplinary group must include, but is not limited to, individuals who are qualified and competent to practice in the following professional roles:

   (i) A doctor of medicine or osteopathy (who is an employee or under contract with the hospice).

   (ii) A registered nurse.

   (iii) A social worker.

   (iv) A pastoral or other counselor.

   Physical therapy services, occupational therapy services, and speech- language pathology services must be available, and when provided, offered in a manner consistent with accepted standards of practice.

   Where appropriate, hospice volunteers will also be members of Olympic Medical Hospice patients' interdisciplinary teams.

   Note: The term "interdisciplinary team" is interchangeable with "interdisciplinary group" here.

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

The in-service training plan for Olympic Medical Hospice staff including continuing education and training to meet Medicare criteria will be provided in response to screening.

OMH training components that will reflect service to identified special populations includes:

- Veterans outreach "We Honor Veterans" program training
- Understanding "Death with Dignity" law and OMC policies
- OMC provides an annual program of training in cultural competence for all employees.

7. Describe your methods for assessing customer satisfaction and quality improvement.

- Due to similar approaches of hospice and home health quality assurance methods, Olympic Medical Hospice will share a Quality Assurance RN staff member with the hospital's home health agency.
- CMS certifies and approves vendors of Medicare hospice customer satisfaction surveys. OMH will contract with one of the CMS-approved vendors to assess its customer satisfaction. OMH will also compare the results of its customer satisfaction with peer organizations via CMS Hospice Compare. This comparison will support its identification and prioritization for areas needing improvement.
- Starting with FY 2016-2017, CMS required all Medicare hospices to submit required data needed for a new nation-wide program of hospice quality improvement. OMH will comply with all CMS requirements including training staff in the submission of all required data.

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

OMH office hours will be 8 a.m. to 5 p.m. Monday through Friday. At all other times, OMH will have paid staff on call and accessible by telephone via a phone call to a main number.

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

Vendor relationships

As a part of the larger medical center, OMH will have access to all current and future vendor relationships and contracts in place for the hospital's inpatient and outpatient services.

Provision of inpatient hospice care

- General Inpatient Care: As an acute care hospital, OMC is able to provide OMH patients with General Inpatient Care under the Medicare Hospice Benefit when that level of care is needed.

- Respite Care: Respite Care under the Medicare Hospice Benefit will be provided in either OMC beds available for such care or under contract with Clallam County nursing homes. Initiation of such arrangements with area nursing homes will take place upon receipt of a hospice Certificate of Need.

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

The Medicare Hospice Benefit

Promoting continuity and avoiding unwarranted fragmentation are both at the heart of the Medicare-certified hospice benefit. The inter-disciplinary hospice team functions to provide continuity through shared development of each patient's plan of care and managing that care every day. Financially, the per diem payment to the hospice for all services puts the control of the full range of care in the hands of the interdisciplinary team.

Community and Provider Education

To enhance continuity of care, OMH will provide community education about the need for early admission to hospice. The OMH relationship to OMC Home Health provides an opportunity to assure that terminally-ill home health patients are aware of their hospice options. And, Olympic Medical Physicians will also be supported in identifying their terminally-

ill patients and providing information about hospice where appropriate.

Death with Dignity

Olympic Medial Center is committed to Clallam County residents' having desired control over their own health care choices. The 61% majority vote by Clallam County residents for the "death with dignity" statewide ballot measure in 2008 indicated this is an important value to the community OMC serves. OMH intends to include in its network providers who will actively support patients pursuing their "death with dignity" options as available under Washington law. As part of this effort, OMH will reach out to End of Life Washington for their advice and support in policy development, staff training and in locating needed resources.

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

    There is no such history.

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

    Please see Appendix L for copies of Olympic Medical Center's licensing and accreditation documents.

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

    Olympic Medical Center was established in 1951 to serve the inpatient health care needs of Clallam County Public Hospital District #2. Today, OMC provides:

    - 67 inpatient beds with an average daily census of 41.
    - Care for 500 obstetrics patients per year
    - Specialty outpatient services including a cancer center, pulmonary rehab and cardiac rehab
    - An award-winning Medicare home health agency.

    Recent successful new facility and program development by the OMC management team includes:

    - Development of a new medical office building of 42,000 square feet

- Development planning for expansion of a busy cancer center at OMC's large outpatient complex located in Sequim.
- Acquisition of local pediatric clinic and merging its operations and finances into OMC clinic system

The administrative and management staff of Olympic Medical Center possesses the clinical and management knowledge to successfully establish a hospice in Clallam County. Its current leadership will develop a team responsible for supporting implementation of the new hospice in accordance with rules and law for the establishment and operations of hospices in Washington.

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

This question is not applicable. Olympic Medical Center does not operate an existing hospice agency under the Medicare hospice benefit

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

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

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

Olympic Medical Center considered the following alternatives when deciding to pursue the hospice project in 2018:

- Acquisition vs. start-up
- Postponing action
- No action

The decision-making criteria were:

- Acquisition availability
- Financial feasibility
- Conformance with OMC's strategic plan and 2018 objectives

The advantages and disadvantages identified in deciding to pursue a Certificate of Need now include:

Conformance with OMC strategies:
Submitting a Certificate of Need application in 2018 to establish a Medicare hospice directly corresponds to OMC's 2018-2020 Strategic Plan and its specific 2018 objective to expand Medicare hospice availability in Clallam County.

Financial feasibility:
As a result of the large size of Clallam County's underserved population and the size of projected demand that stems from that unmet need, OMC's new hospice can confidently project steady growth and positive financial results. Comparing financial feasibility of an acquisition vs. startup would depend on the price OMC paid for the acquisition if one were available.

Acquisition available:
There is one Medicare-certified hospice in Clallam County and it is not available for sale at this time. it was determined that area residents should not have to wait to have additional and needed access to hospice care.

Capital costs:
Olympic Medical Center can readily fund the required start up expense related to establishing a new hospice in Clallam County. The pro forma revenue and expense statement shows that the initial investment will be recouped within a reasonable time.

Staffing impact:
Acquisition of an existing hospice could be more cost efficient, depending on the staffing configuration and management organization of the acquired hospice. Yet, expansion of hospice services in Clallam County beyond current levels, via either method, would have an equal impact on staffing.

Summary: One alternative – acquisition - was eliminated because it is not feasible. Considering the other two alternatives - act now or wait - in light of the criteria above, the advantages and disadvantages taken together make it clear that establishment of a new hospice agency now is the preferred alternative.

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

Low hospice lengths of stay in Washington and Clallam County, plus 2017

revisions to CMS payment formulas for hospice care, substantially reduce the potential for exceeding Medicare cost caps.

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

System impacts

Health care system efficiency is embedded in the hospice concept. Patients who no longer wish to undergo curative treatment have the opportunity to substitute palliative and comfort care for the remaining course of their illnesses. This means the resources expended are more appropriate to the patient and family's goals.

The avoidance of ICU admissions of terminally ill patients who do not wish to die in a hospital is an example of the cost efficiency of this approach.

Comprehensive hospice care is covered by a per diem payment across care settings. Coordination of the multi-disciplinary care by the hospice team also fosters system efficiency by providing the right care at the right time. This reduces expensive duplication and unnecessary re-work typical of other parts of the health care system.

Staff efficiency

Hospice fosters staff efficiency in the health care system by allocating scarce RN resources to those who need that level of care. Instead of a patient's requiring 1:1 or 1:2 RN staffing for 3 shifts a day in a hospital ICU, the patient is at home with sufficient personal care and nursing resources to provide necessary palliative and comfort care.

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

Upon receipt of a hospice Certificate of Need, OMC will undertake a remodeling project in vacant space adjacent its home health agency office currently located near the hospital campus in a one -story office building already owned by the hospital.

Chief aspects of the project that limit capital costs:

a. The OMH office space is not located in expensive inpatient hospital space but in a one-story existing office building.
b. The construction of OMH office space is limited to that required for OMH staff and is adjacent OMC home health

offices where OMC home health administrative staff to be shared with OMH is already housed.

c. The construction consists of remodeling existing vacant space and will be undertaken by OMC internal construction staff rather than under contract to a potentially more expensive outside contractor.

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

   To contain long term energy consumption and related operating costs, OMC's remodeling of the OMH office space will utilize LED lighting wherever appropriate.

List of Appendices

Olympic Medical Hospice

Medicare hospice Certificate of Need Application

Olympic Medical Center, Clallam County Washington

Appendix A	Letter of intent
Appendix B	Olympic Medical Center organization chart
Appendix C	OMH Medical Director, draft job description
Appendix D	Line drawings, current and planned office space
Appendix E	Clallam County Tax Assessor, Recorded Ownership
Appendix F	DOH Hospice Need Methodology, 2018
Appendix G	Admissions policy
Appendix H	Charity care policy
Appendix I	Patient referral policy
Appendix J	Financial Assumptions & Staffing Summary Draft Proforma Operating Statement Estimated Capital Expense and Depreciation Draft Pro Forma Cash Flow and Balance Sheet
Appendix K	Commitment letter from Chief Financial Officer
Appendix L	OMC License and Accreditation documents
Appendix M	Historical Financial Statements, OMC, 2015-2017

Appendix A	Letter of intent

OLYMPIC
MEDICAL CENTER

www.olympicmedical.org
(360) 417-7000

939 Caroline Street • Port Angeles, WA 98362

November 30, 2018

Janis Sigman, Manager
Certificate of Need Program
Washington State Department of Health
PO Box 47852
Olympia, Washington 98504-7852

Dear Ms. Sigman,

This letter is to notify the Department of Health that Clallam County Public Hospital District No. 2, dba Olympic Medical Center, intends to seek Certificate of Need approval to establish a Medicare-certified hospice agency to serve residents of Clallam County, Washington.

Upon receipt of a Certificate of Need, Olympic Medical Center will provide Medicare and Medicaid hospice services to terminally-ill residents of Clallam County, Washington. Our current estimate of capital costs is $150,000.

Would you please provide us with all criteria and standards by which you will evaluate our application? If I can answer any questions or if you need further information, please contact me.

Sincerely,

Eric Lewis

Eric Lewis
Chief Executive Officer
elewis@olympicmedical.org
(360) 417-7705

Appendix B	Olympic Medical Center organization chart

OLYMPIC MEDICAL CENTER

Organizational Chart
5/2/2018

Note: Printed copies are for reference only.
Please refer to SharePoint for the latest version.

COMMUNITY

Board of Commissioners

John Beitzel (P) — **Thom Hightower, RN**
Jean Hordyk — **Jim Leskinovitch**
John Nutter (S) — **John Miles, MD**
Tom Oblak

(P = 2018 President) (S = 2018 Secretary)

Financial Auditor – Moss Adams LLC
Compliance Auditor – WA State
Internal Auditor – Darryl Wolfe
Treasurer – Joel Lewis
Compliance Officer – Donna Davison
General Counsel – Jennifer Burkhardt
Attorney – Craig L. Miller

Medical Executive Committee and Medical Staff

Quality Management Oversight Committee (QMOC)

Chief Executive Officer
(Eric Lewis)

Olympic Medical Physicians Council (OMP Council)

Chief Financial Officer
(ALT Member)
(Darryl Wolfe)

Accounting
Accounts Payable
Revenue Cycle
- Patient Access Services
- Health Information Mgmt
- Patient Financial Services
- Payroll

Materials Management
Plant Operations
- Construction

Information Services
- Information Technology
- Clinical Informatics & Applications

Heart Center
- Rhythm Clinic

Chief Human Resource Officer / General Counsel
(ALT Member)
(Jennifer Burkhardt)

Risk and Compliance Officer
(ALT Member)
(Donna Davison)

Risk Management
Compliance

Human Resources
Legal / Contracts
Employee Relations
Communications / Public Relations
Marketing
Employee Safety & Health
Patient Experience
Support Services
- Nutrition Services
  - o Diabetes Program*
- Environmental Services
  - o Laundry
- Security / Safety
- Emergency Preparedness
- Volunteers

Chief Nursing Officer / Hospital COO
(ALT Member)
(Lorraine Wall, RN)
Assistant CEO

Medical / Surgical / Pediatric
ICU / Telemetry
Surgical Services
- Short Stay Unit

Obstetrics
- New Family Services

Emergency
Nursing Administration
Pharmacy
Home Health
Education

Chief Medical Officer / Safety Officer
(ALT Member)
(Scott Kennedy, MD)

Medical Staff Services
Safety Support Services
- Infection Prevention

Hospital Medical Directors
Wound Care Services
Hospitalist Services
Anesthesia Services
Quality Support Services
Case Management
Physical Therapy & Rehabilitation
Respiratory Therapy
Laboratory
Diagnostic Imaging*

Chief Physician Officer (OMP)
(ALT Member)
(Joshua Jones, MD)

Olympic Medical Physicians Clinics*
- General Surgery Clinic
- Orthopedic Clinics
- Primary Care Clinics
- Sleep Center
- Specialty Clinic - Sequim
- Specialty Clinic - Port Angeles
- Walk-In Clinic – Sequim
- Walk-In Clinic – Port Angeles
- Women's Clinic
- Children's Clinic
- Lung Center

Cancer Center *
Physician Recruitment
Swedish Health Network Affiliation

* ***Indicates responsibility to CNO for nursing-related oversight.***

Appendix C	OMH Medical Director, draft job description

DRAFT

OLYMPIC MEDICAL CENTER
Position Description

TITLE:	**Hospice Medical Director**		
DEPARTMENT:	Olympic Medical Physicians		
REPORTS TO:	Chief Physician Officer		
SUPERVISES:	None		
UNION:		**EXEMPT:**	
POSITION/PAY GRADE:	$216,000/year @ 1.0 FTE	**BENEFITS:**	
REPLACES:			
REVIEWED/REVISED:			

JOB SUMMARY

Under the direction of the OMP Chief Physician officer, the **Hospice Medical Director** is the administrative physician charged with the medical oversight of the Olympic Medical Home Health Hospice.

The **Hospice Medical Director** is responsible for the direction of the care and treatment to hospice patients by the hospice care team. He or she also work closely with the Olympic Medical Home Health and Hospice program Director to ensure patient access, quality care and improvement, appropriate evidence-based protocols and workflows.

The **Hospice Medical Director** position is designed as a carve out position from an existing or new clinical position, but the exact time needed for completion of tasks will be determined by the Chief Physician Officer.

QUALIFICATIONS AND EQUIPMENT COMPETENCIES

EDUCATION

MD or DO required.

EXPERIENCE

Two or more years' experience as Medical Director preferred. Knowledge of and recent experience in palliative care with an emphasis on pain control and symptoms associated with a terminal illness.

LICENSURE/CREDENTIALS

MD or DO, current Washington State Medical License. Board Certification preferred in one of the following: Oncology, Geriatric Medicine, Internal Medicine, Primary Care. Subspecialty certification in Hospice and Palliative Care strongly preferred.

EQUIPMENT, SYSTEMS, TOOLS

Basic Skills	Advanced Skills	Item
X		Calculator
X		Computer
X		Copier
X		Fax
X		Healthcare Info Systems
X		MS Excel

Basic Skills	Advanced Skills	Item
X		MS Outlook
X		MS PowerPoint
X		MS Word
X		Telephone/Voicemail
		Visio (or flowchart software)
X		Web Research

Other (please list): Epic, SharePoint, Microsoft Office Suite

PERFORMANCE EXPECTATIONS FOR SUPERVISORS, MANAGERS, DIRECTORS

Responsible for meeting or exceeding compliance with all relevant accreditation standards. In general, the supervisor, manager or director will:

- Address all expectations, identify and organize priorities, develop strategies and approaches to continual performance improvement activities that best meet patient-focused and structure standards.
- Meet or exceed standard expectations for direct and indirect patient outcomes and manage continual performance improvement processes to improve future outcomes.
- When applicable, gather data on clinical outcomes and related processes, use data to guide internal quality improvement efforts and for performance data reporting.

ESSENTIAL DUTIES

CORE COMPETENCIES

Hospice Medical Direction	
1.	Supports OMC's Strategic Plan and works to implement the OMP Way.
2.	Works to ensure the OMP Compact is followed by all OMP/OMC personnel.
3.	Provide physician direction and guidance to the hospice program, to staff and volunteers to assure the maintenance of quality care for patients and their families.
4.	Consult and work with patient's attending physician. The attending physician is encouraged to provide primary care to his/her patient even though the patient also receives hospice care. May take over as attending physician, if primary physician requests.
5.	Consult with patient's physician and other members of the hospice team to accomplish effective pain control and symptom management for hospice patients.
6.	Serves as a liaison and contact between the hospice program, hospital medical staff, community physicians and others engaged in the health care services in order to introduce the hospice program and foster physician and professional awareness, understanding and involvement.
7.	Uses patient satisfaction monitoring tools to improve patient relationships and as the basis for quality improvement activities by the hospice team.
8.	Certify and re-certify terminally ill patients for hospice eligibility. Assist in developing the Plan of Care for each patient/family with the coordination of the patient's physician.
9.	Provides input to the CNO and Home Health Director in creating and monitoring the annual budget for OMC area of responsibility.
10.	Attends interdisciplinary meetings and participates in the development of quality assurance and performance improvement work
11.	Maintains clinical records, statistics, reports and records for purposes of evaluation and reporting of agency activities as prescribed and in compliance with local, state and federal regulations.

12.	Assists hospice administrative director and other hospice personnel in the planning, implementation and evaluation of in-service and continuing education programs.
13.	Assists in the development, review and implementation of hospice policies, goals and objectives.
14.	Participates in community activities that promote understanding of hospice by members of the community.
15.	Maintain active medical staff privileges and abides by Medical Staff Bylaws and hospital policies.
General	
16.	Maintains professional growth and development through seminars, workshops and professional affiliations to keep abreast of latest trends in field of expertise.
17.	Works to ensure no injuries to self or others by following safe work practices and policies. This includes, but is not limited to: security and safety, understanding of MSDS, equipment, infection control, fire, disaster, body mechanics and Basic Life Support.
18.	Ensures the interface with team members and other support groups is conducted in a courteous and efficient manner conducive with the organization's values.
19.	Conducts self in a professional manner and ensures personal appearance meets the standards necessary to perform the job function while representing the organization.
20.	Ensures that additional accountabilities, as may be required by management, be handled in a manner necessary to meet organizational standards.
21.	Performs other job-related duties as required.

WORKING CONDITIONS

LOCATION OF WORK

Office and clinic settings. Must be able to travel. Work/visit OMC and all areas of OMP in Clallam County.

PHYSICAL DEMANDS

Able to:

- lift and/or move up to 10 lbs. frequently and up to 20 lbs. occasionally while using correct body mechanics.
- sit and perform with simple manual dexterity over long periods of time (up to four hours).
- bend, stand, walk, stoop.
- use hands to finger, handle, feel.
- reach with hands and arms.
- communicate by means of spoken and written word and perceive sounds by ear.
- Identify and distinguish colors (i.e., to help determine patient condition), see clearly and adjust focus at 20 inches or less (close vision) and at 20 feet or more (distance vision), visually perceive the world in three dimensions (depth perception).
- wear protective equipment.

EXPOSURE TO HAZARDS

Table Key N/A: Not Applicable F: Frequent (34%-67% of the time)
O: Occasional (0%-33% of the time) C: Constant (67%-100% of the time)

Hazard	N/A	O	F	C
Vibration	X			
Excessive noise	X			

Hazard	N/A	O	F	C
Above/Below normal temperature	X			
Working with chemicals/fumes	X			

Exposure to aggressive/angry people		X		
Exposure to blood/body fluids	X			
Exposure to anesthetic agents	X			
Moving mechanical parts	X			
Wet/humid conditions	X			
Falling (due to working at heights)	X			

Electrical shock	X			
Exposure to radiation	X			
Exposure to infectious disease		X		
Airborne particles/dust	X			
Burns/High temperature tools/objects	X			
Sharp objects (needles, etc.)	X			

KNOWLEDGE, SKILLS AND ABILITIES

- Ability to provide appropriate data and benchmark information. Knowledge of health care systems to include acute care, outpatient care, long-term care, home health, and other systems is highly desirable.
- Must possess logical thinking skills and be able to respond effectively to the most sensitive inquiries or complaints.
- Demonstrates competency in ability to care for customers/patients across the age continuum, and communicates effectively with all levels of staff and management.
- Ability to provide effective leadership, while managing multiple priorities and practicing within legal and ethical guidelines.

EMPLOYEE ACKNOWLEDGMENT

I have read and understand the qualifications and expectations of this position.

Employee _____ Date _____

APPROVED BY

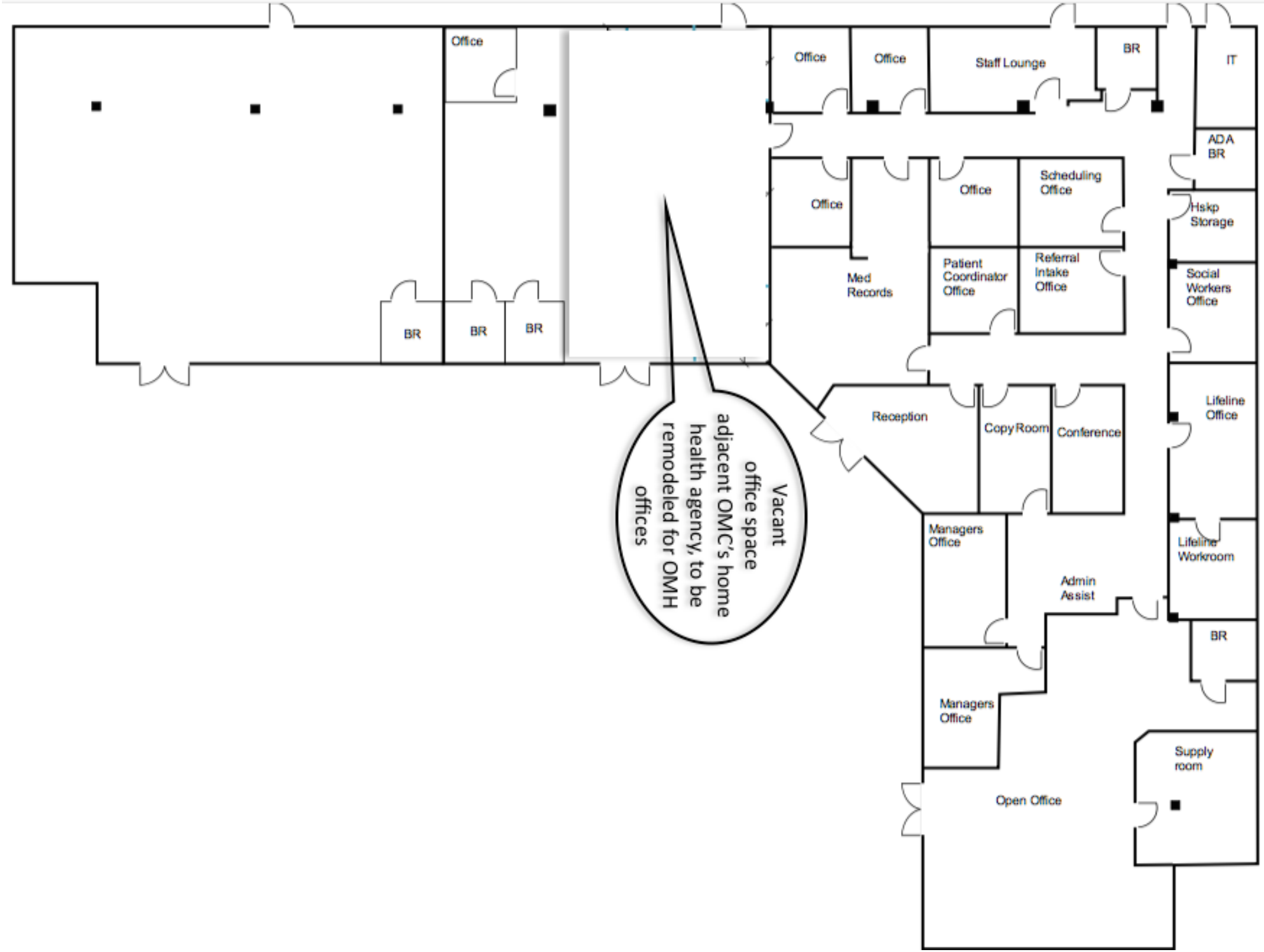
Administrator/Chief Executive Officer _____ Date _____

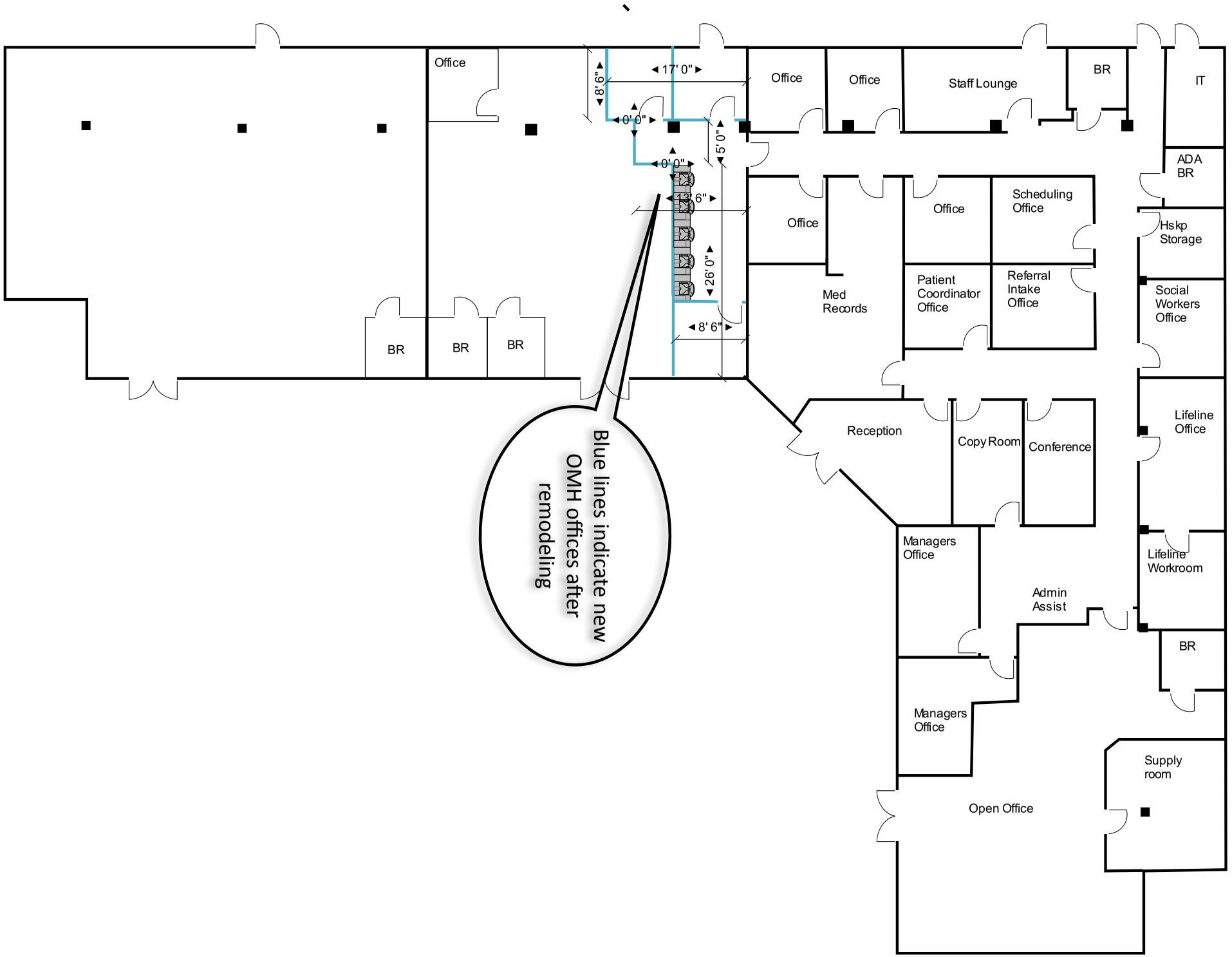
Chief Physician Officer _____ Date _____

Human Resources _____ Date _____

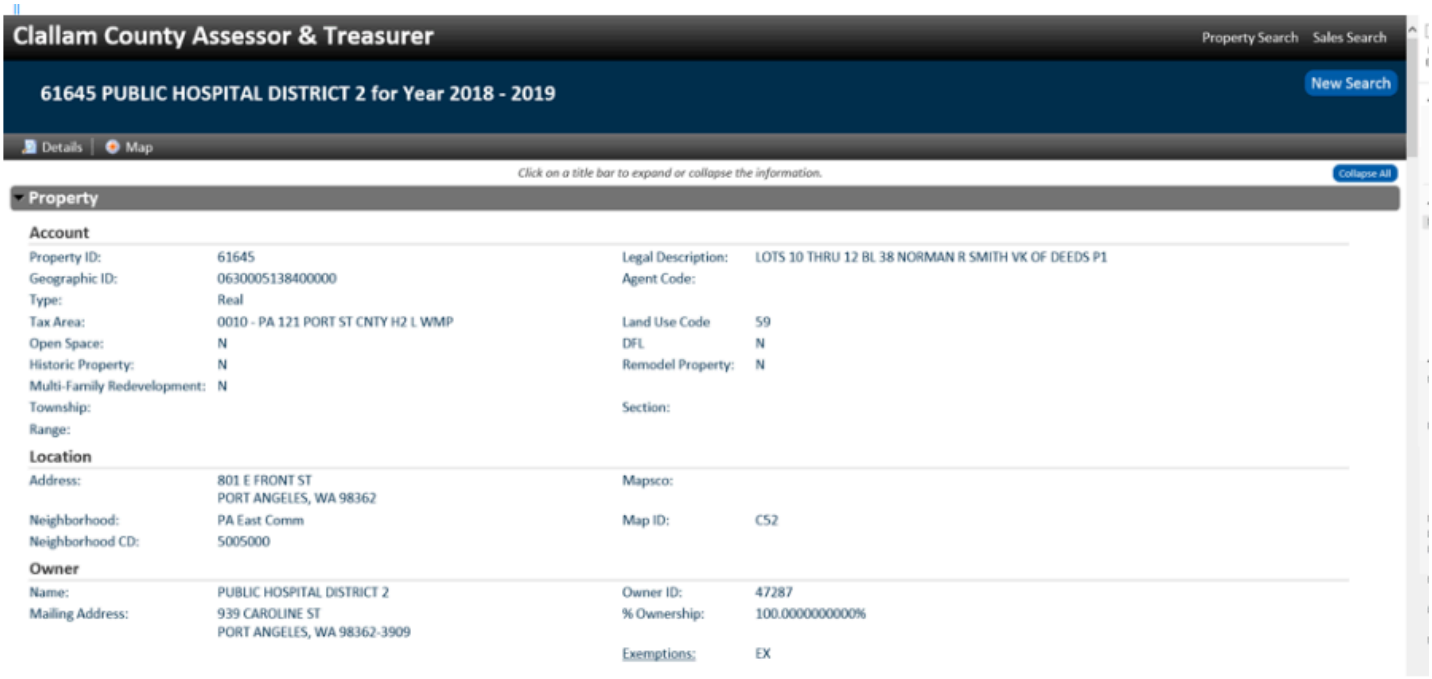
The above statements are intended to describe the general nature and level of work being performed. They are not intended to be construed as an exhaustive list of all responsibilities, duties and skills required of personnel classified in this position.

Appendix D	Line drawings, current and planned office space


Office
Office
Office
Staff Lounge
BR
IT
ADA BR
Office
Office
Scheduling Office
Hskp Storage
Med Records
Patient Coordinator Office
Referral Intake Office
Social Workers Office
BR
BR
BR
Reception
Copy Room
Conference
Lifeline Office
Vacant office space adjacent OMC's home health agency, to be remodeled for OMH offices
Managers Office
Lifeline Workroom
Admin Assist
BR
Managers Office
Supply room
Open Office


Office
8' 6"
17' 0"
0' 0"
5' 0"
0' 0"
13' 6"
26' 0"
8' 6"
BR
BR
BR
Office
Office
Staff Lounge
BR
IT
ADA BR
Office
Office
Scheduling Office
Hskp Storage
Med Records
Patient Coordinator Office
Referral Intake Office
Social Workers Office
Reception
Copy Room
Conference
Lifeline Office
Managers Office
Admin Assist
Lifeline Workroom
BR
Managers Office
Supply room
Open Office
Blue lines indicate new OMH offices after remodeling

Appendix E	Clallam County Tax Assessor, Recorded Ownership



Clallam County Assessor & Treasurer

Property Search Sales Search

61645 PUBLIC HOSPITAL DISTRICT 2 for Year 2018 - 2019

New Search

Details | Map

Click on a title bar to expand or collapse the information.

Collapse All

Property

Account

Property ID:	61645	Legal Description:	LOTS 10 THRU 12 BL 38 NORMAN R SMITH VK OF DEEDS P1
Geographic ID:	0630005138400000	Agent Code:	
Type:	Real		
Tax Area:	0010 - PA 121 PORT ST CNTY H2 L WMP	Land Use Code	59
Open Space:	N	DFL	N
Historic Property:	N	Remodel Property:	N
Multi-Family Redevelopment:	N		
Township:		Section:	
Range:			

Location

Address:	801 E FRONT ST PORT ANGELES, WA 98362	Mapsco:	
Neighborhood:	PA East Comm	Map ID:	C52
Neighborhood CD:	5005000		

Owner

Name:	PUBLIC HOSPITAL DISTRICT 2	Owner ID:	47287
Mailing Address:	939 CAROLINE ST PORT ANGELES, WA 98362-3909	% Ownership:	100.0000000000%
		Exemptions:	EX

Appendix F	DOH Hospice Need Methodology, 2018

Department of Health-Updated
2018-2019 Hospice Numeric Need Methodology
Effective 10/15/2018

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
2015	4,455
2016	3,768
2017	3,757
average:	3,993

Deaths ages 0-64	
Year	Deaths
2015	14,365
2016	13,557
2017	14,113
average:	14,012

Use Rates	
0-64	28.50%
65+	60.91%

Hospice admissions ages 65+	
Year	Admissions
2015	24,527
2016	24,738
2017	26,365
average:	25,210

Deaths ages 65+	
Year	Deaths
2015	40,149
2016	41,104
2017	42,918
average:	41,390

Source:
2018 Survey for CY2017 Hospice Data-facility self-report to department
Vital Statistics 2017
Prepared by Beth Harlow - October 2018

Department of Health-Updated
2018-2019 Hospice Numeric Need Methodology
Effective 10/15/2018

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	2015	2016	2017	2015-2017 Average Deaths
Adams	35	34	38	**36**
Asotin	62	50	49	**54**
Benton	372	352	385	**370**
Chelan	152	123	124	**133**
Clallam	203	172	180	**185**
Clark	881	781	883	**848**
Columbia	14	12	19	**15**
Cowlitz	280	290	351	**307**
Douglas	82	56	71	**70**
Ferry	23	20	30	**24**
Franklin	111	115	133	**120**
Garfield	4	4	6	**5**
Grant	197	191	203	**197**
Grays Harbor	238	233	238	**236**
Island	165	134	166	**155**
Jefferson	67	69	69	**68**
King	3,397	3,204	3,256	**3,286**
Kitsap	537	518	485	**513**
Kittitas	82	59	91	**77**
Klickitat	33	50	63	**49**
Lewis	236	194	210	**213**
Lincoln	20	26	20	**22**
Mason	184	164	169	**172**
Okanogan	128	110	119	**119**
Pacific	71	59	88	**73**
Pend Oreille	41	35	34	**37**
Pierce	1,892	1,883	1,936	**1,904**
San Juan	32	36	18	**29**
Skagit	279	248	271	**266**
Skamania	34	39	16	**30**
Snohomish	1,478	1,440	1,483	**1,467**
Spokane	1,230	1,168	1,147	**1,182**
Stevens	127	103	96	**109**
Thurston	581	485	530	**532**
Wahkiakum	5	10	3	**6**
Walla Walla	122	123	123	**123**
Whatcom	371	365	367	**368**
Whitman	74	42	57	**58**
Yakima	525	560	586	**557**

65+				
County	2015	2016	2017	2015-2017 Average Deaths
Adams	102	92	78	**91**
Asotin	212	192	190	**198**
Benton	1,103	1,075	1,081	**1,086**
Chelan	543	535	556	**545**
Clallam	754	762	842	**786**
Clark	2,553	2,589	2,579	**2,574**
Columbia	48	48	116	**71**
Cowlitz	864	863	917	**881**
Douglas	230	227	232	**230**
Ferry	54	64	60	**59**
Franklin	257	242	284	**261**
Garfield	28	20	17	**22**
Grant	488	479	509	**492**
Grays Harbor	555	606	622	**594**
Island	597	565	630	**597**
Jefferson	313	293	308	**305**
King	9,308	9,766	10,039	**9,704**
Kitsap	1,610	1,704	1,780	**1,698**
Kittitas	223	243	237	**234**
Klickitat	119	145	151	**138**
Lewis	667	676	721	**688**
Lincoln	78	102	105	**95**
Mason	499	494	550	**514**
Okanogan	340	303	350	**331**
Pacific	258	222	262	**247**
Pend Oreille	101	120	133	**118**
Pierce	4,550	4,751	5,019	**4,773**
San Juan	118	126	115	**120**
Skagit	909	979	1,007	**965**
Skamania	53	64	65	**61**
Snohomish	3,833	3,857	4,118	**3,936**
Spokane	3,361	3,356	3,527	**3,415**
Stevens	359	336	376	**357**
Thurston	1,651	1,661	1,768	**1,693**
Wahkiakum	39	39	37	**38**
Walla Walla	468	485	501	**485**
Whatcom	1,262	1,353	1,329	**1,315**
Whitman	223	212	236	**224**
Yakima	1,419	1,458	1,471	**1,449**

Source:
Vital Statistics 2017
Prepared by Beth Harlow - October 2018

Department of Health-Updated
2018-2019 Hospice Numeric Need Methodology
Effective 10/15/2018

Washington State Department of Health

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	2015-2017 Average Deaths	Projected Patients - 28.50% of Deaths
Adams	36	10
Asotin	54	15
Benton	370	105
Chelan	133	38
Clallam	185	53
Clark	848	242
Columbia	15	4
Cowlitz	307	87
Douglas	70	20
Ferry	24	7
Franklin	120	34
Garfield	5	1
Grant	197	56
Grays Harbor	236	67
Island	155	44
Jefferson	68	19
King	3,286	936
Kitsap	513	146
Kittitas	77	22
Klickitat	49	14
Lewis	213	61
Lincoln	22	6
Mason	172	49
Okanogan	119	34
Pacific	73	21
Pend Oreille	37	10
Pierce	1,904	543
San Juan	29	8
Skagit	266	76
Skamania	30	8
Snohomish	1,467	418
Spokane	1,182	337
Stevens	109	31
Thurston	532	152
Wahkiakum	6	2
Walla Walla	123	35
Whatcom	368	105
Whitman	58	16
Yakima	557	159

65+		
County	2015-2017 Average Deaths	Projected Patients - 60.91% of Deaths
Adams	91	55
Asotin	198	121
Benton	1,086	662
Chelan	545	332
Clallam	786	479
Clark	2,574	1,568
Columbia	71	43
Cowlitz	881	537
Douglas	230	140
Ferry	59	36
Franklin	261	159
Garfield	22	13
Grant	492	300
Grays Harbor	594	362
Island	597	364
Jefferson	305	186
King	9,704	5,911
Kitsap	1,698	1,034
Kittitas	234	143
Klickitat	138	84
Lewis	688	419
Lincoln	95	58
Mason	514	313
Okanogan	331	202
Pacific	247	151
Pend Oreille	118	72
Pierce	4,773	2,907
San Juan	120	73
Skagit	965	588
Skamania	61	37
Snohomish	3,936	2,397
Spokane	3,415	2,080
Stevens	357	217
Thurston	1,693	1,031
Wahkiakum	38	23
Walla Walla	485	295
Whatcom	1,315	801
Whitman	224	136
Yakima	1,449	883

Department of Health-Updated
2018-2019 Hospice Numeric Need Methodology
Effective 10/15/2018

Washington State Department of Health

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

0-64								
County	Projected Patients	2015-2017 Average Population	2018 projected population	2019 projected population	2020 projected population	2018 potential volume	2019 potential volume	2020 potential volume
Adams	10	17,768	18,029	18,160	18,291	10	10	10
Asotin	15	16,906	16,779	16,715	16,652	15	15	15
Benton	105	163,693	166,554	167,984	169,415	107	108	109
Chelan	38	61,520	61,991	62,227	62,463	38	38	38
Clallam	53	52,661	52,550	52,494	52,439	53	53	53
Clark	242	393,291	405,282	411,278	417,273	249	253	257
Columbia	4	2,947	2,863	2,822	2,780	4	4	4
Cowlitz	87	85,517	85,717	85,817	85,917	88	88	88
Douglas	20	33,938	34,732	35,130	35,527	20	21	21
Ferry	7	5,782	5,680	5,628	5,577	7	7	7
Franklin	34	81,742	85,922	88,012	90,102	36	37	38
Garfield	1	1,644	1,602	1,581	1,560	1	1	1
Grant	56	82,660	84,909	86,033	87,158	58	58	59
Grays Harbor	67	58,675	57,817	57,387	56,958	66	66	65
Island	44	62,664	62,964	63,114	63,264	44	44	45
Jefferson	19	20,653	20,688	20,705	20,722	20	20	20
King	936	1,820,215	1,863,482	1,885,115	1,906,749	959	970	981
Kitsap	146	214,045	217,040	218,538	220,035	148	149	150
Kittitas	22	36,768	37,892	38,453	39,015	23	23	23
Klickitat	14	16,082	15,828	15,702	15,575	14	14	13
Lewis	61	61,796	62,398	62,700	63,001	61	62	62
Lincoln	6	8,042	7,923	7,864	7,805	6	6	6
Mason	49	49,162	50,142	50,632	51,122	50	51	51
Okanogan	34	32,906	32,545	32,364	32,183	34	33	33
Pacific	21	14,972	14,688	14,545	14,403	20	20	20
Pend Oreille	10	9,998	9,905	9,859	9,812	10	10	10
Pierce	543	729,937	747,538	756,339	765,139	556	562	569
San Juan	8	11,194	10,974	10,863	10,753	8	8	8
Skagit	76	98,616	100,076	100,807	101,537	77	77	78
Skamania	8	9,266	9,254	9,248	9,242	8	8	8
Snohomish	418	672,806	694,793	705,787	716,781	432	439	445
Spokane	337	416,684	421,066	423,256	425,447	340	342	344
Stevens	31	34,459	34,226	34,109	33,992	31	31	31
Thurston	152	228,261	234,880	238,190	241,500	156	158	160
Wahkiakum	2	2,669	2,555	2,498	2,441	2	2	2
Walla Walla	35	50,111	50,546	50,763	50,981	35	35	36
Whatcom	105	178,234	183,023	185,418	187,812	108	109	110
Whitman	16	42,965	43,137	43,222	43,308	17	17	17
Yakima	159	217,605	221,051	222,774	224,497	161	163	164

Source:
OFM, "2017 County Age and Sex Projections, five-year intervals and age groups"
Prepared by Beth Harlow - October 2018

Department of Health-Updated
2018-2019 Hospice Numeric Need Methodology
Effective 10/15/2018

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	2015-2017 Average Population	2018 projected population	2019 projected population	2020 projected population	2018 potential volume	2019 potential volume	2020 potential volume
Adams	55	1,887	2,114	2,227	2,341	62	65	69
Asotin	121	5,233	5,619	5,812	6,005	129	134	138
Benton	662	27,492	29,821	30,986	32,150	718	746	774
Chelan	332	14,279	15,343	15,876	16,408	356	369	381
Clallam	479	20,401	21,334	21,800	22,267	501	512	523
Clark	1568	68,044	75,085	78,605	82,125	1,730	1,811	1,892
Columbia	43	1,135	1,202	1,236	1,269	46	47	48
Cowlitz	537	19,684	21,326	22,148	22,969	582	604	626
Douglas	140	6,831	7,595	7,976	8,358	156	163	171
Ferry	36	1,949	2,095	2,168	2,241	39	40	42
Franklin	159	7,921	8,765	9,188	9,610	176	184	193
Garfield	13	607	633	645	658	14	14	14
Grant	300	13,011	14,244	14,861	15,477	328	342	356
Grays Harbor	362	14,535	15,594	16,123	16,653	388	402	415
Island	364	18,625	19,701	20,239	20,777	385	395	406
Jefferson	186	10,580	11,252	11,588	11,924	197	203	209
King	5911	268,307	296,484	310,572	324,660	6,531	6,842	7,152
Kitsap	1034	47,697	51,788	53,833	55,878	1,123	1,167	1,212
Kittitas	143	6,760	7,351	7,647	7,943	155	161	168
Klickitat	84	5,051	5,570	5,829	6,088	93	97	102
Lewis	419	15,576	16,398	16,808	17,219	441	452	463
Lincoln	58	2,687	2,823	2,891	2,959	61	62	64
Mason	313	14,123	15,311	15,905	16,499	340	353	366
Okanogan	202	9,198	10,050	10,475	10,901	220	230	239
Pacific	151	6,258	6,584	6,747	6,910	158	162	166
Pend Oreille	72	3,378	3,742	3,925	4,107	80	84	87
Pierce	2907	114,409	125,262	130,688	136,114	3,183	3,321	3,459
San Juan	73	5,099	5,545	5,768	5,991	79	82	86
Skagit	588	24,021	26,595	27,881	29,168	651	682	714
Skamania	37	2,286	2,542	2,670	2,798	41	43	45
Snohomish	2397	101,674	113,447	119,333	125,219	2,675	2,814	2,952
Spokane	2080	77,325	84,343	87,852	91,361	2,269	2,363	2,457
Stevens	217	9,930	10,884	11,360	11,837	238	249	259
Thurston	1031	44,534	48,683	50,757	52,832	1,127	1,176	1,224
Wahkiakum	23	1,316	1,441	1,503	1,565	26	27	28
Walla Walla	295	10,819	10,944	11,006	11,068	299	300	302
Whatcom	801	35,688	39,164	40,902	42,640	879	918	957
Whitman	136	4,659	5,237	5,526	5,815	153	162	170
Yakima	883	34,949	36,670	37,530	38,391	926	948	970

Source:
OFM, "2017 County Age and Sex Projections, five-year intervals and age groups"
Prepared by Beth Harlow - October 2018

Department of Health-Updated
2018-2019 Hospice Numeric Need Methodology
Effective 10/15/2018

Washington State Department of Health

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	2018 potential volume	2019 potential volume	2020 potential volume	Current Capacity	2018 Admits (Unmet)	2019 Admits (Unmet)	2020 Admits (Unmet)
Adams	72	76	79	**33.67**	39	42	45
Asotin	145	149	153	**73.33**	71	76	80
Benton	825	854	883	**902.67**	(78)	(49)	(20)
Chelan	395	407	420	**371.67**	23	36	48
Clallam	553	564	575	**129.67**	424	434	445
Clark	1,979	2,064	2,148	**1,881.00**	98	183	267
Columbia	50	51	52	**19.33**	30	32	33
Cowlitz	669	692	714	**774.67**	(105)	(83)	(60)
Douglas	176	184	192	**144.33**	32	40	48
Ferry	46	47	48	**27.33**	18	20	21
Franklin	212	221	230	**148.67**	63	72	82
Garfield	15	15	16	**4.00**	11	11	12
Grant	386	401	416	**225.00**	161	176	191
Grays Harbor	455	467	480	**280.33**	174	187	200
Island	429	440	450	**307.33**	122	133	143
Jefferson	217	223	229	**168.00**	49	55	61
King	7,490	7,812	8,133	**7,847.23**	(357)	(36)	286
Kitsap	1,271	1,317	1,362	**1,152.67**	119	164	209
Kittitas	178	185	191	**135.00**	43	50	56
Klickitat	107	111	115	**156.63**	(50)	(46)	(42)
Lewis	503	514	525	**438.33**	64	76	87
Lincoln	67	68	70	**19.00**	48	49	51
Mason	390	403	417	**241.67**	148	162	175
Okanogan	254	263	272	**190.33**	63	73	82
Pacific	179	183	186	**97.00**	82	86	89
Pend Oreille	90	94	98	**58.00**	32	36	40
Pierce	3,739	3,883	4,028	**3,895.33**	(157)	(12)	132
San Juan	87	90	93	**75.33**	12	15	18
Skagit	728	760	792	**628.67**	99	131	163
Skamania	50	52	54	**39.00**	11	13	15
Snohomish	3,107	3,252	3,398	**2,635.33**	471	617	763
Spokane	2,609	2,705	2,801	**2,664.00**	(55)	41	137
Stevens	269	279	290	**138.33**	131	141	151
Thurston	1,283	1,334	1,384	**1,104.30**	179	229	280
Wahkiakum	27	28	29	**6.33**	21	22	23
Walla Walla	334	336	338	**317.00**	17	19	21
Whatcom	986	1,027	1,067	**858.67**	128	168	208
Whitman	170	178	187	**227.33**	(58)	(49)	(41)
Yakima	1,087	1,110	1,133	**1,123.67**	(36)	(13)	10

Source:
2016-2018 Surveys for CY2015-2017 Historical Data - facility self-report to department
Prepared by Beth Harlow - October 2018

Department of Health-Updated
2018-2019 Hospice Numeric Need Methodology
Effective 10/15/2018

Washington State Department of Health

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	2018 Admits (Unmet)	2019 Admits (Unmet)	2020 Admits (Unmet)	Statewide ALOS	2018 Patient Days (unmet)	2019 Patient Days (unmet)	2020 Patient Days (unmet)
Adams	39	42	45	**60.86**	2,344	2,551	2,758
Asotin	71	76	80	**60.86**	4,341	4,608	4,875
Benton	(78)	(49)	(20)	**60.86**	(4,732)	(2,971)	(1,209)
Chelan	23	36	48	**60.86**	1,400	2,162	2,924
Clallam	424	434	445	**60.86**	25,779	26,442	27,105
Clark	98	183	267	**60.86**	5,959	11,119	16,278
Columbia	30	32	33	**60.86**	1,850	1,924	1,997
Cowlitz	(105)	(83)	(60)	**60.86**	(6,413)	(5,044)	(3,674)
Douglas	32	40	48	**60.86**	1,917	2,407	2,897
Ferry	18	20	21	**60.86**	1,115	1,194	1,272
Franklin	63	72	82	**60.86**	3,840	4,409	4,978
Garfield	11	11	12	**60.86**	672	688	703
Grant	161	176	191	**60.86**	9,782	10,693	11,604
Grays Harbor	174	187	200	**60.86**	10,615	11,387	12,160
Island	122	133	143	**60.86**	7,419	8,065	8,711
Jefferson	49	55	61	**60.86**	2,974	3,333	3,693
King	(357)	(36)	286	**60.86**	(21,735)	(2,169)	17,397
Kitsap	119	164	209	**60.86**	7,217	9,978	12,739
Kittitas	43	50	56	**60.86**	2,613	3,014	3,414
Klickitat	(50)	(46)	(42)	**60.86**	(3,048)	(2,791)	(2,535)
Lewis	64	76	87	**60.86**	3,907	4,598	5,288
Lincoln	48	49	51	**60.86**	2,919	3,005	3,092
Mason	148	162	175	**60.86**	9,011	9,842	10,674
Okanogan	63	73	82	**60.86**	3,863	4,419	4,976
Pacific	82	86	89	**60.86**	4,979	5,205	5,432
Pend Oreille	32	36	40	**60.86**	1,947	2,180	2,413
Pierce	(157)	(12)	132	**60.86**	(9,530)	(740)	8,050
San Juan	12	15	18	**60.86**	727	916	1,105
Skagit	99	131	163	**60.86**	6,025	7,975	9,925
Skamania	11	13	15	**60.86**	641	766	892
Snohomish	471	617	763	**60.86**	28,686	37,548	46,411
Spokane	(55)	41	137	**60.86**	(3,355)	2,497	8,348
Stevens	131	141	151	**60.86**	7,957	8,586	9,215
Thurston	179	229	280	**60.86**	10,905	13,963	17,021
Wahkiakum	21	22	23	**60.86**	1,269	1,334	1,399
Walla Walla	17	19	21	**60.86**	1,026	1,139	1,251
Whatcom	128	168	208	**60.86**	7,769	10,228	12,687
Whitman	(58)	(49)	(41)	**60.86**	(3,512)	(2,996)	(2,480)
Yakima	(36)	(13)	10	**60.86**	(2,201)	(802)	598

Department of Health-Updated
2018-2019 Hospice Numeric Need Methodology
Effective 10/15/2018

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	**2018 Patient Days (unmet)**	**2019 Patient Days (unmet)**	**2020 Patient Days (unmet)**	**2018 ADC (unmet)**	**2019 ADC (unmet)**	**2020 ADC (unmet)**
Adams	2,344	2,551	2,758	6	7	8
Asotin	4,341	4,608	4,875	12	13	13
Benton	(4,732)	(2,971)	(1,209)	(13)	(8)	(3)
Chelan	1,400	2,162	2,924	4	6	8
Clallam	25,779	26,442	27,105	71	72	74
Clark	5,959	11,119	16,278	16	30	45
Columbia	1,850	1,924	1,997	5	5	5
Cowlitz	(6,413)	(5,044)	(3,674)	(18)	(14)	(10)
Douglas	1,917	2,407	2,897	5	7	8
Ferry	1,115	1,194	1,272	3	3	3
Franklin	3,840	4,409	4,978	11	12	14
Garfield	672	688	703	2	2	2
Grant	9,782	10,693	11,604	27	29	32
Grays Harbor	10,615	11,387	12,160	29	31	33
Island	7,419	8,065	8,711	20	22	24
Jefferson	2,974	3,333	3,693	8	9	10
King	(21,735)	(2,169)	17,397	(60)	(6)	48
Kitsap	7,217	9,978	12,739	20	27	35
Kittitas	2,613	3,014	3,414	7	8	9
Klickitat	(3,048)	(2,791)	(2,535)	(8)	(8)	(7)
Lewis	3,907	4,598	5,288	11	13	14
Lincoln	2,919	3,005	3,092	8	8	8
Mason	9,011	9,842	10,674	25	27	29
Okanogan	3,863	4,419	4,976	11	12	14
Pacific	4,979	5,205	5,432	14	14	15
Pend Oreille	1,947	2,180	2,413	5	6	7
Pierce	(9,530)	(740)	8,050	(26)	(2)	22
San Juan	727	916	1,105	2	3	3
Skagit	6,025	7,975	9,925	17	22	27
Skamania	641	766	892	2	2	2
Snohomish	28,686	37,548	46,411	79	103	127
Spokane	(3,355)	2,497	8,348	(9)	7	23
Stevens	7,957	8,586	9,215	22	24	25
Thurston	10,905	13,963	17,021	30	38	47
Wahkiakum	1,269	1,334	1,399	3	4	4
Walla Walla	1,026	1,139	1,251	3	3	3
Whatcom	7,769	10,228	12,687	21	28	35
Whitman	(3,512)	(2,996)	(2,480)	(10)	(8)	(7)
Yakima	(2,201)	(802)	598	(6)	(2)	2

Department of Health-Updated
2018-2019 Hospice Numeric Need Methodology
Effective 10/15/2018

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	2018 ADC (unmet)	2019 ADC (unmet)	2020 ADC (unmet)	Numeric Need?	Agencies Needed?
Adams	6	7	8	FALSE	FALSE
Asotin	12	13	13	FALSE	FALSE
Benton	(13)	(8)	(3)	FALSE	FALSE
Chelan	4	6	8	FALSE	FALSE
Clallam	71	72	74	TRUE	2.12
Clark	16	30	45	TRUE	1.27
Columbia	5	5	5	FALSE	FALSE
Cowlitz	(18)	(14)	(10)	FALSE	FALSE
Douglas	5	7	8	FALSE	FALSE
Ferry	3	3	3	FALSE	FALSE
Franklin	11	12	14	FALSE	FALSE
Garfield	2	2	2	FALSE	FALSE
Grant	27	29	32	FALSE	FALSE
Grays Harbor	29	31	33	FALSE	FALSE
Island	20	22	24	FALSE	FALSE
Jefferson	8	9	10	FALSE	FALSE
King	(60)	(6)	48	TRUE	1.36
Kitsap	20	27	35	FALSE	FALSE
Kittitas	7	8	9	FALSE	FALSE
Klickitat	(8)	(8)	(7)	FALSE	FALSE
Lewis	11	13	14	FALSE	FALSE
Lincoln	8	8	8	FALSE	FALSE
Mason	25	27	29	FALSE	FALSE
Okanogan	11	12	14	FALSE	FALSE
Pacific	14	14	15	FALSE	FALSE
Pend Oreille	5	6	7	FALSE	FALSE
Pierce	(26)	(2)	22	FALSE	FALSE
San Juan	2	3	3	FALSE	FALSE
Skagit	17	22	27	FALSE	FALSE
Skamania	2	2	2	FALSE	FALSE
Snohomish	79	103	127	TRUE	3.63
Spokane	(9)	7	23	FALSE	FALSE
Stevens	22	24	25	FALSE	FALSE
Thurston	30	38	47	TRUE	1.33
Wahkiakum	3	4	4	FALSE	FALSE
Walla Walla	3	3	3	FALSE	FALSE
Whatcom	21	28	35	FALSE	FALSE
Whitman	(10)	(8)	(7)	FALSE	FALSE
Yakima	(6)	(2)	2	FALSE	FALSE

Department of Health-Updated
2018-2019 Hospice Numeric Need Methodology

Effective 10/15/2018

	0-64			65+		
County	**2015**	**2016**	**2017**	**2015**	**2016**	**2017**
ADAMS	35	34	38	102	92	78
ASOTIN	62	50	49	212	192	190
BENTON	372	352	385	1,103	1,075	1,081
CHELAN	152	123	124	543	535	556
CLALLAM	203	172	180	754	762	842
CLARK	881	781	883	2,553	2,589	2,579
COLUMBIA	14	12	19	48	48	116
COWLITZ	280	290	351	864	863	917
DOUGLAS	82	56	71	230	227	232
FERRY	23	20	30	54	64	60
FRANKLIN	111	115	133	257	242	284
GARFIELD	4	4	6	28	20	17
GRANT	197	191	203	488	479	509
GRAYS HARBOR	238	233	238	555	606	622
ISLAND	165	134	166	597	565	630
JEFFERSON	67	69	69	313	293	308
KING	3,397	3,204	3,256	9,308	9,766	10,039
KITSAP	537	518	485	1,610	1,704	1,780
KITTITAS	82	59	91	223	243	237
KLICKITAT	33	50	63	119	145	151
LEWIS	236	194	210	667	676	721
LINCOLN	20	26	20	78	102	105
MASON	184	164	169	499	494	550
OKANOGAN	128	110	119	340	303	350
PACIFIC	71	59	88	258	222	262
PEND OREILLE	41	35	34	101	120	133
PIERCE	1,892	1,883	1,936	4,550	4,751	5,019
SAN JUAN	32	36	18	118	126	115
SKAGIT	279	248	271	909	979	1,007
SKAMANIA	34	39	16	53	64	65
SNOHOMISH	1,478	1,440	1,483	3,833	3,857	4,118
SPOKANE	1,230	1,168	1,147	3,361	3,356	3,527
STEVENS	127	103	96	359	336	376
THURSTON	581	485	530	1,651	1,661	1,768
WAHKIAKUM	5	10	3	39	39	37
WALLA WALLA	122	123	123	468	485	501
WHATCOM	371	365	367	1,262	1,353	1,329
WHITMAN	74	42	57	223	212	236
YAKIMA	525	560	586	1,419	1,458	1,471

Department of Health-Updated
2018-2019 Hospice Numeric Need Methodology
Effective 10/15/2018

0-64 Total Admissions by County

Sum of 0-64	Column Labels		
Row Labels	**2015**	**2016**	**2017**
Adams	8	6	4
Asotin	12	10	7
Benton	108	106	110
Chelan	49	35	44
Clallam	13	6	14
Clark	257	310	282
Columbia	3	0	1
Cowlitz	119	105	124
Douglas	19	19	19
Ferry	2	3	7
Franklin	26	16	15
Garfield	0	0	1
Grant	31	42	44
Grays Harbor	29	66	72
Island	33	32	35
Jefferson	16	15	14
King	1,125	906	862
Kitsap	177	132	104
Kittitas	15	20	46
Klickitat	9	30	17
Lewis	76	53	45
Lincoln	2	4	3
Mason	47	18	34
Okanogan	38	35	34
Pacific	13	15	17
Pend Oreille	12	11	8
Pierce	747	453	419
San Juan	5	11	3
Skagit	77	62	61
Skamania	11	14	4
Snohomish	450	366	339
Spokane	386	367	397
Stevens	24	13	25
Thurston	161	132	144
Wahkiakum	1	0	1
Walla Walla	39	45	45
Whatcom	129	122	139
Whitman	2	9	29
Yakima	184	179	188
Grand Total	**4,455**	**3,768**	**3,757**

65+ Total Admissions by County

Sum of 65+	Column Labels		
Row Labels	**2015**	**2016**	**2017**
Adams	28	25	30
Asotin	59	47	85
Benton	758	751	875
Chelan	363	305	319
Clallam	103	110	143
Clark	1,159	1,737	1,898
Columbia	18	19	17
Cowlitz	636	645	695
Douglas	145	102	129
Ferry	15	18	37
Franklin	157	110	122
Garfield	7	3	1
Grant	163	179	216
Grays Harbor	118	264	292
Island	263	195	364
Jefferson	172	120	167
King	6,788	6,510	6,739
Kitsap	951	938	1,156
Kittitas	111	79	134
Klickitat	71	72	82
Lewis	343	378	420
Lincoln	9	17	22
Mason	203	191	232
Okanogan	199	133	132
Pacific	41	99	106
Pend Oreille	32	56	55
Pierce	3,310	3,401	3,356
San Juan	67	70	70
Skagit	479	591	616
Skamania	32	35	21
Snohomish	2,439	2,228	2,084
Spokane	2,199	2,176	2,467
Stevens	105	120	128
Thurston	887	880	899
Wahkiakum	8	5	4
Walla Walla	273	273	276
Whatcom	708	712	766
Whitman	187	207	248
Yakima	921	937	962
Grand Total	**24,527**	**24,738**	**26,365**

Total Admissions by County - Not Adjusted for New Approvals

Column1	Total 2015	Total 2016	Total 2017	Average
Adams	36	31	34	**33.67**
Asotin	71	57	92	**73.33**
Benton	866	857	985	**902.67**
Chelan	412	340	363	**371.67**
Clallam	116	116	157	**129.67**
Clark	1,416	2,047	2,180	**1,881.00**
Columbia	21	19	18	**19.33**
Cowlitz	755	750	819	**774.67**
Douglas	164	121	148	**144.33**
Ferry	17	21	44	**27.33**
Franklin	183	126	137	**148.67**
Garfield	7	3	2	**4.00**
Grant	194	221	260	**225.00**
Grays Harbor	147	330	364	**280.33**
Island	296	227	399	**307.33**
Jefferson	188	135	181	**168.00**
King	7,913	7,416	7,601	**7,643.33**
Kitsap	1,128	1,070	1,260	**1,152.67**
Kittitas	126	99	180	**135.00**
Klickitat	80	102	99	**93.67**
Lewis	419	431	465	**438.33**
Lincoln	11	21	25	**19.00**
Mason	250	209	266	**241.67**
Okanogan	237	168	166	**190.33**
Pacific	54	114	123	**97.00**
Pend Oreille	44	67	63	**58.00**
Pierce	4,057	3,854	3,775	**3,895.33**
San Juan	72	81	73	**75.33**
Skagit	556	653	677	**628.67**
Skamania	43	49	25	**39.00**
Snohomish	2,889	2,594	2,423	**2,635.33**
Spokane	2,585	2,543	2,864	**2,664.00**
Stevens	129	133	153	**138.33**
Thurston	1,048	1,012	1,043	**1,034.33**
Wahkiakum	9	5	5	**6.33**
Walla Walla	312	318	321	**317.00**
Whatcom	837	834	905	**858.67**
Whitman	189	216	277	**227.33**
Yakima	1,105	1,116	1,150	**1,123.67**

Total Admissions by County - Adjusted for New

Column1	Total 2015	Total 2016	Total 2017	Average
Adams	36	31	34	**33.67**
Asotin	71	57	92	**73.33**
Benton	866	857	985	**902.67**
Chelan	412	340	363	**371.67**
Clallam	116	116	157	**129.67**
Clark	1,416	2,047	2,180	**1,881.00**
Columbia	21	19	18	**19.33**
Cowlitz	755	750	819	**774.67**
Douglas	164	121	148	**144.33**
Ferry	17	21	44	**27.33**
Franklin	183	126	137	**148.67**
Garfield	7	3	2	**4.00**
Grant	194	221	260	**225.00**
Grays Harbor	147	330	364	**280.33**
Island	296	227	399	**307.33**
Jefferson	188	135	181	**168.00**
King	8,123	7,626	7,793	**7,847.23**
Kitsap	1,128	1,070	1,260	**1,152.67**
Kittitas	126	99	180	**135.00**
Klickitat	80	102	288	**156.63**
Lewis	419	431	465	**438.33**
Lincoln	11	21	25	**19.00**
Mason	250	209	266	**241.67**
Okanogan	237	168	166	**190.33**
Pacific	54	114	123	**97.00**
Pend Oreille	44	67	63	**58.00**
Pierce	4,057	3,854	3,775	**3,895.33**
San Juan	72	81	73	**75.33**
Skagit	556	653	677	**628.67**
Skamania	43	49	25	**39.00**
Snohomish	2,889	2,594	2,423	**2,635.33**
Spokane	2,585	2,543	2,864	**2,664.00**
Stevens	129	133	153	**138.33**
Thurston	1,048	1,012	1,253	**1,104.30**
Wahkiakum	9	5	5	**6.33**
Walla Walla	312	318	321	**317.00**
Whatcom	837	834	905	**858.67**
Whitman	189	216	277	**227.33**
Yakima	1,105	1,116	1,150	**1,123.67**

Agencies that have operated for <3 years:
Wesley Homes Hospice - approved in 2015, operational since 2017 in King County
Heart of Hospice - approved in August 2017. Operational since August 2017 in Klickitat County.
Envision Hospice - approved in September 2018.

Calculation for "default values" per WAC 246-310-290(7)(b), assumption of 35 ADC, 60.86 ALOS per CMS

35 ADC * 365 days per year = 12,775 default patient days
12,775 patient days/60.86 ALOS = 209.9 default admissions

For both affected counties, the actual volumes from these recently approved agnecies will be subtracted, and default values will be added.

Appendix G	Admissions policy

OLYMPIC MEDICAL CENTER

Admission To Home Health or Hospice DRAFT

Group	Process	Approved Date
Patient Care	OMHHH	12/12/2018

Note: Printed copies are for reference only. Please refer to SharePoint for the latest version.

Purpose:
To establish admission criteria for patients referred to Olympic Medical Home Health and Hospice in accordance with policy

Policy:

1. Patients and their families are accepted for care if their needs are compatible with services provided by the agency and criteria for acceptance are satisfied. Patients are accepted for treatment regardless of race, religious philosophy, nationality, marital status, age, sex, ethnic origin, sexual orientation, source of financial support, or disability, unless such disability cannot be effectively managed by Olympic Medical Home Health and Hospice.
2. Criteria for Admission to Olympic Medical Home Health and Hospice:
    a. Patient service locations:
        - Home Health patients must live in Clallam or West Jefferson counties.
        - Hospice patients must live in Clallam County.
    b. The patient is under the care of a physician, which means a doctor of medicine, osteopathy, or podiatry, legally authorized to practice medicine or surgery in the state of Washington.
    c. Hospice patients are admitted upon recommendation of the Hospice Medical Director in consultation with, or input from the attending Provider (if any).
    d. Attending physician and/or Hospice Medical Director establishes the plan of care and certifies to the necessity for home health and/or hospice
    e. The patient must not pose a potential safety risk to clinicians and must not be an active IV drug abuser for home infusion. Referrals in question will be evaluated on a case by case basis to determine acceptance.
    f. There is a reasonable expectation that the patient's medical, nursing, therapeutic, social, and personal care needs can be met at the level of intensity required by the patient's condition, including consideration of potential medical emergencies.
    g. Patients meet specific criteria set by reimbursing insurance, such as Medicare requires that Home Care patients are homebound, in need of skilled care and have a face-to-face physician encounter 90 days prior or within 30 days after home health admission. Hospice patients must be certified as being terminally ill with a prognosis of 6 months or less, if the terminal illness runs its normal course.
    h. Adequate and suitable agency personnel and resources including equipment and supplies are available to provide the required service(s).
    i. The patient is in need of home health or hospice services on an intermittent or part-time basis.
    j. The patient and family are willing to cooperate in developing the plan of care by providing information and assistance as needed.
    k. Adequate information is obtainable from patient, family, medical, nursing, therapy, social, or other sources to facilitate the development and implementation of an effective plan of care.
    l. If necessary, there is a family member or significant other able and willing to participate in the patient's care.

m. Home Health Patients residing in any facility or institution which provides on-site skilled services will not be accepted if services ordered are a duplication of services already provided. Hospice patients residing in any facility or institution which provides on-site skilled services will be accepted if they meet admission criteria.
n. The patient or legal representative must give consent for care and sign the following forms:
    - Consent Form
    - Supply Letter (if applicable)
    - Financial Responsibility
o. In the event that the patient has no durable power of attorney or next of kin and is unable to sign or to give consent, the attending physician will be asked to sign consent for care.
    - Referral Intake will contact the power of attorney for verbal consent and process the referral when this is obtained. A contact note will be documented in the patient's medical record.
    - Medical Records will mail forms described above to the power of attorney for signature upon admission.

Approval & Review Tracking:	**Next Review: 3/31/2021**
Approved By:	X _____ X _____ Chief Nursing Officer **Lorraine Wall** [Additional Signtures]
Reviewed by:	*12/18 - Joan Warren, Lorraine Wall, Sandy Ulf*

11.01 - Admissions at Olympic Medical Center

Group	Process	Approved Date
Administrative	Patient Care	3/1/2016

Note: Printed copies are for reference only. Please refer to SharePoint for the latest version.

PURPOSE: To ensure that all patients admitted to the hospital are treated in a nondiscriminatory manner, respectful of patient rights, and consistent with applicable State and Federal law.

POLICY: Olympic Medical Center is dedicated to providing services to patients in a safe manner that respects, protects, and promotes patient rights taking into consideration the patients' physical, emotional, and medical needs. Patient admissions will be conducted free from discrimination based on age, race, color, creed, ethnicity, religion, national origin, marital status, sex, sexual orientation, gender identity or expression, disability, veteran or military status, or any other basis prohibited by Federal, State, or local law.

All individuals have access to emergency care twenty-four hours a day.

Inpatient admissions are permitted only with orders from a provider who has Olympic Medical Center medical staff admitting privileges. Consideration must be given to the Hospital's capabilities, as well as availability of staffing and space.

During admission and through their visit patients will be treated with respect and courtesy. Their rights, privileges, and decisions shall be acknowledged and honored within the capabilities of the Hospital. Consideration shall be given for their comfort, health, and safety.

Patients (or their legally authorized representative) will be provided with essential information as required by law. Information on the following will be made available during the admission process:

- Patient Rights and Responsibilities
- Notice of Privacy Practices
- Advanced Directives*
- Financial Assistance
- Consent for Treatment
- Contact Information for Grievances

* *Patients will be queried about the existence of their advanced directives for information and documentation in the medical record.*

Assistance or accommodations for those with disabilities will be provided to the extent of the Hospital's resources and in compliance with the Americans with Disabilities Act. Language interpretative services will be made available for non-English speaking patients. Sign language interpretative services will be made available for hearing impaired patients, as requested.

Patients are to be admitted and discharged in a safe manner, taking into consideration their physical and medical needs. The decision as to the mode of transport rests with the admitting or discharging nurse. Any questions regarding mode of transport may be referred to the nursing supervisor.

Admin Policy References:

11.13 - Accepting Acute Care Patients
11.13.01 - Patient Screening & Treatment for Acute Care
11.13.02 - Transfer of Patient for Acute Care
11.14 - High Census Periods/Diversion
11.05 - Patient Rights and Responsibilities
11.12 - Advance Directives
11.30 - Consents
10.11 - Americans with Disabilities Act (ADA)
9.03 – Financial Assistance Program

Approval & Review Tracking:		**Next Review: 3/31/2018**
Approved By:	X Chief Executive Officer **Eric Lewis**	
Reviewed by: (Name/Date)	*02/84, 08/84, 02/90, 02/96, 12/98; 04/99, 06/02, 10/07, 02/12, 02/13, 3/16 by: L. Jenny, 03/88, 01/90, 04/93, 04/99, 04/02; 04/05; 3/14 D. Davison*	
Committees Review	[Committee 1]	[Review 1]
	[Committee 2]	[Review 2]
	[Committee 3]	[Review 3]
	[Committee 4]	[Review 4]

Appendix H	Charity care policy

9.03 - Financial Assistance Program

Group	Process	Approved Date
Administrative	Finance	1/18/2018

Note: Printed copies are for reference only. Please refer to SharePoint for the latest version.

PURPOSE

Consistent with its mission to work together to provide excellence in healthcare, Olympic Medical Center is committed to providing financial assistance to uninsured and underinsured individuals who are in need of emergency or medically necessary treatment and have a household income between 100% and 300% of the Federal Poverty Level Guidelines (FPL).

In accordance with the Patient Protection and Affordable Care Act (PPACA) and section 501(r) of the Internal Revenue Service code, all financial assistance eligible patients will not be charged more for emergency or medically necessary care than the amount generally billed (AGB) to insured patients.

The purpose of this policy is to outline the circumstances under which financial assistance (also referred to as charity care) may be provided to qualifying low income patients for medically necessary healthcare services provided by Olympic Medical Center.

POLICY

In recognition of the need of individuals with limited financial resources to obtain certain critical healthcare services, Olympic Medical Center is committed to the provision of medically necessary healthcare services to community members and those in emergent medical need.

Financial assistance is provided only when care is deemed medically necessary and after patients have been found to meet all financial criteria. Olympic Medical Center offers both free care and discounted care, depending on individuals' family size and income.

Consideration for financial assistance will be given equally to all qualifying individuals, regardless of race, color, sex, religion, age, national origin, veteran's status, marital status, sexual orientation, immigration status or other legally protected status.

Patients seeking assistance may first be asked to apply for other external programs (such as Medicaid) as appropriate *before* eligibility under this policy is determined. Additionally, any uninsured patients who are believed to have the financial ability to purchase health insurance may be encouraged to do so to help ensure healthcare accessibility and overall well-being.

Individuals eligible for financial assistance under this policy shall not be charged more than the amounts generally billed (AGB) to individuals who have insurance. This value shall be calculated using the "look-back" method based on actual paid claims from Medicare fee-for-service and private health insurers. The current AGB can be obtained by contacting the Patient Financial Services Department and is updated annually.

DEFINITIONS

The following terms are meant to be interpreted as follows within the policy:

1. **Financial assistance:** Healthcare services provided which are not expected to result in cash inflows; medically necessary services rendered without expected payment to individuals meeting established criteria.
2. **Medically Necessary**: Hospital services or care rendered to a patient, both inpatient and outpatient, in order to diagnose, alleviate, correct, cure, or prevent the onset or worsening of conditions that endanger life, cause suffering or pain, cause physical deformity of malfunction, threaten to cause or aggravate a handicap, or result in overall illness or infirmity per WAC 246-453-010(7).
3. **Emergency Care:** Immediate care which is necessary to prevent serious jeopardy to a patient's health; serious impairment to bodily functions, and/or serious dysfunction of any organs or body parts.
4. **Family:** per WAC 246-453-010 (18) 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. **Uninsured:** Patients with no insurance or third-party assistance to help resolve their financial liability to healthcare providers.
6. **Underinsured:** Patients who have limited healthcare coverage, or coverage that leaves the patient with an out of pocket liability, and therefore may still require financial assistance.
7. **Catastrophic Care Assistance:** Financial assistance given to patients whose medical expenses exceed one-fourth of their total household income.
8. **Application Period:** Begins on the date healthcare services are provided and ends on the date that an account has been legally suited/garnished per legal judgement.

ELIGIBILITY REQUIREMENTS

To be eligible for Financial Assistance, a person may be deemed to have undue financial hardships, considering income and family size as determined by the hospital that make them unable to pay for all or a portion of their medical care. Financial Assistance shall be applied to those charges that are not covered by public or private sponsorship in accordance with WAC 246-453-020(4). Such consideration will include a review of gross income and family size

Per WAC 246-453-030 For the purpose of reaching an initial determination of sponsorship status, hospitals shall rely upon information provided orally by the responsible party. The hospital may require the responsible party to sign a statement attesting to the accuracy of the information provided to the hospital for purposes of the initial determination of sponsorship status.

The following documents shall be considered sufficient evidence upon which to base the final determination of charity care sponsorship status, when the income information is analyzed as may be appropriate:

- Pay stubs with the year to date totals
- Income tax return from the most recently filed calendar year or verification of non-filing
- Forms approving or denying eligibility for Medicaid and or state funded medical assistance
- Forms approving or denying unemployment compensation
- Written statements from employers or welfare agencies
- Last three months of checking and saving bank statements
- Letter of support from the individuals providing for basic needs

Olympic Medical Center patients who are deemed financial assistance eligible will not be charged more than amounts generally billed to insured patients for emergency or medically necessary care.

CRITERIA FOR EVALUATION

Any unusual circumstances or special hardships, including catastrophic hospitalization costs, will be considered and constitute justification for extending Financial Assistance to patients who do not meet all of the additional criteria. Administration has the discretion to bypass the charity care application process for those patients who cannot complete the application process or provide documentation supporting their application for charity care, in compliance with WAC 246-453-030(4).

Any person of the family classified as indigent or medically indigent, but ineligible for state or federal medical assistance, is eligible for consideration to receive discounted care. Medical indigence refers to those who are too impoverished to meet their medical expenses. It may also include those whose income is sufficient to pay for basic living costs but not for medical care and those persons with generally inadequate income who are suddenly faced with catastrophic medical bills.

Patients will be provided with applications for Financial Assistance upon request or review. Any and all other benefits will be assessed to determine eligibility for Financial Assistance. Those who meet the criteria mentioned above will be considered for full or partial Financial Assistance eligibility. Patients with documented income under 100% of Federal Poverty Level (FPL) will receive a full discount. A sliding payment schedule, based on the Federal Poverty Guidelines (between 100% and 300% of FPL), is used as a guide to determine the amount for which a family is responsible, with added consideration for any special circumstances. The sliding fee schedule applies only to those charges that are not covered by any public or private sponsorship in accordance with WAC 246-453-050(1)(a).

The patient will receive written notice that will include the level of discount allowed. Approval will be valid for 90 days and a new application will be required after such time. If the outstanding balance is not paid, the hospital reserves the right to assign unpaid balances to an outside collection agency.

Any responsible party who has been initially determined to meet the criteria identified within WAC 246-453-040 shall be provided with at least fourteen calendar days or such time as the person's medical condition may require, or such time as may reasonably be necessary to secure and to present documentation as described within WAC 246-453-030 prior to receiving a final determination of sponsorship status. Olympic Medical Center shall make a determination within fourteen (14) days after receipt of the application. If the Financial Assistance application is denied, the written notice will include a reason for denial, payment terms and instructions for the appeal process. The patient may appeal the decision by providing additional proof of income or family size within 30 days. If Olympic Medical Center has initiated collection activities and discovers an appeal has been filed, they shall cease collection efforts until the appeal is finalized. The patient will receive a written notice of the final decision. In making a determination, the applicant may be required to provide the hospital with additional documentation of items on the application. Failure to provide such documentation may result in denial of the application. In the event that Olympic Medical Center's final decision of appeal affirms the previous denial of charity care designation under the criteria described in WAC 246-453-040, the responsible party and the Department of Health shall be notified in writing of the decision and the basis for the decision, and the Department of Health shall be provided with copies of documentation upon which the decision was based.

Per WAC 246-453-020(11) In the event that a responsible party pays a portion or all of the charges related to appropriate medical services, and is subsequently found to have met the charity care criteria at the time that services were provided, any payments in excess of the amount determined to be appropriate in accordance with WAC 246-453-040 shall be refunded to the patient within thirty (30) days of achieving the charity care designation.

PUBLIC NOTIFICATION

Notice shall be publicly available in accordance of WAC 246-453-020(2) that charges for services provided to those persons meeting the criteria established within WAC 246-453-040 may be waived or reduced. Olympic Medical Center assistance policy, financial assistance application, and summary of the financial assistance policy are available to patients in English and Spanish. These documents are available free of charge at our facilities, by mail, and online.
All patients are provided with information about the availability of Financial Assistance upon registration. Signs advertising Financial Assistance will be posted throughout Olympic Medical Center facilities. Billing statements sent to responsible parties will contain information regarding the availability of Financial Assistance.

A document that identifies providers who comply with Olympic Medical Center's Financial Assistance Policy and those who maintain their own separate policies is available on our website and maintained by Medical Staff Services. This document will be updated by Medical Staff Services on a quarterly basis.

PLAIN LANGUAGE SUMMARY

In accordance of the 501 (r) charity requirements, a "Plain Language Summary" of the Olympic Medical Center Financial Assistance Policy will accompany all billing statements and be presented to patients during all financial discussions.

Olympic Medical Center will not pursue extraordinary collections actions against an individual without first using reasonable efforts to determine if such individual is eligible for financial assistance.

COLLECTION EFFORTS FOR OUTSTANDING PATIENT ACCOUNTS

Pending final eligibility determination, Olympic Medical Center will not initiate collection efforts or requests for deposits, provided that the responsible party within a reasonable time is cooperative with Olympic Medical Center's efforts to reach a determination of Financial Assistance eligibility status. Extreme Collection Activities (ECA) may only be initiated 120 days after the date of first billing statement. However, an account will be considered for Financial Assistance up until it has been suited by the collection agency. Accounts that have been suited or have had garnishments applied will not be considered eligible for Financial Assistance.

ATTACHMENT A - CHARITY CARE PERCENTAGE SLIDING FEE SCHEDULE

The full amount of charges will be reviewed to be charity care for any guarantor whose gross family income is at or below 100% of the current federal poverty guidelines, consistent with WAC 246-453, provided that such persons are not eligible for other private or public health coverage sponsorship RCW 70.170.060(5). In determining the applicability of the Olympic Medical Center sliding fee schedule gross income and family size are taken into account for guarantors with income between 101% and 300% of the federal poverty guidelines.

The Collection Department will process each application for approval or denial, and the application along with a Determination of Eligibility form will be forwarded to the Supervisor of Patient Accounts for final approval based on the following guidelines:

$0 - $2,500	Financial Services Representatives
$2,500 - $10,000	Financial Services Supervisor
$10,000 - $50,000	Director of Revenue Cycle Management
Over - $50,000	Chief Financial Officer

Approval & Review Tracking:		**Next Review: 3/31/2020**
Approved By:	1/19/2018 X Eric Lewis Chief Executive Officer Signed by: elewis@olympicmedical.org **Eric Lewis**	
Reviewed by: (Name/Date)	*Reviewed 11/93, 4/96, 10/98, 02/01, 6/03; 5/05, 01/07 J. Nutter; 04/09, 05/11 M. Sager; 6/12 J. Weber; 10/15 J. Weber, B. Shillington, J. Weber 11/16* *Revised 6/87, 12/89, 5/91, 10/98, 02/01, 6/03: by W. Lyon, E. Lewis, CFO, 9/14 B.Shillington; 10/15 J. Weber, B. Shillington, J. Weber, B. Shillington, DOH, 02/16, J. Weber 11/16*	
Committees Review	[Committee 1]	[Review 1]
	[Committee 2]	[Review 2]
	[Committee 3]	[Review 3]
	[Committee 4]	[Review 4]

Appendix I	Patient referral policy

OLYMPIC MEDICAL CENTER

Intake and Referral Process DRAFT

Group	Process	Approved Date
Patient Care	OMHHH	12/12/2018

Note: Printed copies are for reference only. Please refer to SharePoint for the latest version.

Purpose:

1. To establish the process for referral, acceptance and intake of patients into Olympic Medical Home Health and Hospice.
2. To provide Home Health and Hospice in compliance with regulatory and best practice standards.

Policy:

Referrals will be accepted and processed during the hours of 8am to 4pm, 7 days per week. Referrals received after normal processing hours will be reviewed at the beginning of the next business day to verify that the referral is valid and appropriate for Home Health or Hospice services. Patients with a valid referral will be have an initial assessment visit within 48 hours unless otherwise ordered by physician.

Procedure for referrals to Home Health or Hospice:

1. Referrals are documented in the computer system.
2. Referral information may be accepted by any of the following methods:
    a. Electronically, typically via Epic
    b. Telephone
    c. Fax
    d. Written order
    e. E-mail from a HIPPA compliant network
    f. In person
3. Referrals may be accepted from any of the following individuals, but a valid physician order is required to provide the initial assessment visit:
    a. Doctors of Medicine, Osteopathy, and Podiatry
    b. Discharge planners from inpatient and outpatient services
    c. Social Service Agencies
    d. Individual patients or their family/caregiver(s)
    e. Case managers and/or insurance company representatives
    f. Other home health organizations
4. Referral Intake personnel receive information regarding patient demographics, diagnosis, services needed, medications, attending physician, hospitalization, etc. in order to make the initial determination of whether the patient's needs can be met and if he/she meets eligibility criteria.
    a. Referral intake verifies eligibility, benefits, and primary care physician coverage for all patients referred to Home Health and Hospice.
    b. When the referral is processed it is reviewed by the Patient Care Coordinator or other designated RN as appropriate for clinical review.
    c. After clinical review, the referral is given to the Scheduling Department who will assign personnel and schedule the initial assessment visit.
    d. If the referral is not from a physician, the physician is contacted to confirm service needs and to obtain verbal orders to evaluate for Home Health or Hospice services.
    e. If referral is not appropriate, Intake personnel provides the referent with the names of other agencies that can provide the required services and/or reasons for denial of service.

f. Clinical Managers are consulted before scheduling a visit when the referral is complex or appropriateness is uncertain.

g. Patients are admitted to OMHHH:
   - For Home Health Services by a nurse, physical therapist, or a speech therapist based on the patient's medical need.
   - For Hospice services by a Registered nurse.

Approval & Review Tracking:	**Next Review: 3/31/2021**
Approved By:	X _____ X _____ Chief Nursing Officer **Lorraine Wall** [Additional Signtures]
Reviewed by:	12/18 - Joan Warren, Lorraine Wall, Sandy Ulf

Appendix J	Financial Assumptions & Staffing Summary Draft Proforma Operating Statement Estimated Capital Expense and Depreciation Draft Pro Forma Cash Flow and Balance Sheet

Assumptions and Methods, Olympic Medical Hospice, Clallam County

	2020	2021	2022	
Admissions (Unduplicated Patients)	108	210	304	See Application Narrative, Need Section, Question 6
Patient Days of Care at ALOS 60 (DOC)	6,480	12,600	18,240	ALOS 60 days, assumption based on WA average
AVERAGE DAILY CENSUS (ADC)	**17.8**	**34.5**	**50.0**	DOC/365
DAYS OF CARE (DOC)				
Routine Home Care	6,318	12,285	17,784	97.5% based on NHPCO and MedPac averages
Inpatient Care	65	126	182	1.0% based on NHPCO and MedPac averages
Continuous Care	65	126	182	1.0% based on NHPCO and MedPac averages
Respite Care	32	63	91	0.5% based on NHPCO and MedPac averages
TOTAL	**6,480**	**12,600**	**18,240**	**100%**
Per Diem Rates				
Routine Home Care	$ 194.39	$ 194.39	$ 194.39	blend base rate with 61+ rate (.8 x 218.54)+(.2 x 171.73) = 194.39
Inpatient Care	$ 782.67	$ 782.67	$ 782.67	2019 CMS Hospice Payment Rate, Clallam County
Continuous Care	$ 1,032.12	$ 1,032.12	$ 1,032.12	2020 CMS Hospice Payment Rate, Clallam County
Respite Care	$ 180.84	$ 180.84	$ 180.84	2021 CMS Hospice Payment Rate, Clallam County
Gross Revenue by Type of Care				
Routine Home Care	$ 1,228,143	$ 2,388,057	$ 3,456,996	Days of Care x Per Diem Rates
Inpatient Care	$ 50,717	$ 98,616	$ 142,759	Days of Care x Per Diem Rates
Continuous Care	$ 66,881	$ 130,047	$ 188,259	Days of Care x Per Diem Rates
Respite Care	$ 5,859	$ 11,393	$ 16,493	Days of Care x Per Diem Rates
TOTAL	**$ 1,351,601**	**$ 2,628,113**	**$ 3,804,506**	
Payer Mix				
Medicare	45%	45%	45%	based on OMC expected payer mix
Medicare	45%	45%	45%	based on OMC expected payer mix
Medicaid	5%	5%	5%	based on OMC expected payer mix
Commercial /Other/Self Pay	5%	5%	5%	based on OMC expected payer mix
TOTAL	100%	100%	100%	
Gross Revenue per Payer				
Medicare Fee For Service	$ 608,220	$ 1,182,651	$ 1,712,028	Gross Revenue Total x % Payer Mix
Medicare Managed Care	$ 608,220	$ 1,182,651	$ 1,712,028	Gross Revenue Total x % Payer Mix
Medicaid	$ 67,580	$ 131,406	$ 190,225	Gross Revenue Total x % Payer Mix
Commercial/Other/Self Pay	$ 67,580	$ 131,406	$ 190,225	Gross Revenue Total x % Payer Mix

STAFFING SUMMARY - BY FTE'S

CLINICAL OPERATIONS	**Salaries**	**2020**	**2021**	**2022**	
Medical Director	216,000	0.20	0.20	0.30	
Bereavement		-	-	-	role included in MSW
Volunteer coordinator		-	-	-	role included in MSW
Physical Therapy	99,153	0.006	0.011	0.017	$ 0.09 per DOC
Occupational Therapy	89,752	0.003	0.005	0.007	$ 0.04 per DOC
Speech/Language	93,745	0.001	0.003	0.004	$ 0.02 per DOC
Hospice Manager	90,000	1.00	1.00	1.00	
RN's	83,137	1.78	3.45	5.00	1 per 10 ADC
Medical Social Worker	70,000	1.01	1.49	2.03	1 per 35 ADC + .5, .5, .6 FTE Vol. Coord/Bereavement
HHA's	36,753	1.78	3.45	5.00	1 HHA per 10 ADC
TOTAL		**5.57**	**9.41**	**13.05**	
ADMINISTRATIVE					
Administrator	105,000	0.20	0.20	0.20	remainder of FTE at home health agency
Reception/Intake/Referral	28,621	0.50	0.50	0.50	remainder of FTE at home health agency
Billing Representative	38,917	0.50	0.50	0.50	remainder of FTE at home health agency
Community Outreach		-	-	-	included in hospital indirect expense
QAPI Coordinator	83,137	0.50	0.50	0.50	remainder of FTE at home health agency
TOTAL		**1.70**	**1.70**	**1.70**	
TOTAL FTE'S		**7.27**	**11.11**	**14.75**	

Olympic Medical Hospice
Clallam County
Projected Statement of Operations, 2020-2022

	2020	2021	2022	Notes and Assumptions
Average Daily Census	17.8	34.5	50.0	
Days of Care	6,480	12,600	18,240	
REVENUE				
Medicare Fee For Service	608,220	1,182,651	1,712,028	
Medicare Managed Care	608,220	1,182,651	1,712,028	
Medicaid	67,580	131,406	190,225	includes Healthy Options
Commercial/Other/Self Pay	67,580	131,406	190,225	Comm.,BHP,TriCare, CHAMPUS
Total Gross Revenue	1,351,601	2,628,113	3,804,506	
Deductions from Revenue				
Contractual Allowances	(13,516)	(26,281)	(38,045)	1% of gross revenue
Bad Debt	(13,516)	(26,281)	(38,045)	1% of gross revenue
Adj. For Charity Care	(13,246)	(25,756)	(37,284)	1% of Total Net Revenue
Total Net Revenue	1,311,323	2,549,795	3,691,132	
PATIENT CARE COSTS				
Salaries and Benefits:				
Physician (Medical Director)	43,200	43,200	64,800	See Staffing Summary
Hospice Manager	90,000	90,000	90,000	See Staffing Summary
RN's	147,597	286,993	415,457	See Staffing Summary
Physical Therapy	583	1,134	1,642	$0.09 per DOC
Occupational Therapy	194	378	547	$0.03 per DOC
Speech/Language	130	252	365	$0.02 per DOC
Medical Social Worker	70,507	104,041	141,945	See Staffing Summary
HHA's	65,249	126,873	183,664	See Staffing Summary
Payroll Taxes & Benefits	125,238	19,586	26,953	30% of Salaries
Total Salaries and Benefits	542,698	672,458	925,373	
Contract Labor:				
Spiritual counselor	28,253	54,936	79,526	$4.36 per DOC
Dietary Counseling	518	1,008	1,459	$0.08 per DOC
Total Contract Labor	28,771	55,944	80,986	
Physician Consulting Fees	14,774	28,728	41,587	$2.28 DOC
Pharmacy/IV's	56,117	109,116	157,958	$8.66 DOC
DME Costs	32,724	63,630	92,112	$5.05 DOC
Medical Supplies	15,422	29,988	43,411	$2.38 DOC
Lab Costs	778	1,512	2,189	$0.12 DOC
Chemotherapy	1,361	2,646	3,830	$0.21 DOC
Radiation Therapy	778	1,512	2,189	$0.12 DOC
Imaging Services	518	1,008	1,459	$0.08 DOC
Ambulance Costs	2,268	4,410	6,384	$0.35 DOC
General Inpatient Costs	50,717	98,616	142,759	$ 782.67 per General inpatient day
Inpatient Respite	11,718	22,786	32,985	$ 180.84 per inpatient respite day
Net SNF Medicaid Costs	7,776	22,680	43,776	DOC x $12 x 10%, 15%, 20%
Mileage	21,708	42,210	61,104	$3.35 DOC
Total Patient Care Costs	**788,128**	**1,157,244**	**1,638,103**	

ADMINISTRATIVE COSTS				
Payroll Taxes & Benefits	28,901	28,901	28,901	30% of Administrative Salaries
B&O Taxes	20,274	39,422	57,068	1.5% of gross revenue
Salaries - Administrative	54,769	54,769	54,769	Staffing Summary
QAPI Coordinator	41,569	41,569	41,569	Staffing Summary
Mileage	9,600	9,600	9,600	$800/month
Advertising	36,000	36,000	36,000	$3000/month
Travel - admin	20,000	10,000	10,000	$20,000/year 1 and $10,000 therafter
Legal & Professional	-	-	-	included in hospital indirect expense
Consulting Fees	3,000	3,000	3,000	$250/month
Software Costs	24,000	24,000	24,000	$2,000/month
Computer @ Software Maintenance	15,000	15,000	15,000	$1250/month
Office expense	15,000	15,000	15,000	space, utilities, purchased services
Repairs/Maintenance	-	-	-	included in hospital indirect expense
Cleaning	-	-	-	included in hospital indirect expense
Insurance	-	-	-	included in hospital indirect expense
Office Supplies	2,250	1,500	1,500	$125/month
Equipment Rental	1,200	1,200	1,200	100/month
Postage	600	600	600	$50/month
Telephones/Pagers	14,400	14,400	14,400	$1200/month
Purchased Services/Utilities	-	-	-	included in hospital indirect expense
Books & References Materials	1,200	1,200	1,200	$100/month
Printing	1,500	1,500	1,500	$125/month
Licenses & Certification	1,400	1,400	1,400	$1400/year for WA license
Education and Training	10,000	10,000	10,000	$10,000/year
Dues and Subscriptions	2,400	2,400	2,400	$200/month
Hospital indirect expenses	162,192	315,374	350,000	Lesser of 12% or $350,000
Total Administrative Costs	465,255	626,834	679,106	
TOTAL COSTS	$ 1,253,383	$ 1,784,078	$ 2,317,209	
EBITDA	57,940	765,717	1,373,923	
EBITDA Margin %	4%	30%	37%	
Depreciation	10,262	10,262	10,262	From OMH Depreciation Table
Amortization	-	-	-	None
EBIT	47,678	755,455	1,363,661	
Interest Expense	-	-	-	None
Earnings before Taxes	47,678	755,455	1,363,661	

Olympic Medical Hospice
Total Proposed Capital Expense, 2020-2022

Item	Estimated Expense	
Office remodeling	112,500.00	450 sq ft x $250 = $112,500
Furnishings	13,500.00	
Telecommunications	2,500.00	
Computers/Copiers/Printers	7,800.00	
Total	**$ 136,300**	

OMH Depreciation Schedule

	Items	Depreciable Years	2020	2021	2022
Office remodeling	112,500.00	15	$ 7,500	$ 7,500	$ 7,500
Furnishings	13,500.00	7	$ 1,929	$ 1,929	$ 1,929
Telecommunications	2,500.00	3	$ 833	$ 833	$ 833
Computers/Copiers/Printers	7,800.00	3	$ 2,600	$ 2,600	$ 2,600
			$ 10,262	**$ 10,262**	**$ 10,262**

Olympic Medical Hospice, Clallam County
Proforma Balance Sheet
For The Periods Ending December 31, 2020 Through 2022

	2020	2021	2022
ASSETS			
Current Assets			
Cash & Cash Equivalents	113,937	838,742	2,194,872
Accounts Receivable (Net)	109,277	212,483	307,594
Total Current Assets	223,214	1,051,225	2,502,466
Property and Equipment			
Fixed Assets	19,800	19,800	19,800
Accumulated Depreciation	(10,262)	(20,524)	(30,786)
Total Property and Equipment	9,538	(724)	(10,986)
Other Assets	-	-	-
Total Assets	**232,752**	**1,050,501**	**2,491,480**
LIABILITIES AND CAPITAL			
Current Liabilities			
Accounts Payable & Accrued Expenses	139,584	196,887	264,477
Accrued Payroll & Related Payables	25,690	30,681	40,408
Total Current Liabilities	165,274	227,567	304,886
Long-Term Liabilities	-	-	-
Total Liabilities	165,274	227,567	304,886
Shareholder Equity (Deficit)	67,478	822,933	2,186,595
Total Liabilities & Capital	**232,752**	**1,050,501**	**2,491,480**

Olympic Medical Hospice, Clallam County
Proforma Cash Flow
For The Periods Ending December 31, 2020 Through 2022

	2020	2021	2022
Cash Flows from operating activities			
Net Income After Depreciation and Amortization	47,678	755,455	1,363,661
Adjustments to reconcile net income to cash provided by Operations			
Depreciation & Amortization Change	10,262	10,262	10,262
Accounts Receivable Change	(109,277)	(103,206)	(95,111)
Accounts Payable Change	139,584	57,302	67,591
Payroll Payable Change	25,690	4,991	9,727
Total Adjustments	66,259	(30,651)	(7,531)
Net Cash provided by Operations	113,937	724,804	1,356,130
Cash Flows from investing activities Used For:			
Capital equipment and furniture	-	-	-
Net cash used in investing	-	-	-
Cash Flows from financing activities			
Proceeds From:			
Capital Contributions			
Used For:			
Dividends	-	-	-
Net cash used in financing	-	-	-
Net increase <decrease> in cash	113,937	724,804	1,356,130
Summary			
Cash Balance at Beg of Period	-	113,937	838,742
Cash Balance at End of Period	113,937	838,742	2,194,872

Appendix K	Commitment letter from Chief Financial Officer

OLYMPIC
MEDICAL CENTER

Working together to provide excellence in health care.

939 Caroline Street ◆ Port Angeles, WA 98362 ◆ (360) 417-7000 ◆ www.olympicmedical.org

December 17, 2018

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

Dear Ms. Sigman,

The Certificate of Need Program's application for a Medicare-certified hospice agency asks for a financial letter of commitment.

The Board of Olympic Medical Center has committed the necessary working capital to finance the establishment and operation of a Medicare-certified hospice agency in Clallam County, Washington.

Sincerely,

Darryl J. Wolfe
Chief Financial Officer
Olympic Medical Center

Appendix L	OMC License and Accreditation documents

Washington State Department of Health

This organization

Olympic Medical Center

is authorized by RCW 70.41 to have a

Hospital Acute Care License

Operated by: **Clallam County Public Hospital Dist No 2**

Number of Licensed Beds: **126**

Medicare Facility ID #:

Located at: **939 Caroline St**
Port Angeles, WA 98362-3909

Secretary

Credential Number
HAC.FS.00000038

Status	Effective Date	Expiration Date
ACTIVE	01/01/2016	12/31/2018

THIS LICENSE IS NON-TRANSFERABLE

CERTIFICATE OF ACCREDITATION

Certificate Number:	Effective date:	Valid until:
215594-2017-AHC-USA-NIAHO	4/11/2017	4/11/2020

This is to certify that

Olympic Medical Center
939 Caroline Street, Port Angeles, WA 98362

has been found to comply with the requirements of the :

NIAHO® Hospital Accreditation Program

Pursuant to the authority granted to DNV GL Healthcare USA, Inc. by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, this organization is deemed in compliance with the Medicare Conditions of Participation for Critical Access Hospitals (42 C.F.R. §485).

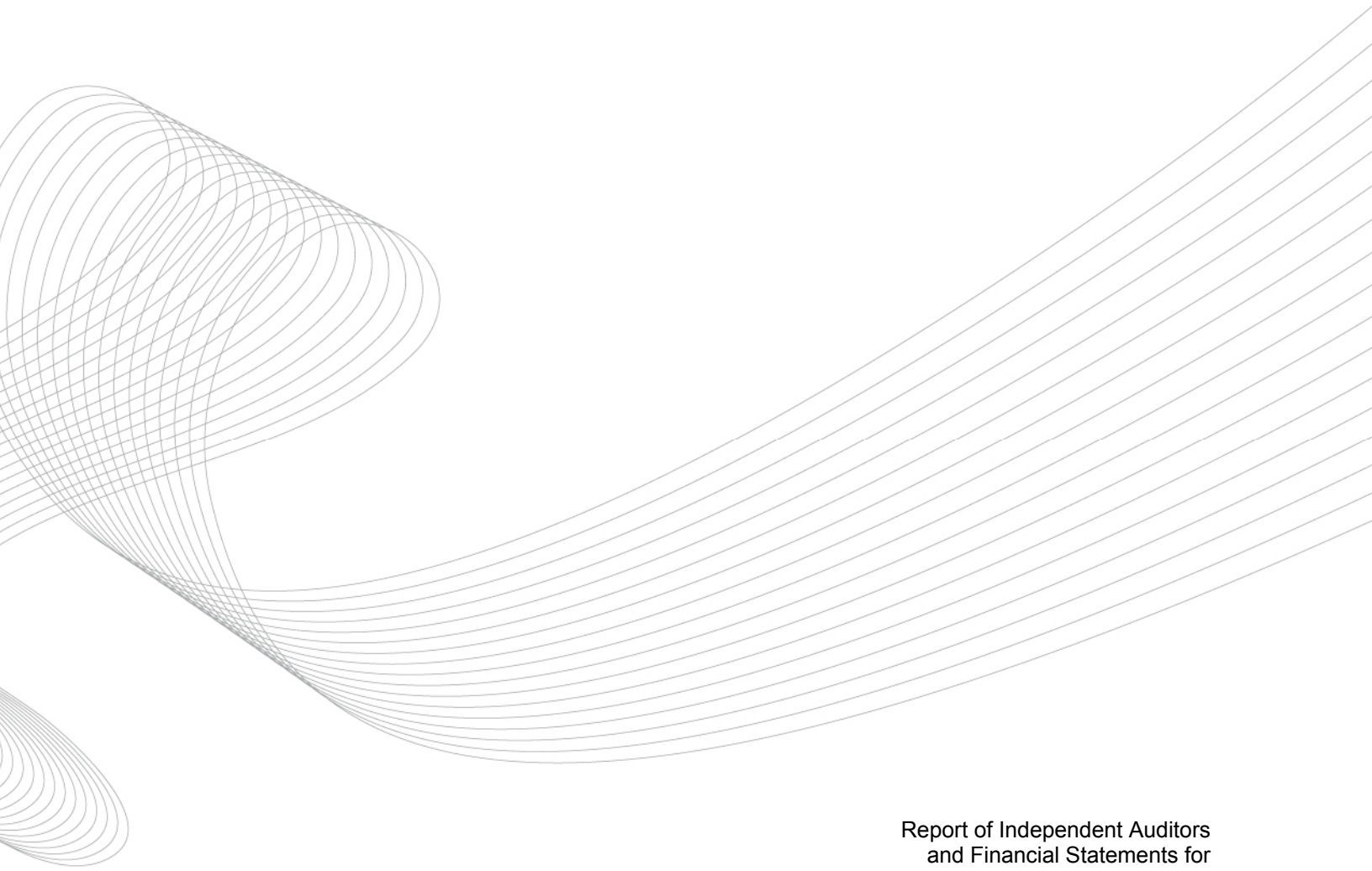
This certificate is valid for a period of three (3) years from the Effective Date of Accreditation.

For the Accreditation Body:
DNV GL - Healthcare
Katy, TX

Patrick Horine
Chief Executive Officer

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Appendix M	Historical Financial Statements, OMC, 2015-2017



Report of Independent Auditors
and Financial Statements for

Public Hospital District No. 2 of Clallam County, Washington dba Olympic Medical Center

December 31, 2015 and 2014

MOSS-ADAMS LLP

Certified Public Accountants | Business Consultants

Report of Independent Auditors
and Financial Statements for

Public Hospital District No. 2 of Clallam County, Washington dba Olympic Medical Center

December 31, 2016 and 2015

MOSS-ADAMS LLP

Certified Public Accountants | Business Consultants

CONTENTS

MOSS-ADAMS LLP
Certified Public Accountants | Business Consultants

REPORT OF INDEPENDENT AUDITORS

To the Board of Commissioners
Public Hospital District No. 2 of Clallam County, Washington
dba Olympic Medical Center

Report on the Financial Statements

We have audited the accompanying financial statements of Public Hospital District No. 2 of Clallam County, Washington, dba Olympic Medical Center (the Medical Center), which comprise the statements of net position as of December 31, 2016 and 2015, and the related statements of revenues, expenses, and changes in net position, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

Our responsibility is to express an opinion on these 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 financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the 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 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 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 financial statements referred to above present fairly, in all material respects, the financial position of the Medical Center as of December 31, 2016 and 2015, and the changes in its net position and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matter

Accounting principles generally accepted in the United States of America require that the accompanying management's discussion and analysis on pages 3 through 10 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Everett, Washington
February 13, 2017

This discussion and analysis provides an overview of the financial position and financial activities of Public Hospital District No. 2 of Clallam County, Washington, doing business as Olympic Medical Center (the Medical Center). Please read it in conjunction with the Medical Center's financial statements and accompanying notes, which follow this section.

Financial Highlights

- One of the core components of the Medical Center's 2016-2018 strategic plan is to successfully complete the Port Angeles Medical Office Building. In 2016, the Medical Center made extensive progress in order to achieve completion of this project in early 2017. This is an investment in facilities and services to appropriately meet the community need.
- The Medical Center's net position increased by $4.3 million in 2016 and increased by $9.1 million in 2015.
- The Medical Center's total operating revenue was $167.3 million in 2016 compared with $161.8 million in 2015.
- The Medical Center invested approximately $29.1 million in capital assets, including improved medical facilities and new medical equipment in 2016 and approximately $14.0 million in 2015, including improved medical facilities and new medical equipment.

Overview of the Financial Statements

The Medical Center's financial statements consist of three statements: a statement of net position; a statement of revenues, expenses, and changes in net position; and a statement of cash flows. These financial statements and related notes provide information about the activities of the Medical Center, including resources held by the Medical Center that are held for specific purposes. The statement of net position includes all of the Medical Center's assets and liabilities using the accrual basis of accounting, as well as an indication about which assets can be used for general purposes and which are designated for a specific purpose. The statement of revenues, expenses, and changes in net position reports all of the revenues and expenses during the time period indicated. The statement of cash flows reports the cash provided by the Medical Center's operating activities, as well as other cash sources such as investment income and cash payments for additions and improvements.

Volumes and Statistics

Following are key operating statistics:

	2016	2015	2014	2016 - 2015 % Change
Available beds	67	67	78	0%
Admissions	4,373	4,301	4,449	2%
Patient days	14,549	14,573	14,330	0%
Imaging procedures	93,768	84,497	78,188	11%
Oncology procedures	27,548	28,901	26,647	-5%
Surgery cases	6,423	6,648	6,564	-3%
Emergency room visits	31,949	30,319	27,835	5%
Home health visits	39,298	30,398	22,176	29%
Clinic visits	111,274	113,971	104,101	-2%
Full-time equivalent employees	1,116	1,050	1,005	6%

Statement of Net Position

The following is a presentation of certain financial information derived from the Medical Center's statement of net position (amounts in thousands):

	2016	2015	2014	2016 - 2015 Change
Assets				
Total current assets	$ 25,374	$ 26,851	$ 27,857	$ (1,477)
Assets limited as to use	48,413	46,709	43,616	1,704
Capital assets, net	118,901	98,799	93,880	20,102
Other assets	2,254	2,255	2,253	(1)
Total assets	$ 194,942	$ 174,614	$ 167,606	$ 20,328
Liabilities				
Current liabilities	$ 22,761	$ 20,153	$ 19,242	$ 2,608
Long-term debt	42,378	28,950	31,919	13,428
Other long-term liabilities	1,455	1,455	1,455	-
Total liabilities	66,594	50,558	52,616	16,036
Net position				
Invested in capital assets, net of related debt	89,946	72,934	71,394	17,012
Unrestricted	38,402	51,122	43,596	(12,720)
Total net position	128,348	124,056	114,990	4,292
Total liabilities and net position	$ 194,942	$ 174,614	$ 167,606	$ 20,328

Statement of Net Position (continued)

Current assets in 2016 included cash and investments (21%), total receivables (62%), supplies inventory (8%), and prepaid expenses (9%). Current assets decreased by 6% in 2016, primarily in cash.

Current assets in 2015 included cash and investments (25%), total receivables (59%), supplies inventory (7%), and prepaid expenses (9%). Current assets decreased by 4% in 2015, primarily in cash.

Assets limited as to use in 2016 totaling $48.4 million included capital reserves of $31.0 million, reserve for accrued liabilities of $1.7 million, and bond proceeds restricted for capital purchases of $16.0 million.

Assets limited as to use in 2015 totaling $46.7 million included capital reserves of $39.0 million, reserve for accrued liabilities of $1.7 million, and bond proceeds restricted for capital purchases of $6.0 million.

Total assets increased $20.3 million (11.6%) in 2016 primarily due to Construction in Progress, which increased $18.7 million. The majority of the increase was related to the Port Angeles Medical Office Building project.

Total assets increased $7.0 million (4.2%) in 2015. Assets limited as to use increased $3.1 million due to increase in capital reserves, and land, building, and equipment increased $4.9 million, primarily due to the completion of the Emergency Department Expansion Project and the start of the Medical Office Building Expansion Project. Cash decreased $1.9 million due to bond payments made at year-end.

In 2016, total current liabilities increased by 12.9% from 2015. Current liabilities in 2016 included accounts payable (44%), accrued vacation and payroll (36%), current portion of long-term debt (15%), and other liabilities (9%). Current liabilities in 2015 included accounts payable (39%), accrued vacation and payroll (37%), current portion of long-term debt (11%), and other liabilities (9%).

Long-term debt, net of current portion, increased by $13.4 million in 2016. Long-term debt, net of current portion, decreased by $3.0 million in 2015.

Total net position increased by $4.3 million to $128.3 million at the end of 2016. The total consists of $89.9 million invested in capital assets, net of related debt, and $38.4 million of unrestricted net position.

Total net position increased by $9.1 million to $124.1 million at the end of 2015. The total consists of $72.9 million invested in capital assets, net of related debt, and $51.1 million of unrestricted net position.

Statement of Revenues, Expenses, and Changes in Net Position

The following is a summary of 2016 compared with 2015 and 2014 annual amounts (amounts in thousands):

	2016	2015	2014	2016 - 2015 Change
Total operating revenue	$ 167,267	$ 161,802	$ 146,783	$ 5,465
Operating expenses				
Wages and benefits	100,279	93,463	89,812	6,816
Professional fees	8,016	7,406	6,505	610
Supplies	26,392	24,588	21,915	1,804
Purchased services, maintenance, and other	18,298	17,212	16,267	1,086
Insurance	1,098	1,175	1,230	(77)
Depreciation and amortization	9,004	9,075	9,549	(71)
Total operating expenses	163,087	152,919	145,278	10,168
Operating income	4,180	8,883	1,505	(4,703)
Net nonoperating revenue	111	183	470	(72)
Increase in net position	$ 4,291	$ 9,066	$ 1,975	$ (4,775)

Total operating revenue was $5.5 million more in 2016 as a result of increased volumes in outpatient and emergency services.

Total operating revenue was $15.0 million more in 2015 as a result of increased volumes in outpatient and emergency services.

Total bad debt provision and charity care provided was $4.2 million in 2016 compared with $4.0 million in 2015 and $7.4 million in 2014. Uncompensated care has stabilized over 2016 and 2015. The decrease from 2014 is due to a decrease in uninsured and underinsured patients and an increase in Medicaid patients.

Statement of Revenues, Expenses, and Changes in Net Position (continued)

The following is a summary of the Medical Center's gross revenue by payor:

	2016	2015	2014
Medicare	59%	59%	58%
Medicaid	16%	17%	16%
Other government	8%	7%	7%
Total governmental payors	83%	83%	81%
Commercial insurance	16%	16%	18%
Private pay	1%	1%	1%
Total	100%	100%	100%

Combined wages and benefits increased by 7.3% in 2016 and 4.1% in 2015. Supplies increased by 7.3% in 2016 and 12.2% in 2015. Purchased services, maintenance, and other increased by 6.3% in 2016 and 5.8% in 2015. Professional fees increased by 7.3% in 2016 and 13.8% in 2015.

Charitable contributions received by the Medical Center in 2016 totaled $189,000, compared with $405,500 in 2015 and $242,800 in 2014. The monetary contributions primarily came from the Olympic Medical Center Foundation, the Olympic Memorial Hospital Auxiliary, and the Sequim Dungeness Hospital Guild.

The Medical Center had operating income of $4.2 million in 2016 compared to operating income of $8.9 million in 2015.

The Medical Center's Cash Flows

The following is a summary of cash flows in 2016, 2015, and 2014 (amounts in thousands):

	2016	2015	2014	2016 - 2015 Change
Net cash from operating activities	$ 10,663	$ 11,081	$ 8,574	$ (418)
Cash from tax revenue	4,418	4,282	4,249	136
Net cash from capital and related financing activities	(15,238)	(14,896)	(11,258)	(342)
Net cash from investing activities	9,681	(7,780)	(4,263)	17,461
Net change in cash and cash equivalents	$ 9,524	$ (7,313)	$ (2,698)	$ 16,837

Net cash from operating activities was $10.7 million in 2016, compared with $11.1 million in 2015. $27.6 million was spent on the purchase of capital assets in 2016.

Net cash from operating activities was $11.1 million in 2015, compared with $8.6 million in 2014. $11.6 million was spent on the purchase of capital assets in 2015.

Capital Assets

At the end of 2016, the Medical Center had $118.9 million invested in capital assets, net of accumulated depreciation, as detailed in Note 4 to the financial statements. In 2016, the Medical Center purchased new capital assets costing approximately $29.1 million. In 2015, the Medical Center purchased new capital assets costing approximately $14.0 million.

Major capital acquisitions in 2016 included the purchase and installation of CT equipment ($1.6 million) and the expansion of outpatient services regarding the Port Angeles Medical Office Building ($18.3 million). The remainder was spent on other building improvements, equipment, and information systems.

The following is a summary of significant 2015 capital additions: the purchase of MRI equipment ($1.0 million) and buildings for the expansion of outpatient services ($8.7 million). The remainder was spent on other building improvements, equipment, and information systems.

On July 6, 2016, the Medical Center's Board of Commissioners approved to move forward with a bid for the Hospital Roof Replacement. The construction contract for $0.2 million was signed on October 21, 2016. As of December 31, 2016, the Medical Center's remaining commitment is $0.2 million. In 2015, the Medical Center had a remaining commitment of $13.4 million for the Port Angeles Medical Office Building and $0.6 million for the CT Remodel Project. As of December 31, 2016, remaining commitment for the Port Angeles Office Building is $1.6 million. All commitments regarding the CT Remodel Project were met in 2016.

See Note 4 for additional information.

Debt

The Medical Center currently has long-term limited tax general obligation (LTGO) debt outstanding in the amount of $45.0 million. This amount consists of the following: 1) $3.4 million remaining of a $10 million bank loan payable over the term of 10 years to pay for the emergency department expansion and related capital equipment. These funds were repurposed in 2012 to pay off $7.5 million in long-term debt issued in 2005 and 2006. The loan was made directly by a bank, has fixed interest of 2.87%, and is callable at the option of the Medical Center after five years. The loan was completed in the second quarter of 2011; 2) $2.4 million remaining of a $10 million bank loan payable over the term of 7 years to purchase an electronic health record system and complete other capital projects. The loan was made directly by a bank and has fixed interest of 1.63%. The loan was completed in the fourth quarter of 2012; 3) $19.2 million remaining of a $20 million bank loan payable over the term of 25 years to expand, make improvements to, and equip the Medical Center's facilities. The loan was made directly by a bank and has fixed interest for 10 years of 3.69%, and is callable at the option of the Medical Center after 10 years. The loan was completed in the fourth quarter of 2013; 4) $20 million bank loan payable over the term of 25 years in order to refinance part of 2011 and 2012 debt balances, expand, make improvements to, and equip the District's health care facilities. The loan was made directly by a bank and has fixed interest for 10 years of 3.04%, and is callable at the option of the Medical Center after 10 years. The loan was completed in the fourth quarter of 2016.

See Note 5 for additional information.

Budget Comparison

The following is a comparison of 2016 actual revenues, expenses, and changes in net position results to 2016 budgeted amounts (amounts in thousands):

	Actual	Budget	Variance
Operating revenues			
Net patient service revenue	$ 160,106	$159,200	$ 906
Property rental, cafeteria, taxes, and other	7,161	6,702	459
Total operating revenue	167,267	165,902	1,365
Operating expenses			
Wages and benefits	100,279	101,297	(1,018)
Professional fees	8,016	7,476	540
Supplies	26,392	24,239	2,153
Purchased services, maintenance, and other	18,298	17,211	1,087
Insurance	1,098	1,209	(111)
Depreciation and amortization	9,004	9,800	(796)
Total operating expenses	163,087	161,232	1,855
Operating income	4,180	4,670	(490)
Net nonoperating revenue	111	95	16
Increase in net position	$ 4,291	$ 4,765	$ (474)

The Medical Center's operating revenue for 2016 was 0.8% higher than budgeted. Total operating expenses for 2016 were higher than budgeted by 1.2%.

The resulting margins for 2016 were 2.5% for operating margin and 2.6% for total margin, compared with budgeted margins of 2.8% and 2.9%, respectively.

Issues Facing the Medical Center

The Medical Center's payor mix of approximately 83% governmental payors is very challenging due to generally low governmental reimbursement levels and the fact that governmental reimbursement reductions have such a significant financial impact on the Medical Center. In addition, cost of healthcare continues to increase in pharmaceutical supplies, medical supplies, medical service, and staffing. Due to nationwide shortages of medical providers, the cost of recruiting and retaining qualified providers are increasing as well.

Because the Medical Center is faced with the reimbursement cuts and cost challenges mentioned above, keeping up with the capital needs of the Medical Center will become more challenging as well.

Summary of Financial Position and Financial Activity in 2016

Overall, the Medical Center's financial performance in 2016 continued to be positive, primarily due to increased outpatient volume and managing expense increases.

The Medical Center is focused on continuing to improve clinical quality and patient safety; providing excellent service and access to all patients, regardless of their insurance or ability to pay; and meeting community needs in core areas of service. Achievement of these goals requires significant investments in capital assets and personnel. The Medical Center's financial position will need to remain strong to continue to achieve these goals.

Contacting the Medical Center's Financial Management

This financial report is designed to provide patients, suppliers, taxpayers, and creditors with a general overview of the Medical Center's finances and to show the Medical Center's accountability for the money it receives. If you have questions about this report or need additional financial information, contact the Medical Center Finance Office at Olympic Medical Center, 939 Caroline, Port Angeles, Washington 98362.

PUBLIC HOSPITAL DISTRICT NO. 2 OF CLALLAM COUNTY, WASHINGTON
dba OLYMPIC MEDICAL CENTER
STATEMENTS OF NET POSITION

ASSETS

	December 31, 2016	December 31, 2015
CURRENT ASSETS		
Cash	$ 5,044,514	$ 6,565,922
Short-term investments	351,277	41,572
Accounts receivable, net of estimated uncollectibles of $3,300,000 and $4,000,000 in 2016 and 2015, respectively	15,702,254	15,912,571
Supplies inventory	2,105,382	1,829,555
Prepaid expenses	2,170,336	2,501,333
Total current assets	25,373,763	26,850,953
ASSETS LIMITED AS TO USE	48,413,137	46,709,216
CAPITAL ASSETS		
Land	9,720,919	9,720,919
Construction in progress	27,864,885	9,127,829
Depreciable capital assets, net of accumulated depreciation	81,314,786	79,950,705
	118,900,590	98,799,453
OTHER ASSETS	2,254,298	2,254,298
Total assets	$ 194,941,788	$ 174,613,920

LIABILITIES AND NET POSITION

CURRENT LIABILITIES		
Accounts payable	$ 9,969,316	$ 7,793,747
Accrued salaries, wages, and payroll taxes	4,536,586	4,108,927
Accrued vacation	3,602,617	3,465,199
Other current liabilities	147,664	215,798
Estimated third-party payor settlements	1,933,228	1,625,623
Current portion of long-term debt	2,571,708	2,943,450
Total current liabilities	22,761,119	20,152,744
LONG-TERM DEBT, net of current portion	42,378,404	28,950,113
OTHER LONG-TERM LIABILITIES	1,454,740	1,454,740
Total liabilities	66,594,263	50,557,597
NET POSITION		
Invested in capital assets, net of related debt	89,945,478	72,934,508
Unrestricted	38,402,047	51,121,815
Total net position	128,347,525	124,056,323
Total liabilities and net position	$ 194,941,788	$ 174,613,920

See accompanying notes.

PUBLIC HOSPITAL DISTRICT NO. 2 OF CLALLAM COUNTY, WASHINGTON
dba OLYMPIC MEDICAL CENTER
STATEMENTS OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION

	Years Ended December 31,	
	2016	2015
OPERATING REVENUES		
Net patient service revenue (net of provision for bad debts of $2,600,000 in 2016 and $2,700,000 in 2015)	$ 160,105,768	$ 155,562,849
Tax revenue for maintenance and operations	4,422,564	4,265,937
Property rental, cafeteria, and other revenue	2,738,301	1,973,242
Total operating revenue	167,266,633	161,802,028
OPERATING EXPENSES		
Salaries and wages	78,197,451	72,160,050
Employee benefits	22,081,136	21,303,036
Professional fees	8,015,799	7,405,698
Supplies	26,392,995	24,588,556
Purchased services, maintenance, and other	18,297,661	17,212,101
Insurance	1,097,866	1,174,676
Depreciation and amortization	9,003,744	9,074,749
Total operating expenses	163,086,652	152,918,866
OPERATING INCOME	4,179,981	8,883,162
NONOPERATING REVENUES (EXPENSES)		
Investment income	649,357	709,274
Interest expense	(640,125)	(772,057)
Other	101,989	245,060
Net nonoperating revenue	111,221	182,277
INCREASE IN NET POSITION	4,291,202	9,065,439
NET POSITION, beginning of year	124,056,323	114,990,884
NET POSITION, end of year	$ 128,347,525	$ 124,056,323

See accompanying notes.

PUBLIC HOSPITAL DISTRICT NO. 2 OF CLALLAM COUNTY, WASHINGTON
dba OLYMPIC MEDICAL CENTER
STATEMENTS OF CASH FLOWS

Increase (Decrease) in Cash and Cash Equivalents

	Years Ended December 31,	
	2016	2015
CASH FLOWS FROM OPERATING ACTIVITIES		
Receipts from and on behalf of patients	$ 160,628,360	$ 153,470,984
Payments to suppliers and contractors	(52,989,719)	(51,548,667)
Payments to employees	(99,713,510)	(92,815,035)
Other receipts and payments, net	2,738,301	1,973,242
Net cash from operating activities	10,663,432	11,080,524
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES		
Tax revenue considered a noncapital financing activity	4,417,894	4,281,903
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES		
Proceeds from sale of capital assets	11,987	28,918
Proceeds from debt issuance	20,000,000	-
Principal payments on long-term debt	(6,943,451)	(2,656,687)
Purchase of capital assets and donation expense	(27,598,742)	(11,589,316)
Interest paid on long-term debt, net of capitalized portion	(708,259)	(679,162)
Net cash from capital and related financing activities	(15,238,465)	(14,896,247)
CASH FLOWS FROM INVESTING ACTIVITIES		
Proceeds from sale/maturity of investments	43,926,657	26,446,641
Purchase of investments	(35,117,734)	(35,142,797)
Cash from investment income, net of amount capitalized	871,779	916,584
Net cash from investing activities	9,680,702	(7,779,572)
NET CHANGE IN CASH AND CASH EQUIVALENTS	9,523,563	(7,313,392)
CASH AND CASH EQUIVALENTS, beginning of year	15,451,345	22,764,737
CASH AND CASH EQUIVALENTS, end of year	$ 24,974,908	$ 15,451,345
RECONCILIATION OF CASH AND CASH EQUIVALENTS TO STATEMENT OF NET POSITION		
Cash	$ 5,044,514	$ 6,565,922
Cash and cash equivalents in short-term investments	351,277	41,572
Cash and cash equivalents in assets limited as to use	19,579,117	8,843,851
	$ 24,974,908	$ 15,451,345

See accompanying notes.

PUBLIC HOSPITAL DISTRICT NO. 2 OF CLALLAM COUNTY, WASHINGTON
dba OLYMPIC MEDICAL CENTER
STATEMENTS OF CASH FLOWS (continued)

Increase (Decrease) in Cash and Cash Equivalents

	Years Ended December 31, 2016	2015
RECONCILIATION OF OPERATING INCOME TO NET CASH FROM OPERATING ACTIVITIES		
Operating income	$ 4,179,981	$ 8,883,162
Tax revenue considered a noncapital financing activity	(4,422,564)	(4,265,937)
Adjustments to reconcile operating income (expense) to net cash from operating activities		
Depreciation and amortization	8,742,905	8,867,475
Provision for bad debts	2,583,038	2,714,548
Loss on disposal of assets	260,839	207,274
Changes in operating assets and liabilities		
Accounts receivable	(2,368,051)	(3,730,557)
Supplies inventory	(275,827)	(15,960)
Estimated third-party payor settlements	307,605	(1,075,856)
Prepaid expenses	330,997	103,778
Accounts payable	759,432	(1,255,454)
Accrued liabilities	565,077	648,051
Net cash from operating activities	$ 10,663,432	$ 11,080,524
SUPPLEMENTAL DISCLOSURE OF NONCASH INVESTING, CAPITAL, AND FINANCING ACTIVITIES		
Change in capital assets included in accounts payable	$ 1,416,137	$ 2,189,110
Donation of capital assets	$ -	$ 285,000

See accompanying notes.

Note 1 - Reporting Entity and Summary of Significant Accounting Policies

Reporting entity - Public Hospital District No. 2 of Clallam County, Washington (dba Olympic Medical Center), serving Port Angeles and Sequim, Washington, and surrounding communities, is organized as a municipal corporation pursuant to the laws of the state of Washington.

Olympic Medical Center (the Medical Center) operates Olympic Memorial Hospital (the Hospital), a general acute-care facility that maintains 126 licensed beds including a birth center. The Medical Center has three divisions: the Hospital; Olympic Medical Physicians, which includes 11 physician clinics; and Olympic Medical Home Health, which provides home health care services. The Hospital division also includes Olympic Medical Imaging Centers, Olympic Medical Cancer Center, Olympic Medical Surgical Services, Olympic Medical Cardiac Services, Olympic Medical Physical Therapy and Rehabilitation, and Olympic Medical Laboratory. The majority of the Medical Center's patients live in Clallam County.

Use of estimates - The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.

Fund accounting - The Medical Center uses the proprietary fund method of accounting whereby revenue and expenses are recognized on the accrual basis.

Cash and cash equivalents - Cash and cash equivalents have original maturity dates of three months or less. For purposes of reporting cash flows, cash and cash equivalents include cash on hand, cash on deposit, and deposits in the local government investment pool. Cash and cash equivalents are included in the following lines on the statement of net position: cash, short-term investments, and assets limited as to use.

Supplies inventory - Supplies inventory, consisting of medicine and medical supplies, is valued at the lower of cost (computed on the first-in, first-out basis) or net realizable value.

Investments in debt securities - Investments in debt securities are reported at fair value except for investments in debt securities with maturities of less than one year at the time of purchase. These investments are reported at amortized cost. Interest, dividends, and gains and losses, both realized and unrealized, on investments in debt securities are included in nonoperating income when earned.

Capital assets - Capital asset acquisitions are recorded at cost. Contributed capital assets are reported at their estimated fair value at the time of their donation. Expenditures for maintenance and repairs are charged to operations as incurred. Betterments and major renewals are capitalized. It is the Medical Center's policy to capitalize assets that cost $2,000 or more and have a useful life of two years or greater.

Note 1 - Reporting Entity and Summary of Significant Accounting Policies (continued)

All capital assets other than land are depreciated or amortized using the straight-line method of depreciation using these asset lives:

Land improvements	5 - 25 years
Buildings and improvements	5 - 40 years
Fixed equipment	3 - 25 years
Movable equipment	2 - 20 years

Other long-term liabilities - The Medical Center has purchased claims-made liability insurance coverage that covers only asserted malpractice claims. The Medical Center recognizes expenses associated with reported claims and estimated claims incurred but not reported in the period in which the incidents are estimated to have occurred, rather than when a claim is asserted. Expenses associated with these incidents are based on historical actuarial assumptions of settlement costs and management estimates.

Risk management - The Medical Center is exposed to various risks of loss from torts; theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries and illness; natural disasters; medical malpractice; and employee health, dental, and accident benefits. Commercial insurance coverage is purchased for claims arising from such matters. Settled claims have not exceeded this commercial coverage in any of the three preceding years.

Net position - Net position of the Medical Center is classified into four components. *Invested in capital assets, net of related debt* consists of capital assets net of accumulated depreciation and reduced by the balances of any outstanding borrowings used to finance the purchase or construction of those assets. *Restricted expendable net positions* are noncapital net positions that must be used for a particular purpose, as specified by creditors, grantors, or contributors external to the Medical Center. *Restricted nonexpendable net position* equals the principal portion of permanent endowments. *Unrestricted net position* is the remaining net position that does not meet the definition of *invested in capital assets, net of related debt* or *restricted*. There were no restricted net positions as of December 31, 2016 and 2015.

Operating revenues and expenses - The Medical Center's statement of revenues, expenses, and changes in net position distinguishes between operating and nonoperating revenues and expenses. Operating revenues result from exchange transactions associated with providing health care services—the Medical Center's principal activity. Nonoperating revenues, including taxes, grants, and contributions received for purposes other than capital asset acquisition, are reported as other operating revenues. Operating expenses are all expenses incurred to provide health care services.

Tax revenue for maintenance and operations - Property taxes are levied by the county on the Medical Center's behalf and are intended to finance the Medical Center's activities of the same calendar year. Amounts levied are based on assessed property values.

Note 1 - Reporting Entity and Summary of Significant Accounting Policies (continued)

Charity care - The Medical Center provides care to indigent patients who meet certain criteria under its charity care policies. Because the Medical Center does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue. Forgone revenue for charity care provided during 2016 and 2015, measured by the Medical Center's standard charges, was approximately $1,606,000 and $1,303,000, respectively.

Federal income tax - The Medical Center is a municipal corporation and is exempt from federal income tax.

New accounting pronouncements - In February 2015, the GASB issued Statement No. 72, *Fair Value Measurement and Application.* Statement No. 72 is intended to address accounting and financial reporting issues related to fair value measurements. The definition of fair value is 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. This statement provides guidance for determining a fair value measurement for financial reporting purposes. This statement also provides guidance for applying fair value to certain investments and disclosures related to all fair value measurements. This guidance is effective for the Medical Center in the year ended December 31, 2016. The Medical Center has adopted this standard in the December 31, 2016, financial statements.

In December 2015, the GASB issued Statement No. 79, *Certain External Investment Pools and Pool Participants.* This statement addresses accounting and financial reporting for certain external investment pools and pool participants. Specifically, it establishes criteria for an external investment pool to qualify for making the election to measure all of its investments at amortized cost for financial reporting purposes. An external investment pool qualifies for that reporting if it meets all of the applicable criteria established in this statement. The specific criteria address (1) how the external investment pool transacts with participants; (2) requirements for portfolio maturity, quality, diversification, and liquidity; and (3) calculation and requirements of a shadow price. Significant noncompliance prevents the external investment pool from measuring all of its investments at amortized cost for financial reporting purposes. Professional judgment is required to determine if instances of noncompliance with the criteria established by this statement during the reporting period, individually or in the aggregate, were significant. This guidance is effective for the District in the year ended December 31, 2016. The District has reviewed and evaluated this statement and has determined there is no material impact to the financial statements for the year ended December 31, 2016.

Subsequent events - Subsequent events are events or transactions that occur after the statements of net position date but before financial statements are available to be issued. The Medical Center recognizes in the financial statements the effects of all subsequent events that provide additional evidence about conditions that existed at the date of the statements of net position, including the estimates inherent in the process of preparing the financial statements. The Medical Center's financial statements do not recognize subsequent events that provide evidence about conditions that did not exist at the date of the statements of net position but arose after the statement of net position date and before the financial statements are available to be issued.

The Medical Center has evaluated subsequent events through February 13, 2017, which is the date the financial statements are available to be issued.

Note 2 - Patient Service Revenue

Patient service revenue is recorded at established rates. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered. Preliminary settlements under reimbursement agreements with third-party payors are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

Reimbursement received from certain third-party payors is subject to audit and retroactive adjustment. Provision for possible adjustment as a result of audits is recorded in the financial statements. When reimbursement settlements are received, or when information becomes available with respect to reimbursement changes, any variations from amounts previously accrued are accounted for in the period in which the settlements are received or the change in information becomes available.

The Medical Center has arrangements with third-party payors that provide for payments to the Medical Center at amounts different from its established rates. 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 predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups (DRGs). Each DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that DRG. The Medical Center's classification of DRGs and the appropriateness of the related patient admission are subject to an independent review by a peer review organization. Most outpatient services to Medicare beneficiaries are paid prospectively based on ambulatory payment classifications (APCs). Physicians and other providers are paid on a fee schedule. The Hospital's cost reports have been reviewed and/or audited by the Medicare fiscal intermediary through 2013. Net revenue from the Medicare program totaled approximately $82,971,000 and $80,971,000 for 2016 and 2015, respectively. Unsecured net patient accounts receivable due from Medicare at December 31, 2016 and 2015, were approximately $5,905,000 and $6,672,000, respectively.

Medicaid - On July 1, 2005, a new inpatient Medicaid reimbursement methodology for all noncritical access Washington State governmental hospitals was implemented called "Certified Public Expenditures." Under this program, the Medical Center is paid for inpatient Medicaid services based on costs, including certain costs of uncompensated care. The estimated costs for inpatient care are calculated as a ratio of cost to charges from a base year (two years before the service year). Under the program, the Medical Center will be reimbursed the higher of the full cost of service or "baseline" reimbursement that would have been received based on the pre-July 1 inpatient payment system. Outpatient services are paid on a fee schedule or a percentage of allowed charges based on a ratio of the Medical Center's allowable operating expenses to total allowable revenue. Physicians and other providers are paid on a fee schedule. Net revenue from the Medicaid program totaled approximately $18,832,000 and $19,653,000 for 2016 and 2015, respectively. Unsecured net patient accounts receivable due from Medicaid at December 31, 2016 and 2015, were approximately $1,078,000 and $1,524,000, respectively.

The Medical Center has also entered into various payment arrangements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations.

Note 2 - Patient Service Revenue (continued)

The following are the components of net patient service revenue for the years ended December 31:

	2016	2015
Gross patient service charges	$ 328,380,845	$ 308,879,834
Adjustments to patient service charges		
Contractual discounts	164,086,537	149,299,422
Provision for bad debts	2,583,038	2,714,548
Charity care	1,605,502	1,303,015
	168,275,077	153,316,985
Net patient service revenue	$ 160,105,768	$ 155,562,849

Note 3 - Deposits and Investments

The Board of Commissioners has internally designated assets to provide for capital improvements and other requirements. The carrying amounts of these, as well as other deposits and investments, are included in the Medical Center's statements of net position as follows:

	2016	2015
Cash	$ 5,044,514	$ 6,565,922
Short-term investments	351,277	41,572
Assets limited as to use		
Capital reserves	30,695,869	38,988,051
Reserve for accrued liabilities	1,722,268	1,692,547
Bond proceeds restricted for capital improvements	15,995,000	6,028,618
Total deposits and investments	$ 53,808,928	$ 53,316,710

Deposits - Deposits with financial institutions are either insured or collateralized. Deposits must be made with financial institutions qualified by the Washington Public Deposit Protection Commission (PDPC). The deposits of the Medical Center are covered by the Federal Deposit Insurance Corporation (FDIC). Collateral protection in excess of the FDIC limit is provided by the Washington PDPC, a multi-financial institution collateral pool. Pledged securities under the PDPC collateral pool are held by the PDPC's agent in the name of the collateral pool.

Note 3 - Deposits and Investments (continued)

Investments - Eligible investments are only those securities and deposits authorized by statute. Eligible investments include:

- Obligations of the U.S. government
- Obligations of U.S. government agencies or government-sponsored corporations
- Obligations of Washington State and its agencies, or of other states and local governments in one of the three highest credit ratings of a nationally recognized rating organization
- Bankers' acceptances with the highest credit rating
- Commercial paper with the highest credit rating
- Repurchase agreements with collateral exceeding 102% of cost and consisting of authorized investments
- State Treasurer's local government investment pool
- Certificates of deposit with financial institutions qualified by the Washington Public Deposit Protection Commission

Credit risk - Credit risk is the risk that an issuer or other counterparty to an investment will not fulfill its obligations. The Medical Center's investment policy limits the types of securities to those authorized by statute; therefore, credit risk is very limited. Obligations of the U.S. government and agencies are rated AAA by Standard and Poor's or Moody's credit rating organizations. Obligations of other states and local governments are rated A or higher by Standard and Poor's or Moody's and have one of the three highest ratings of nationally recognized rating organizations and are general obligations of those entities. The Medical Center's portfolio currently includes no bankers' acceptances or commercial paper.

The composition of investments, reported at fair value by investment type at December 31, 2016, and excluding unrestricted cash, short-term investments, and other assets limited as to use balances of $27,813,717, is as follows:

Investment Type	Quoted Prices in Active Markets for Identical Assets (Level 1)	Percentage of Totals
U.S. government agency obligations	$ 5,544,964	21%
State and local government obligations	20,450,247	79%
Total	$ 25,995,211	100%

Note 3 - Deposits and Investments (continued)

The composition of investments, reported at fair value by investment type at December 31, 2015, and excluding unrestricted cash, short-term investments, and other assets limited as to use balances of $18,267,742, is as follows:

Investment Type	Quoted Prices in Active Markets for Identical Assets (Level 1)	Percentage of Totals
U.S. government agency obligations	$ 11,186,812	32%
State and local government obligations	23,862,156	68%
Total	$ 35,048,968	100%

Custodial credit risk - Custodial credit risk is the risk that in the event of a failure of the counterparty, the Medical Center will not be able to recover the value of the investment or collateral securities that are in the possession of an outside party. All U.S. government, U.S. government agency, and state and local agency securities are held by the Medical Center's safekeeping custodian acting as an independent third party and carry no custodial credit risk. Cash deposits and certificates of deposit are collateralized by the State Collateral Pool that insures public deposits and carry no custodial credit risk. Deposits with the state investment pool are covered by the state's master custodial agreement and carry no custodial credit risk.

Concentration of credit risk - Concentration of credit risk is the risk of loss attributed to the magnitude of the Medical Center's investment in a single issuer. The Medical Center mitigates credit risk by limiting the percentage of the portfolio invested with any one issuer.

Interest rate risk - Interest rate risk is the risk that changes in interest rates of debt instruments will adversely affect the fair value of an investment. The Medical Center manages interest rate risk by having policy limitations on the maximum maturity of any one security and limits to 35% the percentage of the investment portfolio maturing in more than five years. As of December 31, 2016, the weighted-average maturity of the portfolio was less than five years.

Note 3 - Deposits and Investments (continued)

Internally designated assets and bond proceeds are generally carried at fair market value. Internally designated assets, short-term investments, and bond proceeds are held in the following investments:

	2016	2015
U.S. government agency obligations	$ 5,544,964	$ 11,186,812
State and local government obligations	20,450,247	23,862,156
Local government investment pool	3,935,394	2,856,805
Cash and cash equivalents - LTGO bond proceeds	15,995,000	6,028,618
Certificates of deposit	2,838,809	2,816,397
	$ 48,764,414	$ 46,750,788

Note 4 - Capital Assets

Capital asset additions, retirements, and balances for the years ended December 31, 2016 and 2015, were as follows:

	Balance January 1, 2016	Additions	Sales and Retirements	Account Transfers	Balance December 31, 2016
ASSETS AT COST					
Land	$ 9,720,919	$ -	$ -	$ -	$ 9,720,919
Land improvements	3,776,945	-	-	355,216	4,132,161
Buildings and improvements	91,469,741	-	238,680	2,141,149	93,372,210
Fixed equipment	22,786,852	-	-	1,221,177	24,008,029
Movable equipment	79,128,292	-	11,247,068	6,662,270	74,543,494
Construction in progress	9,127,829	29,116,868	-	(10,379,812)	27,864,885
	216,010,578	29,116,868	11,485,748	-	233,641,698
LESS ACCUMULATED DEPRECIATION					
Land improvements	2,259,834	167,132	-	-	2,426,966
Buildings and improvements	42,434,496	3,074,265	24,663	-	45,484,098
Fixed equipment	16,266,431	710,080	-	-	16,976,511
Movable equipment	56,250,364	4,791,428	11,188,259	-	49,853,533
	117,211,125	8,742,905	11,212,922	-	114,741,108
	$ 98,799,453	$ 20,373,963	$ 272,826	$ -	$ 118,900,590

Note 4 - Capital Assets (continued)

	Balance January 1, 2015	Additions	Sales and Retirements	Account Transfers	Balance December 31, 2015
ASSETS AT COST					
Land	$ 8,984,894	$ 428,848	$ -	$ 307,177	$ 9,720,919
Land improvements	3,750,326	-	-	26,619	3,776,945
Buildings and improvements	87,665,214	-	1,051,024	4,855,551	91,469,741
Fixed equipment	22,180,412	-	5,831	612,271	22,786,852
Movable equipment	79,290,736	-	2,246,974	2,084,530	79,128,292
Construction in progress	3,419,339	13,594,638	-	(7,886,148)	9,127,829
	205,290,921	14,023,486	3,303,829	-	216,010,578
LESS ACCUMULATED DEPRECIATION					
Land improvements	2,092,283	167,551	-	-	2,259,834
Buildings and improvements	40,350,536	2,901,459	817,499	-	42,434,496
Fixed equipment	15,614,453	657,809	5,831	-	16,266,431
Movable equipment	53,354,015	5,140,656	2,244,307	-	56,250,364
	111,411,287	8,867,475	3,067,637	-	117,211,125
	$ 93,879,634	$ 5,156,011	$ 236,192	$ -	$ 98,799,453

As of December 31, 2016, the Medical Center had a remaining commitment in the amount of $1,600,000 million related to the Port Angeles Medical Office Building.

The Medical Center recorded $394,000 and $490,000 of net capitalized interest in 2016 and 2015, respectively. The loss on disposal of assets of $260,839 and $207,274 as of December 31, 2016 and 2015, respectively, was included in the depreciation and amortization line on the statements of revenues, expenses, and changes in net position.

Note 5 - Long-Term Debt

During the second quarter of 2011, the Medical Center issued $10 million of debt directly with a bank. The debt has a 10-year term with fixed interest at 2.87% and is callable at the option of the Medical Center after five years or prior with a penalty. Principal and interest payments are due every six months with level payments, and the collateral for the debt is the Medical Center's revenues and tax levy.

During the fourth quarter of 2012, the Medical Center issued $10 million of debt directly with a bank. The debt has a seven-year term with fixed interest at 1.63% and is callable at the option of the Medical Center with a penalty. Principal and interest payments are due every six months with level payments, and the collateral for the debt is the Medical Center's revenues and tax levy.

Note 5 - Long-Term Debt (continued)

During the fourth quarter of 2013, the Medical Center entered into a $20 million debt agreement directly with a bank. The debt has a 25-year term with fixed interest at 3.69% through November 30, 2023, at which point the bank has the option to tender the bond without premium or penalty. For the period beginning December 1, 2023, the bond shall bear interest at 3.69% plus or minus .00675% for each one basis point variance in the 10-year U.S. Treasury Constant Maturity Note rate or other applicable Index Rate as defined by the bank. Principal and interest payments are due every six months with level payments, and the collateral for the debt is the Medical Center's revenues and tax levy.

During the fourth quarter of 2016, the Medical Center entered into a $20 million debt agreement directly with a bank. The debt has a 25-year term with fixed interest at 3.04% through December 1, 2026, at which point the bank has the option to tender the bond without premium or penalty. For the period beginning December 2, 2026, the bond shall bear interest at 3.04% plus or minus .00675% for each one basis point variance in the 10-year U.S. Treasury Constant Maturity Note rate or other applicable Index Rate as defined by the bank. Principal and interest payments are due every six months with level payments, and the collateral for the debt is the Medical Center's revenues and tax levy.

Principal and interest repayments on long-term debt are as follows:

	Principal	Interest
2017	$ 2,571,708	$ 1,417,455
2018	2,623,963	1,365,200
2019	2,696,089	1,293,344
2020	1,935,003	1,222,364
2021	1,980,389	1,159,635
2022 - 2026	33,142,960	11,546,104
	$ 44,950,112	$ 18,004,102

The schedule of long-term debt activity for the years ended December 31, 2016 and 2015, is as follows:

	Balance December 31, 2015	Additions	Reductions	Balance December 31, 2016	Principal Amounts Due Within One Year	Interest Amounts Due Within One Year
Long-term debt						
LTGO Bond 2011	$ 6,338,163	$ -	$ (2,982,559)	$ 3,355,604	$ 633,066	$ 97,714
LTGO Bond 2012	5,828,848	-	(3,406,643)	2,422,205	792,399	39,397
LTGO Bond 2013	19,726,552	-	(554,249)	19,172,303	577,940	702,155
LTGO Bond 2016	-	20,000,000	-	20,000,000	568,303	578,189
Total long-term debt	$ 31,893,563	$ 20,000,000	$ (6,943,451)	$ 44,950,112	$ 2,571,708	$ 1,417,455
Other liabilities						
Other long-term liabilities	$ 1,454,740	$ -	$ -	$ 1,454,740	$ -	$ -

Note 5 - Long-Term Debt (continued)

	Balance December 31, 2014	Additions	Reductions	Balance December 31, 2015	Principal Amounts Due Within One Year	Interest Amounts Due Within One Year
Long-term debt						
LTGO Bond 2011	$ 7,293,118	$ -	$ (954,955)	$ 6,338,163	$ 982,559	$ 172,556
LTGO Bond 2012	7,259,532	-	(1,430,684)	5,828,848	1,403,701	89,068
LTGO Bond 2013	19,997,600	-	(271,048)	19,726,552	557,190	722,905
Total long-term debt	$ 34,550,250	$ -	$ (2,656,687)	$ 31,893,563	$ 2,943,450	$ 984,529
Other liabilities						
Other long-term liabilities	$ 1,454,740	$ -	$ -	$ 1,454,740	$ -	$ -

Note 6 - Property Taxes

The County Treasurer acts as an agent to collect property taxes levied in the county. Taxes are levied annually, on January 1, on property values listed as of the prior May 31. Assessed values are established by the county assessor at 100% of fair market value. A reevaluation of all property is required every four years.

Taxes are due in two equal installments on April 30 and October 31. Collections are distributed monthly by the County Treasurer.

The Medical Center is permitted by law to levy up to $0.75 per $1,000 of assessed valuation for general purposes. The Washington State Constitution and Washington State Law, RCW 84-55-010, limit the rate. The Medical Center may also levy taxes at a lower rate. Additional amounts of tax need to be authorized by a vote of the residents of Clallam County.

For 2016, the Medical Center's regular levy was $0.58708 per $1,000 of assessed valuation. The Medical Center received $4,423,000 from the County for the regular levy and revenues related to the harvest of timber within the community. For 2015, the Medical Center's regular levy was $.60065 per $1,000 of assessed valuation. The Medical Center received $4,266,000 from the County for the regular levy and revenues related to the harvest of timber within the community.

Property taxes are recorded as receivables when levied. Because state law allows for sale of property for failure to pay taxes, no estimate of uncollectible taxes is made.

Note 7 - Employee Benefit Plans

The Medical Center has a defined contribution pension plan covering substantially all qualified employees. All qualified employees may participate in the Medical Center's retirement plan. The employer's annual contribution is set by the plan documents. The Medical Center's liability under the plan is limited to its annual contribution. It is the Medical Center's policy to currently fund pension costs accrued under this plan.

The Medical Center has deferred compensation plans created in accordance with Internal Revenue Code Section 457 and Revenue Code Section 403(b). The plans are available to eligible employees and permit them to defer a portion of their salary until withdrawn in future years. The Medical Center makes contributions based on a percentage of certain employees' compensation. The deferred compensation is not available to employees until termination, retirement, death, or unforeseeable emergency. The Medical Center fully funds all compensation deferred under the plan agreements through deposits.

Contributions to the employee benefit plans from both the Medical Center and employees totaled approximately $8,251,000 in 2016 and $7,808,000 in 2015.

Note 8 - Collective Bargaining Agreements

At December 31, 2016, the Medical Center had a total of approximately 1,311 employees. Of this total, approximately 724 are covered by collective bargaining agreements.

Note 9 - Contingencies

Litigation - The Medical Center is involved in litigation arising in the ordinary course of business. Based on consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect on the Medical Center's future financial position or results from operations.

Compliance with laws and regulations - The Medical Center is subject to many complex federal, state, and local laws and regulations. Compliance with these laws and regulations is subject to government review and interpretation, and unknown or unasserted regulatory actions. Government activity with respect to investigations and allegations regarding possible violations of these laws and regulations by health care providers, including those related to medical necessity, coding, and billing for services, has increased significantly. Violations of these laws can result in large fines and penalties, sanctions on providing future services, and repayment of past patient service revenues. The Medical Center has implemented a voluntary corporate compliance program, which includes guidance for all Medical Center employees' adherence to applicable laws and regulations. Management believes any actions that may result from investigations of noncompliance with laws and regulations will not have a material effect on the Medical Center's future financial position or results of operations.

Note 10 - Concentration of Credit Risk

The Medical Center grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors at December 31, 2016 and 2015, was as follows:

	2016	2015
Medicare	44%	44%
Medicaid	12%	15%
Other third-party payors	30%	28%
Patients	14%	13%
	100%	100%

Note 11 - Disclosures About Fair Value of Financial Instruments

The following methods and assumptions were used to estimate the fair value of each class of financial instrument for which it is practicable to estimate that value:

Cash equivalents and short-term investments - The carrying amount reported on the statements of net position approximates fair value.

Assets limited as to use - The carrying amount approximates the fair values of investments. The fair values are estimated based on quoted market prices, if available, or estimated using quoted market prices of similar investments.

Accounts payable and accrued expenses - The carrying amount reported on the statements of net position for accounts payable and accrued expenses approximates fair value.

Estimated third-party payor settlements - The carrying amount reported on the statements of net position for estimated third-party payor settlements approximates fair value.

Long-term debt - The Medical Center is not able to estimate the fair value of its bonds because there is no trading of the bonds in secondary markets to establish a current fair value, as the bonds were privately placed with a financial institution.

Note 12 - Operating Leases

The Medical Center leases certain facilities and equipment under operating lease arrangements. The following is a schedule by year of future minimum lease payments as of December 31, 2016:

2017	$	196,626
2018		197,020
2019		197,415
2020		182,735
2021		170,312
2022 - 2025		468,359
Total minimum lease payments	$	1,412,467

Rent expense on operating leases for 2016 and 2015 was $273,000 and $282,000, respectively.

CONTENTS

MOSS-ADAMS LLP
Certified Public Accountants | Business Consultants

REPORT OF INDEPENDENT AUDITORS

To the Board of Commissioners
Public Hospital District No. 2 of Clallam County, Washington
dba Olympic Medical Center

Report on Financial Statements

We have audited the accompanying financial statements of Public Hospital District No. 2 of Clallam County, Washington, dba Olympic Medical Center (the Medical Center), which comprise the statements of net position as of December 31, 2015 and 2014, and the related statements of revenues, expenses, and changes in net position and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of 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 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 financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the 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 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 financial statements.

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

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Medical Center as of December 31, 2015 and 2014, and the changes in its net position and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matter

Accounting principles generally accepted in the United States of America require that the accompanying management's discussion and analysis on pages 3 through 10 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Everett, Washington
February 10, 2016

This discussion and analysis provides an overview of the financial position and financial activities of Public Hospital District No. 2 of Clallam County, Washington, doing business as Olympic Medical Center (the Medical Center). Please read it in conjunction with the Medical Center's financial statements and accompanying notes, which follow this section.

Financial Highlights

- One of the core components of the Medical Center's 2014–2016 strategic plan is the affiliation with Swedish Medical Center (Swedish) and the implementation of a new Electronic Health Records system (EHR). The affiliation with Swedish provides the Medical Center with the opportunity to be a part of the larger Providence and Swedish EHR system. In 2015, the Medical Center continued achieving stability of the EHR and financial software programs, which were implemented in 2013. In 2013, the Medical Center implemented Epic to fulfill the Electronic Health Records requirements and implemented Lawson to meet the need for financial software that interfaces with Epic.
- The Medical Center's net position increased by $9.1 million in 2015 and increased by $2.0 million in 2014.
- The Medical Center's total operating revenue was $161.8 million in 2015 compared with $146.8 million in 2014.
- The Medical Center invested approximately $14.0 million in capital assets, including improved medical facilities and new medical equipment in 2015 and approximately $7.5 million in 2014, including improved medical facilities and new medical equipment.

Overview of the Financial Statements

The Medical Center's financial statements consist of three statements: a statement of net position; a statement of revenues, expenses, and changes in net position; and a statement of cash flows. These financial statements and related notes provide information about the activities of the Medical Center, including resources held by the Medical Center that are held for specific purposes. The statement of net position includes all of the Medical Center's assets and liabilities using the accrual basis of accounting, as well as an indication about which assets can be used for general purposes and which are designated for a specific purpose. The statement of revenues, expenses, and changes in net position reports all of the revenues and expenses during the time period indicated. The statement of cash flows reports the cash provided by the Medical Center's operating activities, as well as other cash sources such as investment income and cash payments for additions and improvements.

Volumes and Statistics

Following are key operating statistics:

	2015	2014	2013	2015 - 2014 % Change
Available beds	67	78	78	-14%
Admissions	4,301	4,449	4,253	-3%
Patient days	14,573	14,330	14,556	2%
Imaging procedures	84,497	78,188	71,202	8%
Oncology procedures	28,901	26,647	25,307	8%
Surgery cases	6,648	6,564	5,807	1%
Emergency room visits	30,319	27,835	26,527	9%
Home health visits	30,398	22,176	19,321	37%
Clinic visits	113,971	104,101	86,245	9%
Full-time equivalent employees	1,050	1,005	950	4%

Statement of Net Position

The following is a presentation of certain financial information derived from the Medical Center's statement of net position (amounts in thousands):

	2015	2014	2013	2015 - 2014 Change
Assets				
Total current assets	$ 26,851	$ 27,857	$ 21,935	$ (1,006)
Assets limited as to use	46,709	43,616	48,727	3,093
Capital assets, net	98,799	93,880	95,928	4,919
Other assets	2,255	2,253	2,255	2
Total assets	$ 174,614	$ 167,606	$ 168,845	$ 7,008
Liabilities				
Current liabilities	$ 20,153	$ 19,242	$ 19,824	$ 911
Long-term debt	28,950	31,919	34,551	(2,969)
Other long-term liabilities	1,455	1,455	1,455	-
Total liabilities	50,558	52,616	55,830	(2,058)
Net position				
Invested in capital assets, net of related debt	72,934	71,394	80,185	1,540
Unrestricted	51,122	43,596	32,830	7,526
Total net position	124,056	114,990	113,015	9,066
Total liabilities and net position	$ 174,614	$ 167,606	$ 168,845	$ 7,008

Statement of Net Position (continued)

Current assets in 2015 included cash and investments (25%), total receivables (59%), supplies inventory (7%), and prepaid expenses (9%). Current assets decreased by 4% in 2015 primarily in cash.

Current assets in 2014 included cash and investments (31%), total receivables (54%), supplies inventory (6%), and prepaid expenses (9%). Current assets increased by 27% in 2014 primarily in cash and investments.

Assets limited as to use in 2015 totaling $46.7 million included capital reserves of $39.0 million, reserve for accrued liabilities of $1.7 million, and bond proceeds restricted for capital purchases of $6.0 million.

Assets limited as to use in 2014 totaling $43.6 million included capital reserves of $29.8 million, reserve for accrued liabilities of $1.6 million, and bond proceeds restricted for capital purchases of $12.1 million.

Total assets increased $7.0 million (4.2%) in 2015. Assets limited as to use increased $3.1 million due to increase in capital reserves, and land, building, and equipment increased $4.9 million, primarily due to the completion of the Emergency Department Expansion Project and the start of the Medical Office Building Expansion Project. Cash decreased $1.9 million due to bond payments made at year-end.

Total assets decreased $1.2 million (1%) in 2014 due to a number of factors. Accounts receivable (AR) decreased as a result of improved collections resulting in accounts receivable days of 39 at year-end. The increase in cash was a result of the improvement in AR days, the receipt of meaningful use funds, and a positive net income. Assets limited as to use decreased as a result of expenditures of the bond proceeds for capital projects.

In 2015, total current liabilities increased by 4.7% from 2014. Current liabilities in 2015 included accounts payable (39%), accrued vacation and payroll (37%), current portion of long-term debt (15%), and other liabilities (9%). Current liabilities in 2014 included accounts payable (36%), accrued vacation and payroll (36%), current portion of long-term debt (14%), and other liabilities (14%).

Long-term debt, net of current portion, decreased by $3.0 million in 2015. Long-term debt, net of current portion, decreased by $2.6 million in 2014.

Total net position increased by $9.1 million to $124.1 million at the end of 2015. The total consists of $72.9 million invested in capital assets, net of related debt, and $51.1 million of unrestricted net position.

Total net position increased by $2.0 million to $115.0 million at the end of 2014. The total consists of $71.4 million invested in capital assets, net of related debt, and $43.6 million of unrestricted net position.

Statement of Revenues, Expenses, and Changes in Net Position

The following is a summary of 2015 compared with 2014 and 2013 annual amounts (amounts in thousands):

	2015	2014	2013	2015 - 2014 Change
Total operating revenue	$ 161,802	$ 146,783	$ 134,966	$ 15,019
Operating expenses				
Wages and benefits	93,463	89,812	85,443	3,651
Professional fees	7,406	6,505	6,491	901
Supplies	24,588	21,915	21,573	2,673
Purchased services, maintenance, and other	17,212	16,267	17,333	945
Insurance	1,175	1,230	1,167	(55)
Depreciation and amortization	9,075	9,549	9,499	(474)
Total operating expenses	152,919	145,278	141,506	7,641
Operating income (loss)	8,883	1,505	(6,540)	7,378
Net nonoperating revenue (expense)	183	470	(458)	(287)
Increase (decrease) in net position	$ 9,066	$ 1,975	$ (6,998)	$ 7,091

Total operating revenue was $15.0 million more in 2015 as a result of increased volumes in outpatient and emergency services.

Total operating revenue was $11.8 million more in 2014 as a result of increased volumes in outpatient and emergency services.

Total bad debt provision and charity care provided was $4.0 million in 2015 compared with $7.4 million in 2014 and $8.9 million in 2013. The decline in uncompensated care is due to a decrease in uninsured and underinsured patients and an increase in Medicaid patients.

Statement of Revenues, Expenses, and Changes in Net Position (continued)

The following is a summary of the Medical Center's gross revenue by payor:

	2015	2014	2013
Medicare	59%	58%	58%
Medicaid	17%	16%	11%
Other government	7%	7%	8%
Total governmental payors	83%	81%	77%
Commercial insurance	16%	18%	19%
Private pay	1%	1%	4%
Total	100%	100%	100%

Combined wages and benefits increased by 4.1% in 2015 and 5.1% in 2014. Supplies increased by 12.2% in 2015 and 1.6% in 2014. Purchased services, maintenance, and other increased by 5.8% in 2015 and decreased by 6.1% in 2014. Professional fees increased by 13.8% in 2015 and increased by 0.2% in 2014.

Charitable contributions received by the Medical Center in 2015 totaled $405,500, compared with $242,800 in 2014 and $65,348 in 2013. In 2015, the Medical Center received a generous private donation of a residence with estimated value of $285,000. The remaining monetary contributions primarily came from the Olympic Medical Center Foundation, the Olympic Memorial Hospital Auxiliary, and the Sequim Dungeness Hospital Guild.

The Medical Center had operating income of $8.9 million in 2015 compared to operating income of $1.5 million in 2014.

The Medical Center's Cash Flows

The following is a summary of cash flows in 2015, 2014, and 2013 (amounts in thousands):

	2015	2014	2013	2015 - 2014 Change
Net cash from operating activities	$ 11,081	$ 8,574	$ (1,745)	$ 2,507
Cash from tax revenue	4,282	4,249	4,185	33
Net cash from capital and related financing activities	(14,896)	(11,258)	(87)	(3,638)
Net cash from investing activities	(7,780)	(4,263)	4,817	(3,517)
Net change in cash and cash equivalents	$ (7,313)	$ (2,698)	$ 7,170	$ (4,615)

Net cash from operating activities was $11.1 million in 2015, compared with $8.6 million in 2014. $11.6 million was spent on the purchase of capital assets in 2015.

The Medical Center's Cash Flows (continued)

Net cash from operating activities was $8.6 million in 2014, compared with a negative $1.7 million in 2013. The negative net cash from operating activities in 2013 was primarily due to the $7.0 million net loss. $7.6 million was spent on the purchase of capital assets in 2014.

Capital Assets

At the end of 2015, the Medical Center had $98.8 million invested in capital assets, net of accumulated depreciation, as detailed in Note 4 to the financial statements. In 2015, the Medical Center purchased new capital assets costing approximately $14.0 million. In 2014, the Medical Center purchased new capital assets costing approximately $7.5 million.

Major capital acquisitions in 2015 included the purchase of MRI equipment ($1.0 million) and buildings for the expansion of outpatient services ($8.7 million). The remainder was spent on other building improvements, equipment, and information systems.

The following is a summary of significant 2014 capital additions: the purchase of 3D mammography equipment ($1.4 million) and real estate for the expansion of outpatient services ($1.2 million). The remainder was spent on other building improvements, equipment, and information systems.

On May 6, 2015, the Medical Center's Board of Commissioners approved a bid for the building of the Port Angeles Medical Office Building. The construction contract for $16.2 million was signed on July 7, 2015. On June 17, 2015, the Medical Center's Board of Commissioners approved a bid for the CT Scan Remodel Project. The construction contract for $0.6 million was signed on November 18, 2015. As of December 31, 2015, the Medical Center's remaining commitment is $13.4 million for the Port Angeles Medical Office Building and $0.6 million for the CT Remodel Project. In 2014, the Medical Center had a remaining commitment of $1.2 million for the expansion of the Emergency Room. All commitments regarding this were met in 2015.

See Note 4 for additional information.

Debt

The Medical Center currently has long-term limited tax general obligation (LTGO) debt outstanding in the amount of $31.9 million. This amount consists of the following: 1) $6.3 million remaining of a $10 million bank loan payable over the term of 10 years to pay for the emergency department expansion and related capital equipment. These funds were repurposed in 2012 to pay off $7.5 million in long-term debt issued in 2005 and 2006. The loan was made directly by a bank, has fixed interest of 2.87%, and is callable at the option of the Medical Center after five years. The loan was completed in the second quarter of 2011; 2) $5.9 million remaining of a $10 million bank loan payable over the term of 7 years to purchase an electronic health record system and complete other capital projects. The loan was made directly by a bank and has fixed interest of 1.63%. The loan was completed in the fourth quarter of 2012; 3) $19.7 million remaining of a $20 million bank loan payable over the term of 25 years to expand, make improvements to, and equip the Medical Center's facilities. The loan was made directly by a bank and has fixed interest for 10 years of 3.69%, and is callable at the option of the Medical Center after 10 years. The loan was completed in the fourth quarter of 2013.

See Note 5 for additional information.

Budget Comparison

The following is a comparison of 2015 actual revenues, expenses, and changes in net position results to 2015 budgeted amounts (amounts in thousands):

	Actual	Budget	Variance
Operating revenues			
Net patient service revenue	$ 155,563	$146,165	$ 9,398
Property rental, cafeteria, taxes, and other	6,239	7,193	(954)
Total operating revenue	161,802	153,358	8,444
Operating expenses			
Wages and benefits	93,463	94,411	(948)
Professional fees	7,406	6,863	543
Supplies	24,588	22,533	2,055
Purchased services, maintenance, and other	17,212	16,211	1,001
Insurance	1,175	1,249	(74)
Depreciation and amortization	9,075	9,700	(625)
Total operating expenses	152,919	150,967	1,952
Operating income	8,883	2,391	6,492
Net nonoperating revenue	183	600	(417)
Increase in net position	$ 9,066	$ 2,991	$ 6,075

The Medical Center's operating revenue for 2015 was 5.5% higher than budgeted. Total operating expenses for 2015 were higher than budgeted by 1.3%.

The resulting margins for 2015 were 5.5% for operating margin and 5.6% for total margin, compared with budgeted margins of 1.6% and 2.0%, respectively.

Issues Facing the Medical Center

The Medical Center's payor mix of approximately 83% governmental payors is very challenging due to generally low governmental reimbursement levels and the fact that governmental reimbursement reductions have such a significant financial impact on the Medical Center. In addition, cost of healthcare continues to increase in pharmaceutical supplies, medical supplies, medical service and staffing. Due to nationwide shortages of medical providers, the cost of recruiting and retaining qualified providers are increasing as well.

Because the Medical Center is faced with the reimbursement cuts and cost challenges mentioned above, keeping up with the capital needs of the Medical Center will become more challenging as well.

Summary of Financial Position and Financial Activity in 2015

Overall, the Medical Center's financial performance in 2015 was a vast improvement over 2014, primarily due to increased outpatient volume and better reimbursement payor mix while managing expense increases.

The Medical Center is focused on continuing to improve clinical quality and patient safety; providing excellent service and access to all patients, regardless of their insurance or ability to pay; and meeting community needs in core areas of service. Achievement of these goals requires significant investments in capital assets and personnel. The Medical Center's financial position will need to remain strong to continue to achieve these goals.

Contacting the Medical Center's Financial Management

This financial report is designed to provide patients, suppliers, taxpayers, and creditors with a general overview of the Medical Center's finances and to show the Medical Center's accountability for the money it receives. If you have questions about this report or need additional financial information, contact the Medical Center Finance Office at Olympic Medical Center, 939 Caroline, Port Angeles, Washington 98362.

PUBLIC HOSPITAL DISTRICT NO. 2 OF CLALLAM COUNTY, WASHINGTON
dba OLYMPIC MEDICAL CENTER
STATEMENTS OF NET POSITION

ASSETS

	December 31, 2015	December 31, 2014
CURRENT ASSETS		
Cash	$ 6,565,922	$ 8,486,412
Short-term investments	41,572	39,012
Accounts receivable, net of estimated uncollectibles of $4,000,000 and $4,700,000 in 2015 and 2014, respectively	15,912,571	14,912,528
Supplies inventory	1,829,555	1,813,595
Prepaid expenses	2,501,333	2,605,111
Total current assets	26,850,953	27,856,658
ASSETS LIMITED AS TO USE	46,709,216	43,615,832
CAPITAL ASSETS		
Land	9,720,919	8,984,894
Construction in progress	9,127,829	3,419,338
Depreciable capital assets, net of accumulated depreciation	79,950,705	81,475,402
	98,799,453	93,879,634
OTHER ASSETS	2,254,298	2,254,298
Total assets	$ 174,613,920	$ 167,606,422

LIABILITIES AND NET POSITION

CURRENT LIABILITIES		
Accounts payable	$ 7,793,747	$ 6,860,091
Accrued salaries, wages, and payroll taxes	4,108,927	3,738,921
Accrued vacation	3,465,199	3,187,154
Other current liabilities	215,798	122,903
Estimated third-party payor settlements	1,625,623	2,701,479
Current portion of long-term debt	2,943,450	2,630,956
Total current liabilities	20,152,744	19,241,504
LONG-TERM DEBT, net of current portion	28,950,113	31,919,294
OTHER LONG-TERM LIABILITIES	1,454,740	1,454,740
Total liabilities	50,557,597	52,615,538
NET POSITION		
Invested in capital assets, net of related debt	72,934,508	71,394,510
Unrestricted	51,121,815	43,596,374
Total net position	124,056,323	114,990,884
Total liabilities and net position	$ 174,613,920	$ 167,606,422

See accompanying notes.

PUBLIC HOSPITAL DISTRICT NO. 2 OF CLALLAM COUNTY, WASHINGTON
dba OLYMPIC MEDICAL CENTER
STATEMENTS OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION

	Years Ended December 31,	
	2015	2014
OPERATING REVENUES		
Net patient service revenue (net of provision for bad debts of $2,700,000 in 2015 and $4,900,000 in 2014)	$ 155,562,849	$ 138,914,707
Tax revenue for maintenance and operations	4,265,937	4,253,605
Property rental, cafeteria, and other revenue	1,973,242	3,615,120
Total operating revenue	161,802,028	146,783,432
OPERATING EXPENSES		
Salaries and wages	72,160,050	69,991,702
Employee benefits	21,303,036	19,819,891
Professional fees	7,405,698	6,505,171
Supplies	24,588,556	21,914,678
Purchased services, maintenance, and other	17,212,101	16,267,483
Insurance	1,174,676	1,229,601
Depreciation and amortization	9,074,749	9,549,255
Total operating expenses	152,918,866	145,277,781
OPERATING INCOME	8,883,162	1,505,651
NONOPERATING REVENUES (EXPENSES)		
Investment income	709,274	816,745
Interest expense	(772,057)	(585,567)
Other	245,060	238,965
Net nonoperating revenue	182,277	470,143
INCREASE IN NET POSITION	9,065,439	1,975,794
NET POSITION, beginning of year	114,990,884	113,015,090
NET POSITION, end of year	$ 124,056,323	$ 114,990,884

See accompanying notes.

Increase (Decrease) in Cash and Cash Equivalents

	Years Ended December 31, 2015	2014
CASH FLOWS FROM OPERATING ACTIVITIES		
Receipts from and on behalf of patients	$ 153,470,984	$ 142,493,705
Payments to suppliers and contractors	(51,548,667)	(48,194,628)
Payments to employees	(92,815,035)	(89,340,070)
Other receipts and payments, net	1,973,242	3,615,120
Net cash from operating activities	11,080,524	8,574,127
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES		
Tax revenue considered a noncapital financing activity	4,281,903	4,248,898
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES		
Proceeds from sale of capital assets	28,912	4,973
Principal payments on long-term debt	(2,656,687)	(3,027,465)
Purchase of capital assets and donation expense	(11,589,316)	(7,641,617)
Interest paid on long-term debt, net of capitalized portion	(679,162)	(594,084)
Net cash from capital and related financing activities	(14,896,253)	(11,258,193)
CASH FLOWS FROM INVESTING ACTIVITIES		
Proceeds from sale/maturity of investments	26,446,641	36,680,775
Purchase of investments	(35,142,797)	(41,809,195)
Cash from investment income, net of amount capitalized	916,584	865,525
Net cash from investing activities	(7,779,572)	(4,262,895)
NET CHANGE IN CASH AND CASH EQUIVALENTS	(7,313,398)	(2,698,063)
CASH AND CASH EQUIVALENTS, beginning of year	22,764,737	25,462,800
CASH AND CASH EQUIVALENTS, end of year	$ 15,451,339	$ 22,764,737
RECONCILIATION OF CASH AND CASH EQUIVALENTS TO STATEMENT OF NET POSITION		
Cash	$ 6,565,922	$ 8,486,412
Cash and cash equivalents in short-term investments	41,572	39,012
Cash and cash equivalents in assets limited as to use	8,843,851	14,239,313
	$ 15,451,345	$ 22,764,737

Increase (Decrease) in Cash and Cash Equivalents

	Years Ended December 31, 2015	2014
RECONCILIATION OF OPERATING INCOME TO NET CASH FROM OPERATING ACTIVITIES		
Operating income	$ 8,883,162	$ 1,505,651
Tax revenue considered a noncapital financing activity	(4,265,937)	(4,253,605)
Adjustments to reconcile operating income (expense) to net cash from operating activities		
Depreciation and amortization	8,867,475	9,440,221
Provision for bad debts	2,714,548	4,946,100
Loss on disposal of assets	207,274	109,034
Changes in operating assets and liabilities		
Accounts receivable	(3,730,557)	(2,497,364)
Supplies inventory	(15,960)	85,281
Estimated third-party payor settlements	(1,075,856)	1,130,262
Prepaid expenses	103,778	(719,814)
Accounts payable	(1,255,454)	(1,643,162)
Accrued liabilities	648,051	471,523
Net cash from operating activities	$ 11,080,524	$ 8,574,127
SUPPLEMENTAL DISCLOSURE OF NONCASH INVESTING, CAPITAL, AND FINANCING ACTIVITIES		
Change in capital assets included in accounts payable	$ 2,189,110	$ (136,603)
Donation of capital assets	$ 285,000	

Note 1 - Reporting Entity and Summary of Significant Accounting Policies

Reporting entity - Public Hospital District No. 2 of Clallam County, Washington (dba Olympic Medical Center), serving Port Angeles and Sequim, Washington, and surrounding communities, is organized as a municipal corporation pursuant to the laws of the state of Washington.

Olympic Medical Center (the Medical Center) operates Olympic Memorial Hospital (the Hospital), a general acute-care facility that maintains 126 licensed beds including a birth center. The Medical Center has three divisions: the Hospital; Olympic Medical Physicians, which includes 10 physician clinics; and Olympic Medical Home Health, which provides home health care services. The Hospital division also includes Olympic Medical Imaging Centers, Olympic Medical Cancer Center, Olympic Medical Surgical Services, Olympic Medical Cardiac Services, Olympic Medical Physical Therapy and Rehabilitation, and Olympic Medical Laboratory. The majority of the Medical Center's patients live in Clallam County.

Use of estimates - The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.

Fund accounting - The Medical Center uses the proprietary fund method of accounting whereby revenue and expenses are recognized on the accrual basis.

Cash and cash equivalents - Cash and cash equivalents have original maturity dates of three months or less. For purposes of reporting cash flows, cash and cash equivalents include cash on hand, cash on deposit, and deposits in the local government investment pool. Cash and cash equivalents are included in the following lines on the statement of net position: cash, short-term investments, and assets limited as to use.

Supplies inventory - Supplies inventory, consisting of medicine and medical supplies, is valued at the lower of cost (computed on the first-in, first-out basis) or net realizable value.

Investments in debt securities - Investments in debt securities are reported at fair value except for investments in debt securities with maturities of less than one year at the time of purchase. These investments are reported at amortized cost. Interest, dividends, and gains and losses, both realized and unrealized, on investments in debt securities are included in nonoperating income when earned.

Capital assets - Capital asset acquisitions are recorded at cost. Contributed capital assets are reported at their estimated fair value at the time of their donation. Expenditures for maintenance and repairs are charged to operations as incurred. Betterments and major renewals are capitalized. It is the Medical Center's policy to capitalize assets that cost $1,000 or more and have a useful life of two years or greater.

Note 1 - Reporting Entity and Summary of Significant Accounting Policies (continued)

All capital assets other than land are depreciated or amortized using the straight-line method of depreciation using these asset lives:

Land improvements	5 - 25 years
Buildings and improvements	5 - 40 years
Fixed equipment	3 - 25 years
Movable equipment	2 - 20 years

Other long-term liabilities - The Medical Center has purchased claims-made liability insurance coverage that covers only asserted malpractice claims. The Medical Center recognizes expenses associated with reported claims and estimated claims incurred but not reported in the period in which the incidents are estimated to have occurred, rather than when a claim is asserted. Expenses associated with these incidents are based on historical actuarial assumptions of settlement costs and management estimates.

Risk management - The Medical Center is exposed to various risks of loss from torts; theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries and illness; natural disasters; medical malpractice; and employee health, dental, and accident benefits. Commercial insurance coverage is purchased for claims arising from such matters. Settled claims have not exceeded this commercial coverage in any of the three preceding years.

Net position - Net position of the Medical Center is classified into four components. *Invested in capital assets, net of related debt* consists of capital assets net of accumulated depreciation and reduced by the balances of any outstanding borrowings used to finance the purchase or construction of those assets. *Restricted expendable net positions* are noncapital net positions that must be used for a particular purpose, as specified by creditors, grantors, or contributors external to the Medical Center. *Restricted nonexpendable net position* equals the principal portion of permanent endowments. *Unrestricted net position* is the remaining net position that does not meet the definition of *invested in capital assets, net of related debt* or *restricted*. There were no restricted net positions as of December 31, 2015 and 2014.

Operating revenues and expenses - The Medical Center's statement of revenues, expenses, and changes in net position distinguishes between operating and nonoperating revenues and expenses. Operating revenues result from exchange transactions associated with providing health care services—the Medical Center's principal activity. Nonoperating revenues, including taxes, grants, and contributions received for purposes other than capital asset acquisition, are reported as other operating revenues. Operating expenses are all expenses incurred to provide health care services.

Tax revenue for maintenance and operations - Property taxes are levied by the county on the Medical Center's behalf and are intended to finance the Medical Center's activities of the same calendar year. Amounts levied are based on assessed property values.

Note 1 - Reporting Entity and Summary of Significant Accounting Policies (continued)

Charity care - The Medical Center provides care to indigent patients who meet certain criteria under its charity care policies. Because the Medical Center does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue. Forgone revenue for charity care provided during 2015 and 2014 measured by the Medical Center's standard charges was approximately $1,303,000 and $2,430,000, respectively.

Federal income tax - The Medical Center is a municipal corporation and is exempt from federal income tax.

Subsequent events - Subsequent events are events or transactions that occur after the statements of net position date but before financial statements are available to be issued. The Medical Center recognizes in the financial statements the effects of all subsequent events that provide additional evidence about conditions that existed at the date of the statements of net position, including the estimates inherent in the process of preparing the financial statements. The Medical Center's financial statements do not recognize subsequent events that provide evidence about conditions that did not exist at the date of the statements of net position but arose after the statement of net position date and before the financial statements are available to be issued.

The Medical Center has evaluated subsequent events through February 10, 2016, which is the date the financial statements are available to be issued.

Note 2 - Patient Service Revenue

Patient service revenue is recorded at established rates. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered. Preliminary settlements under reimbursement agreements with third-party payors are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

Reimbursement received from certain third-party payors is subject to audit and retroactive adjustment. Provision for possible adjustment as a result of audits is recorded in the financial statements. When reimbursement settlements are received, or when information becomes available with respect to reimbursement changes, any variations from amounts previously accrued are accounted for in the period in which the settlements are received or the change in information becomes available.

Note 2 - Patient Service Revenue (continued)

The Medical Center has arrangements with third-party payors that provide for payments to the Medical Center at amounts different from its established rates. 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 predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups (DRGs). Each DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that DRG. The Medical Center's classification of DRGs and the appropriateness of the related patient admission are subject to an independent review by a peer review organization. Most outpatient services to Medicare beneficiaries are paid prospectively based on ambulatory payment classifications (APCs). Physicians and other providers are paid on a fee schedule. The Hospital's cost reports have been reviewed and/or audited by the Medicare fiscal intermediary through 2012. Net revenue from the Medicare program totaled approximately $80,971,000 and $73,800,000 for 2015 and 2014, respectively. Unsecured net patient accounts receivable due from Medicare at December 31, 2015 and 2014, were approximately $6,672,000 and $6,265,000, respectively.

Medicaid - On July 1, 2005, a new inpatient Medicaid reimbursement methodology for all noncritical access Washington State governmental hospitals was implemented called "Certified Public Expenditures." Under this program, the Medical Center is paid for inpatient Medicaid services based on costs, including certain costs of uncompensated care. The estimated costs for inpatient care are calculated as a ratio of cost to charges from a base year (two years before the service year). Under the program, the Medical Center will be reimbursed the higher of the full cost of service or "baseline" reimbursement that would have been received based on the pre-July 1 inpatient payment system. Outpatient services are paid on a fee schedule or a percentage of allowed charges based on a ratio of the Medical Center's allowable operating expenses to total allowable revenue. Physicians and other providers are paid on a fee schedule. Net revenue from the Medicaid program totaled approximately $19,653,000 and $14,885,000 for 2015 and 2014, respectively. Unsecured net patient accounts receivable due from Medicaid at December 31, 2015 and 2014, were approximately $1,524,000 and $1,654,000, respectively.

The Medical Center has also entered into various payment arrangements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations.

Note 2 - Patient Service Revenue (continued)

The following are the components of net patient service revenue for the years ended December 31:

	2015	2014
Gross patient service charges	$ 308,879,834	$ 281,058,910
Adjustments to patient service charges		
Contractual discounts	149,299,422	134,738,571
Provision for bad debts	2,714,548	4,946,100
Charity care	1,303,015	2,459,532
	153,316,985	142,144,203
Net patient service revenue	$ 155,562,849	$ 138,914,707

Note 3 - Deposits and Investments

The Board of Commissioners has internally designated assets to provide for capital improvements and other requirements. The carrying amounts of these, as well as other deposits and investments, are included in the Medical Center's statements of net position as follows:

	2015	2014
Cash	$ 6,565,922	$ 8,486,412
Short-term investments	41,572	39,012
Assets limited as to use		
Capital reserves	38,988,051	29,912,157
Reserve for accrued liabilities	1,692,547	1,645,290
Bond proceeds restricted for capital improvements	6,028,618	12,058,385
Total deposits and investments	$ 53,316,710	$ 52,141,256

Deposits - Deposits with financial institutions are either insured or collateralized. Deposits must be made with financial institutions qualified by the Washington Public Deposit Protection Commission (PDPC). The deposits of the Medical Center are covered by the Federal Deposit Insurance Corporation (FDIC). Collateral protection in excess of the FDIC limit is provided by the Washington PDPC, a multi-financial institution collateral pool. Pledged securities under the PDPC collateral pool are held by the PDPC's agent in the name of the collateral pool.

Note 3 - Deposits and Investments (continued)

Investments - Eligible investments are only those securities and deposits authorized by statute. Eligible investments include:

- Obligations of the U.S. government
- Obligations of U.S. government agencies or government-sponsored corporations
- Obligations of Washington State and its agencies, or of other states and local governments in one of the three highest credit ratings of a nationally recognized rating organization
- Bankers' acceptances with the highest credit rating
- Commercial paper with the highest credit rating
- Repurchase agreements with collateral exceeding 102% of cost and consisting of authorized investments
- State Treasurer's local government investment pool
- Certificates of deposit with financial institutions qualified by the Washington Public Deposit Protection Commission

Credit risk - Credit risk is the risk that an issuer or other counterparty to an investment will not fulfill its obligations. The Medical Center's investment policy limits the types of securities to those authorized by statute; therefore, credit risk is very limited. Obligations of the U.S. government and agencies are rated AAA by Standard and Poor's or Moody's credit rating organizations. Obligations of other states and local governments are rated A or higher by Standard and Poor's or Moody's and have one of the three highest ratings of nationally recognized rating organizations and are general obligations of those entities. The Medical Center's portfolio currently includes no bankers' acceptances or commercial paper.

Custodial credit risk - Custodial credit risk is the risk that in the event of a failure of the counterparty, the Medical Center will not be able to recover the value of the investment or collateral securities that are in the possession of an outside party. All U.S. government, U.S. government agency, and state and local agency securities are held by the Medical Center's safekeeping custodian acting as an independent third party and carry no custodial credit risk. Cash deposits and certificates of deposit are collateralized by the State Collateral Pool that insures public deposits and carry no custodial credit risk. Deposits with the state investment pool are covered by the state's master custodial agreement and carry no custodial credit risk.

Concentration of credit risk - Concentration of credit risk is the risk of loss attributed to the magnitude of the Medical Center's investment in a single issuer. The Medical Center mitigates credit risk by limiting the percentage of the portfolio invested with any one issuer.

Interest rate risk - Interest rate risk is the risk that changes in interest rates of debt instruments will adversely affect the fair value of an investment. The Medical Center manages interest rate risk by having policy limitations on the maximum maturity of any one security and limits to 35% the percentage of the investment portfolio maturing in more than five years. As of December 31, 2015, the weighted-average maturity of the portfolio was less than five years.

Note 3 - Deposits and Investments (continued)

Internally designated assets and bond proceeds are generally carried at fair market value. Internally designated assets, short-term investments, and bond proceeds are held in the following investments:

	2015	2014
U.S. government agency obligations	$ 11,186,812	$ 8,562,601
State and local government obligations	23,862,156	18,019,740
Local government investment pool	2,856,805	2,219,940
Cash and cash equivalents - LTGO bond proceeds	6,028,618	12,058,385
Certificates of deposit	2,816,397	2,794,178
	$ 46,750,788	$ 43,654,844

Note 4 - Capital Assets

Capital asset additions, retirements, and balances for the years ended December 31, 2015 and 2014, were as follows:

	Balance January 1, 2015	Additions	Sales and Retirements	Account Transfers	Balance December 31, 2015
ASSETS AT COST					
Land	$ 8,984,894	$ 428,848	$ -	$ 307,177	$ 9,720,919
Land improvements	3,750,326	-	-	26,619	3,776,945
Buildings and improvements	87,665,214	-	1,051,024	4,855,551	91,469,741
Fixed equipment	22,180,412	-	5,831	612,271	22,786,852
Movable equipment	79,290,736	-	2,246,974	2,084,530	79,128,292
Construction in progress	3,419,339	13,594,638	-	(7,886,148)	9,127,829
	205,290,921	14,023,486	3,303,829	-	216,010,578
LESS ACCUMULATED DEPRECIATION					
Land improvements	2,092,283	167,551	-	-	2,259,834
Buildings and improvements	40,350,536	2,901,459	817,499	-	42,434,496
Fixed equipment	15,614,453	657,809	5,831	-	16,266,431
Movable equipment	53,354,015	5,140,662	2,244,313	-	56,250,364
	111,411,287	8,867,481	3,067,643	-	117,211,125
	$ 93,879,634	$ 5,156,005	$ 236,186	$ -	$ 98,799,453

Note 4 - Capital Assets (continued)

	Balance January 1, 2014	Additions	Sales and Retirements	Account Transfers	Balance December 31, 2014
ASSETS AT COST					
Land	$ 8,376,894	$ 608,000	$ -	$ -	$ 8,984,894
Land improvements	3,709,814	-	2,685	43,197	3,750,326
Buildings and improvements	85,858,801	553,991	-	1,252,422	87,665,214
Fixed equipment	21,723,248	-	87,299	544,463	22,180,412
Movable equipment	78,201,633	15,740	2,194,061	3,267,424	79,290,736
Construction in progress	2,199,562	6,327,283	-	(5,107,506)	3,419,339
	200,069,952	7,505,014	2,284,045	-	205,290,921
LESS ACCUMULATED DEPRECIATION					
Land improvements	1,921,494	172,691	1,902	-	2,092,283
Buildings and improvements	37,507,705	2,842,831	-	-	40,350,536
Fixed equipment	15,015,334	668,303	69,184	-	15,614,453
Movable equipment	49,697,406	5,755,561	2,098,952	-	53,354,015
	104,141,939	9,439,386	2,170,038	-	111,411,287
	$ 95,928,013	$ (1,934,372)	$ 114,007	$ -	$ 93,879,634

As of December 31, 2015, the Medical Center had a remaining commitment in the amount of $13.4 million related to the Port Angeles Medical Office Building.

The Medical Center recorded $489,941 and $509,716 of net capitalized interest in 2015 and 2014, respectively. The loss on disposal of assets of $207,274 and $109,034 as of December 31, 2015 and 2014, respectively, was included in the depreciation and amortization line on the statements of revenues, expenses, and changes in net position.

Note 5 - Long-Term Debt

During the second quarter of 2009, the Medical Center issued $3 million of debt directly with a bank. The debt has a five-year term with fixed interest at 2.90% and is not callable. Principal and interest payments are due every six months with level payments, and the collateral for the debt is the Medical Center's revenues and tax levy. This debt was paid off in full in December 2014.

During the second quarter of 2011, the Medical Center issued $10 million of debt directly with a bank. The debt has a 10-year term with fixed interest at 2.87% and is callable at the option of the Medical Center after five years or prior with a penalty. Principal and interest payments are due every six months with level payments, and the collateral for the debt is the Medical Center's revenues and tax levy.

Note 5 - Long-Term Debt (continued)

During the fourth quarter of 2012, the Medical Center issued $10 million of debt directly with a bank. The debt has a seven-year term with fixed interest at 1.63% and is callable at the option of the Medical Center with a penalty. Principal and interest payments are due every six months with level payments, and the collateral for the debt is the Medical Center's revenues and tax levy.

During the fourth quarter of 2013, the Medical Center entered into a $20 million debt agreement directly with a bank. The debt has a 25-year term with fixed interest at 3.69% through November 30, 2023, at which point the Bank has the option to tender the bond without premium or penalty. For the period beginning December 1, 2023, the bond shall bear interest at 3.69% plus or minus .00675% for each one basis point variance in the 10-year U.S. Treasury Constant Maturity Note rate or other applicable Index Rate as defined by the Bank. Principal and interest payments are due every six months with level payments, and the collateral for the debt is the Medical Center's revenues and tax levy.

Principal and interest repayments on long-term debt are as follows:

	Principal	Interest
2016	$ 2,943,450	$ 984,529
2017	3,041,598	911,344
2018	3,116,451	836,388
2019	3,185,287	759,395
2020	1,746,129	688,796
2021 - 2023	17,860,648	1,779,475
	$ 31,893,563	$ 5,959,927

The schedule of long-term debt activity for the years ended December 31, 2015 and 2014, is as follows:

	Balance December 31, 2014	Additions	Reductions	Balance December 31, 2015	Principal Amounts Due Within One Year	Interest Amounts Due Within One Year
Long-term debt						
LTGO Bond 2011	$ 7,293,118	$ -	$ (954,955)	$ 6,338,163	$ 982,559	$ 172,556
LTGO Bond 2012	7,259,532	-	(1,430,684)	5,828,848	1,403,701	89,068
LTGO Bond 2013	19,997,600	-	(271,048)	19,726,552	557,190	722,905
Total long-term debt	$ 34,550,250	$ -	$ (2,656,687)	$ 31,893,563	$ 2,943,450	$ 984,529
Other liabilities						
Other long-term liabilities	$ 1,454,740	$ -	$ -	$ 1,454,740	$ -	$ -

Note 5 - Long-Term Debt (continued)

	Balance December 31, 2013	Additions	Reductions	Balance December 31, 2014	Principal Amounts Due Within One Year	Interest Amounts Due Within One Year
Long-term debt						
LTGO Bond 2009	$ 700,843	$ -	$ (700,843)	$ -	$ -	$ -
LTGO Bond 2011	8,221,244	-	(928,126)	7,293,118	954,955	200,255
LTGO Bond 2012	8,637,172	-	(1,377,640)	7,259,532	1,404,954	112,247
LTGO Bond 2013	19,997,600	-	-	19,997,600	271,047	738,000
Capital lease	20,856	-	(20,856)	-	-	-
Total long-term debt	$ 37,577,715	$ -	$ (3,027,465)	$ 34,550,250	$ 2,630,956	$ 1,050,502
Other liabilities						
Other long-term liabilities	$ 1,454,740	$ -	$ -	$ 1,454,740	$ -	$ -

Note 6 - Property Taxes

The County Treasurer acts as an agent to collect property taxes levied in the county. Taxes are levied annually, on January 1, on property values listed as of the prior May 31. Assessed values are established by the county assessor at 100% of fair market value. A reevaluation of all property is required every four years.

Taxes are due in two equal installments on April 30 and October 31. Collections are distributed monthly by the County Treasurer.

The Medical Center is permitted by law to levy up to $0.75 per $1,000 of assessed valuation for general purposes. The Washington State Constitution and Washington State Law, RCW 84-55-010, limit the rate. The Medical Center may also levy taxes at a lower rate. Additional amounts of tax need to be authorized by a vote of the residents of Clallam County.

For 2015, the Medical Center's regular levy was $.60065 per $1,000 on a total assessed valuation of $6,609,112,655, for a total regular levy of $4,265,937. For 2014, the Medical Center's regular levy was $.59455 per $1,000 on a total assessed valuation of $6,566,115,434, for a total regular levy of $4,253,605.

Property taxes are recorded as receivables when levied. Because state law allows for sale of property for failure to pay taxes, no estimate of uncollectible taxes is made.

Note 7 - Employee Benefit Plans

The Medical Center has a defined contribution pension plan covering substantially all qualified employees. All qualified employees may participate in the Medical Center's retirement plan. The employer's annual contribution is set by the plan documents. The Medical Center's liability under the plan is limited to its annual contribution. It is the Medical Center's policy to currently fund pension costs accrued under this plan.

The Medical Center has deferred compensation plans created in accordance with Internal Revenue Code Section 457 and Revenue Code Section 403(b). The plans are available to eligible employees and permit them to defer a portion of their salary until withdrawn in future years. The Medical Center makes contributions based on a percentage of certain employees' compensation. The deferred compensation is not available to employees until termination, retirement, death, or unforeseeable emergency. The Medical Center fully funds all compensation deferred under the plan agreements through deposits.

Contributions to the employee benefit plans from both the Medical Center and employees totaled approximately $7,808,000 in 2015 and $7,400,000 in 2014.

Note 8 - Collective Bargaining Agreements

At December 31, 2015, the Medical Center had a total of approximately 1,221 employees. Of this total, approximately 773 are covered by collective bargaining agreements.

Note 9 - Contingencies

Litigation - The Medical Center is involved in litigation arising in the ordinary course of business. Based on consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect on the Medical Center's future financial position or results from operations.

Compliance with laws and regulations - The Medical Center is subject to many complex federal, state, and local laws and regulations. Compliance with these laws and regulations is subject to government review and interpretation, and unknown or unasserted regulatory actions. Government activity with respect to investigations and allegations regarding possible violations of these laws and regulations by health care providers, including those related to medical necessity, coding, and billing for services, has increased significantly. Violations of these laws can result in large fines and penalties, sanctions on providing future services, and repayment of past patient service revenues. The Medical Center has implemented a voluntary corporate compliance program, which includes guidance for all Medical Center employees' adherence to applicable laws and regulations. Management believes any actions that may result from investigations of noncompliance with laws and regulations will not have a material effect on the Medical Center's future financial position or results of operations.

Note 10 - Concentration of Credit Risk

The Medical Center grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors at December 31, 2015 and 2014, was as follows:

	2015	2014
Medicare	44%	42%
Medicaid	15%	15%
Other third-party payors	28%	27%
Patients	13%	16%
	100%	100%

Note 11 - Disclosures About Fair Value of Financial Instruments

The following methods and assumptions were used to estimate the fair value of each class of financial instrument for which it is practicable to estimate that value:

Cash equivalents and short-term investments - The carrying amount reported on the statements of net position approximates fair value.

Assets limited as to use - The carrying amount approximates the fair values of investments. The fair values are estimated based on quoted market prices, if available, or estimated using quoted market prices of similar investments.

Accounts payable and accrued expenses - The carrying amount reported on the statements of net position for accounts payable and accrued expenses approximates fair value.

Estimated third-party payor settlements - The carrying amount reported on the statements of net position for estimated third-party payor settlements approximates fair value.

Long-term debt - The Medical Center is not able to estimate the fair value of its bonds because there is no trading of the bonds in secondary markets to establish a current fair value, as the bonds were privately placed with a financial institution.

Note 12 - Operating Leases

The Medical Center leases certain facilities and equipment under operating lease arrangements. The following is a schedule by year of future minimum lease payments as of December 31, 2015:

2016	$	195,158
2017		195,550
2018		195,955
2019		196,359
2020		181,325
2021 - 2024		632,268
Total minimum lease payments	$	1,596,615

Rent expense on operating leases for 2015 and 2014 was $281,894 and $350,428, respectively.

Appendix L	Commitment letter from Chief Financial Officer

OLYMPIC
MEDICAL CENTER

Working together to provide excellence in health care.

939 Caroline Street ◆ Port Angeles, WA 98362 ◆ (360) 417-7000 ◆ www.olympicmedical.org

December 17, 2018

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

Dear Ms. Sigman,

The Certificate of Need Program's application for a Medicare-certified hospice agency asks for a financial letter of commitment.

The Board of Olympic Medical Center has committed the necessary working capital to finance the establishment and operation of a Medicare-certified hospice agency in Clallam County, Washington.

Sincerely,

Darryl J. Wolfe
Chief Financial Officer
Olympic Medical Center

REPORT OF INDEPENDENT AUDITORS
AND FINANCIAL STATEMENTS

PUBLIC HOSPITAL DISTRICT NO. 2 OF CLALLAM COUNTY, WASHINGTON dba OLYMPIC MEDICAL CENTER

December 31, 2017 and 2016

MOSSADAMS

Table of Contents

MOSSADAMS

Report of Independent Auditors

To the Board of Commissioners
Public Hospital District No. 2 of Clallam County, Washington
dba Olympic Medical Center

Report on the Financial Statements

We have audited the accompanying financial statements of Public Hospital District No. 2 of Clallam County, Washington, dba Olympic Medical Center (the Medical Center) as of and for the years ended December 31, 2017 and 2016, and the related notes to the financial statements, which collectively comprise the Medical Center's basic financial statements as listed in the table of contents.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the 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 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 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 financial statements referred to above present fairly, in all material respects, the financial position of the Medical Center as of December 31, 2017 and 2016, and the changes in financial position and cash flows thereof for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matter

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the accompanying management's discussion and analysis on pages 3 through 10 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated February 14, 2018, on our consideration of the Medical Center's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Medical Center's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Medical Center's internal control over financial reporting and compliance.

Moss Adams LLP

Everett, Washington
February 14, 2018

This discussion and analysis provides an overview of the financial position and financial activities of Public Hospital District No. 2 of Clallam County, Washington, doing business as Olympic Medical Center (the Medical Center). Please read it in conjunction with the Medical Center's financial statements and accompanying notes, which follow this section.

Financial Highlights

- One of the core components of the Medical Center's 2016–2018 strategic plan is to successfully complete the Port Angeles Medical Office Building. In early 2017, the Medical Center successfully completed this project. This is an investment in facilities and services to appropriately meet the community need.
- The Medical Center's net position decreased by $2.5 million in 2017 and increased by $4.3 million in 2016.
- The Medical Center's total operating revenue was $180.4 million in 2017 compared with $167.3 million in 2016.
- The Medical Center invested approximately $9.4 million in capital assets, including improved medical facilities and new medical equipment in 2017 and approximately $29.1 million in 2016, including improved medical facilities and new medical equipment.

Overview of the Financial Statements

The Medical Center's financial statements consist of three statements: a statement of net position; a statement of revenues, expenses, and changes in net position; and a statement of cash flows. These financial statements and related notes provide information about the activities of the Medical Center, including resources held by the Medical Center that are held for specific purposes. The statement of net position includes all of the Medical Center's assets and liabilities using the accrual basis of accounting, as well as an indication about which assets can be used for general purposes and which are designated for a specific purpose. The statement of revenues, expenses, and changes in net position reports all of the revenues and expenses during the time period indicated. The statement of cash flows reports the cash provided by the Medical Center's operating activities, as well as other cash sources such as investment income and cash payments for additions and improvements.

Volumes and Statistics

Following are key operating statistics:

Medical Center Key Operating Statistics

	2017	2016	2015	2017 - 2016 % Change
Available beds	67	67	67	0%
Admissions	4,379	4,373	4,301	0%
Patient days	14,414	14,549	14,573	-1%
Imaging procedures	90,432	93,768	84,497	-4%
Oncology procedures	29,546	27,548	28,901	7%
Surgery cases	6,973	6,423	6,648	9%
Emergency room visits	29,865	31,949	30,319	-7%
Home health visits	47,938	39,298	30,398	22%
Clinic visits	139,394	111,274	113,971	25%
Full-time equivalent employees	1,227	1,116	1,050	10%

Statement of Net Position

The following is a presentation of certain financial information derived from the Medical Center's statement of net position (amounts in thousands):

	2017	2016	2015	2017 - 2016 Change
Assets				
Total current assets	$ 26,987	$ 25,374	$ 26,851	$ 1,613
Assets limited as to use	36,041	48,413	46,709	(12,372)
Capital assets, net	117,687	118,901	98,799	(1,214)
Other assets	2,254	2,254	2,255	-
Total assets	$ 182,969	$ 194,942	$ 174,614	$ (11,973)
Liabilities				
Current liabilities	$ 18,211	$ 22,761	$ 20,153	$ (4,550)
Long-term debt	37,853	42,378	28,950	(4,525)
Other long-term liabilities	1,065	1,455	1,455	(390)
Total liabilities	57,129	66,594	50,558	(9,465)
Net position				
Invested in capital assets, net of related debt	87,345	89,946	72,934	(2,601)
Unrestricted	38,495	38,402	51,122	93
Total net position	125,840	128,348	124,056	(2,508)
Total liabilities and net position	$ 182,969	$ 194,942	$ 174,614	$ (11,973)

Statement of Net Position (continued)

Current assets in 2017 included cash and investments (18%), total receivables (65%), supplies inventory (8%), and prepaid expenses (9%). Current assets increased by 6% in 2017, primarily in receivables.

Current assets in 2016 included cash and investments (21%), total receivables (62%), supplies inventory (8%), and prepaid expenses (9%). Current assets decreased by 6% in 2016, primarily in cash.

Assets limited as to use in 2017 totaling $36 million included capital reserves of $25.6 million, reserve for accrued liabilities of $1.7 million, and bond proceeds restricted for capital purchases of $9.1 million.

Assets limited as to use in 2016 totaling $48.4 million included capital reserves of $31.0 million, reserve for accrued liabilities of $1.7 million, and bond proceeds restricted for capital purchases of $16.0 million.

Total assets decreased $12 million (6%) in 2017 primarily due to Board Designated Assets which decreased $12.4 million.

Total assets increased $20.3 million (11.6%) in 2016 primarily due to Construction in Progress, which increased $18.7 million. The majority of the increase was related to the Port Angeles Medical Office Building project.

In 2017, total current liabilities decreased by 20% from 2016. Current liabilities in 2017 included accounts payable (34%), accrued vacation and payroll (50%), current portion of long-term debt (9%), and other liabilities (7%). Current liabilities in 2016 included accounts payable (44%), accrued vacation and payroll (36%), current portion of long-term debt (15%), and other liabilities (9%).

Long-term debt, net of current portion, decreased by $4.5 million in 2017. Long-term debt, net of current portion, increased by $13.4 million in 2016.

Total net position decreased by $2.5 million to $125.8 million at the end of 2017. The total consists of $87.3 million invested in capital assets, net of related debt, and $38.5 million of unrestricted net position.

Total net position increased by $4.3 million to $128.3 million at the end of 2016. The total consists of $89.9 million invested in capital assets, net of related debt, and $38.4 million of unrestricted net position.

Statement of Revenues, Expenses, and Changes in Net Position

The following is a summary of 2017 compared with 2016 and 2015 annual amounts (amounts in thousands):

	2017	2016	2015	2017 - 2016 Change
Total operating revenue	$ 180,450	$ 167,267	$ 161,802	$ 13,183
Operating expenses				
Wages and benefits	115,451	100,279	93,463	15,172
Professional fees	8,888	8,016	7,406	872
Supplies	27,162	26,392	24,588	770
Purchased services, maintenance, and other	20,259	18,298	17,212	1,961
Insurance	699	1,098	1,175	(399)
Depreciation and amortization	10,656	9,004	9,075	1,652
Total operating expenses	183,115	163,087	152,919	20,028
Operating income (loss)	(2,665)	4,180	8,883	(6,845)
Net nonoperating revenue	158	111	183	47
Change in net position	$ (2,507)	$ 4,291	$ 9,066	$ (6,798)

Total operating revenue was $13.2 million more in 2017 as a result of increased volumes in outpatient services.

Total operating revenue was $5.5 million more in 2016 as a result of increased volumes in outpatient and emergency services.

Total bad debt provision and charity care provided was $5.0 million in 2017 compared with $4.2 million in 2016 and $4.0 million in 2015. Uncompensated care continued to stabilize over 2017 and 2016.

Statement of Revenues, Expenses, and Changes in Net Position (continued)

The following is a summary of the Medical Center's gross revenue by payor:

	2017	2016	2015
Medicare	58%	59%	59%
Medicaid	17%	16%	17%
Other government	8%	8%	7%
Total governmental payors	83%	83%	83%
Commercial insurance	16%	16%	16%
Private pay	1%	1%	1%
Total	100%	100%	100%

Combined wages and benefits increased by 15.1% in 2017 and 7.3% in 2016. Supplies increased by 2.9% in 2017 and 7.3% in 2016. Purchased services, maintenance, and other increased by 11.3% in 2017 and 6.3% in 2016. Professional fees increased by 10.9% in 2017 and 7.3% in 2016.

Charitable contributions received by the Medical Center in 2017 totaled $422,000, compared with $189,000 in 2016, and $405,500 in 2015. The monetary contributions primarily came from the Olympic Medical Center Foundation, the Olympic Memorial Hospital Auxiliary, and the Sequim Dungeness Hospital Guild.

The Medical Center had an operating loss of $2.5 million in 2017 compared to operating income of $4.2 million in 2016.

The Medical Center's Cash Flows

The following is a summary of cash flows in 2017, 2016, and 2015 (amounts in thousands):

	2017	2016	2015	2017 - 2016 Change
Net cash from operating activities	$ 550	$ 10,663	$ 11,081	$ (10,113)
Cash from tax revenue	4,572	4,418	4,282	154
Net cash from capital and related financing activities	(18,706)	(15,238)	(14,896)	(3,468)
Net cash from investing activities	4,376	9,681	(7,780)	(5,305)
Net change in cash and cash equivalents	$ (9,208)	$ 9,524	$ (7,313)	$ (18,732)

Net cash from operating activities was $550,000 in 2017, compared with $10.7 million in 2016. $12.6 million was spent on the purchase of capital assets in 2017.

Net cash from operating activities was $10.7 million in 2016, compared with $11.1 million in 2015. $27.6 million was spent on the purchase of capital assets in 2016.

Capital Assets

At the end of 2017, the Medical Center had $117.7 million invested in capital assets, net of accumulated depreciation, as detailed in Note 4 to the financial statements. In 2017, the Medical Center purchased new capital assets costing approximately $9.4 million. In 2016, the Medical Center purchased new capital assets costing approximately $29.1 million.

Major capital acquisitions in 2017 included expansion of outpatient services regarding the Port Angeles Medical Office Building ($2.3 million) and design of the Cancer Center Expansion ($0.9 million). The remainder was spent on other building improvements, equipment, and information systems.

The following is a summary of significant 2016 capital additions: the purchase and installation of CT equipment ($1.6 million) and the expansion of outpatient services regarding the Port Angeles Medical Office Building ($18.3 million). The remainder was spent on other building improvements, equipment, and information systems.

On February 15, 2017, the Medical Center's Board of Commissioners approved an architectural contract with Coates Design Architects for the design of the Cancer Center Expansion. The architectural contract for $0.8 million was signed on February 15, 2017. On September 20, 2017, the Medical Center's Board of Commissioners approved an architectural contract with Insight Architecture for the Central Sterile Processing Expansion Project. The architectural contract for $0.5 million was signed September 29, 2017. As of December 31, 2017, the Medical Center's remaining commitment is $0.2 million for Coates Design and $0.4 million for Insight Architecture. In 2016, the Medical Center had remaining commitments of $1.6 million for the Port Angeles Office Building and $0.2 million for the Hospital Roof Replacement. All commitments regarding the Port Angeles Office Building and Hospital Roof Replacement were met in 2017.

See Note 4 for additional information.

Debt

The Medical Center currently has long-term limited tax general obligation (LTGO) debt outstanding in the amount of $39.4 million. This amount consists of the following: 1) $1.1 million remaining of a $10 million bank loan payable over the term of 10 years to pay for the emergency department expansion and related capital equipment. These funds were repurposed in 2012 to pay off $7.5 million in long-term debt issued in 2005 and 2006. The loan was made directly by a bank, has fixed interest of 2.87%, and is callable at the option of the Medical Center after five years. The loan was completed in the second quarter of 2011; 2) $0.3 million remaining of a $10 million bank loan payable over the term of 7 years to purchase an electronic health record system and complete other capital projects. The loan was made directly by a bank and has fixed interest of 1.63%. The loan was completed in the fourth quarter of 2012; 3) $18.6 million remaining of a $20 million bank loan payable over the term of 25 years to expand, make improvements to, and equip the Medical Center's facilities. The loan was made directly by a bank and has fixed interest for 10 years of 3.69%, and is callable at the option of the Medical Center after 10 years. The loan was completed in the fourth quarter of 2013; 4) $19.4 remaining of a $20 million bank loan payable over the term of 25 years in order to refinance part of 2011 and 2012 debt balances, expand, make improvements to, and equip the District's health care facilities. The loan was made directly by a bank and has fixed interest for 10 years of 3.04%, and is callable at the option of the Medical Center after 10 years. The loan was completed in the fourth quarter of 2016.

See Note 5 for additional information.

Budget Comparison

The following is a comparison of 2017 actual revenues, expenses, and changes in net position results to 2017 budgeted amounts (amounts in thousands):

	Actual	Budget	Variance
Operating revenues			
Net patient service revenue	$ 173,471	$177,244	$ (3,773)
Property rental, cafeteria, taxes, and other	6,979	6,494	485
Total operating revenue	180,450	183,738	(3,288)
Operating expenses			
Wages and benefits	115,451	116,479	(1,028)
Professional fees	8,888	7,975	913
Supplies	27,162	28,772	(1,610)
Purchased services, maintenance, and other	20,259	18,360	1,899
Insurance	699	1,118	(419)
Depreciation and amortization	10,656	9,500	1,156
Total operating expenses	183,115	182,204	911
Operating income (loss)	(2,665)	1,534	(4,199)
Net nonoperating revenue	158	500	(342)
Change in net position	$ (2,507)	$ 2,034	$ (4,541)

The Medical Center's operating revenue for 2017 was 1.8% lower than budgeted. Total operating expenses for 2017 were higher than budgeted by 0.5%.

The resulting margins for 2017 were negative 1.5% for operating margin and negative 1.4% for total margin, compared with budgeted margins of 0.8% and 1.1%, respectively.

Issues Facing the Medical Center

The Medical Center's payor mix of approximately 83% governmental payors is very challenging due to generally low governmental reimbursement levels and the fact that governmental reimbursement reductions have such a significant financial impact on the Medical Center. In addition, cost of healthcare continues to increase in pharmaceutical supplies, medical supplies, medical service, and staffing. Due to nationwide shortages of medical providers and other medical professionals, the cost of recruiting and retaining qualified medical professionals are increasing as well.

Because the Medical Center is faced with the reimbursement cuts and cost challenges mentioned above, keeping up with the capital needs of the Medical Center will become more challenging as well.

Summary of Financial Position and Financial Activity in 2017

Overall, the Medical Center's financial performance in 2017 was challenged as a result of 1) escalating construction and medical equipment costs, 2) increases in workforce costs, and 3) continued downward pressure on reimbursement.

The Medical Center is focused on continuing to improve clinical quality and patient safety; providing excellent service and access to all patients, regardless of their insurance or ability to pay; and meeting community needs in core areas of service. Achievement of these goals requires significant investments in capital assets and personnel. The Medical Center's financial position will need to remain strong to continue to achieve these goals.

Contacting the Medical Center's Financial Management

This financial report is designed to provide patients, suppliers, taxpayers, and creditors with a general overview of the Medical Center's finances and to show the Medical Center's accountability for the money it receives. If you have questions about this report or need additional financial information, contact the Medical Center Finance Office at Olympic Medical Center, 939 Caroline, Port Angeles, Washington 98362.

Public Hospital District No. 2 of Clallam County, Washington
dba Olympic Medical Center
Statements of Net Position

ASSETS

	December 31, 2017	December 31, 2016
CURRENT ASSETS		
Cash	$ 4,517,648	$ 5,044,514
Short-term investments	353,699	351,277
Accounts receivable, net of estimated uncollectibles of $3,400,000 and $3,300,000 in 2017 and 2016, respectively	17,556,344	15,702,254
Supplies inventory	2,059,052	2,105,382
Prepaid expenses	2,500,383	2,170,336
Total current assets	26,987,126	25,373,763
ASSETS LIMITED AS TO USE	36,040,602	48,413,137
CAPITAL ASSETS		
Land	9,830,130	9,720,919
Construction in progress	2,373,982	27,864,885
Depreciable capital assets, net of accumulated depreciation	105,482,648	81,314,786
	117,686,760	118,900,590
OTHER ASSETS	2,254,298	2,254,298
Total assets	$ 182,968,786	$ 194,941,788

LIABILITIES AND NET POSITION

CURRENT LIABILITIES		
Accounts payable	$ 6,158,991	$ 9,969,316
Accrued salaries, wages, and payroll taxes	5,251,091	4,536,586
Accrued vacation	3,894,083	3,602,617
Other current liabilities	450,935	147,664
Estimated third-party payor settlements	881,409	1,933,228
Current portion of long-term debt	1,574,438	2,571,708
Total current liabilities	18,210,947	22,761,119
LONG-TERM DEBT, net of current portion	37,853,109	42,378,404
OTHER LONG-TERM LIABILITIES	1,064,513	1,454,740
Total liabilities	57,128,569	66,594,263
NET POSITION		
Invested in capital assets, net of related debt	87,344,930	89,945,478
Unrestricted	38,495,287	38,402,047
Total net position	125,840,217	128,347,525
Total liabilities and net position	$ 182,968,786	$ 194,941,788

See accompanying notes.

Public Hospital District No. 2 of Clallam County, Washington
dba Olympic Medical Center
Statements of Revenues, Expenses, and Changes in Net Position

	Years Ended December 31,	
	2017	2016
OPERATING REVENUES		
Net patient service revenue (net of provision for bad debts of $2,300,000 in 2017 and $2,600,000 in 2016)	$ 173,471,456	$ 160,105,768
Tax revenue for maintenance and operations	4,570,480	4,422,564
Property rental, cafeteria, and other revenue	2,407,956	2,738,301
Total operating revenue	180,449,892	167,266,633
OPERATING EXPENSES		
Salaries and wages	89,102,752	78,197,451
Employee benefits	26,348,654	22,081,136
Professional fees	8,887,739	8,015,799
Supplies	27,162,202	26,392,995
Purchased services, maintenance, and other	20,259,390	18,297,661
Insurance	698,948	1,097,866
Depreciation and amortization	10,655,598	9,003,744
Total operating expenses	183,115,283	163,086,652
OPERATING INCOME (LOSS)	(2,665,391)	4,179,981
NONOPERATING REVENUES (EXPENSES)		
Investment income	687,378	649,357
Interest expense	(940,156)	(640,125)
Other	410,861	101,989
Net nonoperating revenue	158,083	111,221
CHANGE IN NET POSITION	(2,507,308)	4,291,202
NET POSITION, beginning of year	128,347,525	124,056,323
NET POSITION, end of year	$ 125,840,217	$ 128,347,525

See accompanying notes.

Increase (Decrease) in Cash and Cash Equivalents

	Years Ended December 31, 2017	Years Ended December 31, 2016
CASH FLOWS FROM OPERATING ACTIVITIES		
Receipts from and on behalf of patients	$ 170,564,145	$ 160,628,360
Payments to suppliers and contractors	(57,976,488)	(52,989,719)
Payments to employees	(114,445,435)	(99,713,510)
Other receipts and payments, net	2,407,956	2,738,301
Net cash from operating activities	550,178	10,663,432
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES		
Tax revenue considered a noncapital financing activity	4,571,882	4,417,894
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES		
Proceeds from sale of capital assets	16,044	11,987
Proceeds from debt issuance	-	20,000,000
Principal payments on long-term debt	(5,522,565)	(6,943,451)
Purchase of capital assets	(12,563,011)	(27,598,742)
Interest paid on long-term debt, net of capitalized portion	(636,885)	(708,259)
Net cash from capital and related financing activities	(18,706,417)	(15,238,465)
CASH FLOWS FROM INVESTING ACTIVITIES		
Proceeds from sale/maturity of investments	44,724,689	43,926,657
Purchase of investments	(40,869,430)	(35,117,734)
Cash from investment income, net of amount capitalized	520,873	871,779
Net cash from investing activities	4,376,132	9,680,702
NET CHANGE IN CASH AND CASH EQUIVALENTS	(9,208,225)	9,523,563
CASH AND CASH EQUIVALENTS, beginning of year	24,974,908	15,451,345
CASH AND CASH EQUIVALENTS, end of year	$ 15,766,683	$ 24,974,908
RECONCILIATION OF CASH AND CASH EQUIVALENTS TO STATEMENT OF NET POSITION		
Cash	$ 4,517,648	$ 5,044,514
Cash and cash equivalents in short-term investments	353,699	351,277
Cash and cash equivalents in assets limited as to use	10,895,336	19,579,117
	$ 15,766,683	$ 24,974,908

See accompanying notes.

Increase (Decrease) in Cash and Cash Equivalents

	Years Ended December 31, 2017	2016
RECONCILIATION OF OPERATING INCOME TO NET CASH FROM OPERATING ACTIVITIES		
Operating income (loss)	$ (2,665,391)	$ 4,179,981
Tax revenue considered a noncapital financing activity	(4,570,480)	(4,422,564)
Adjustments to reconcile operating income (expense) to net cash from operating activities		
Depreciation and amortization	10,056,265	8,742,905
Provision for bad debts	2,313,127	2,583,038
Loss on disposal of assets	599,333	260,839
Changes in operating assets and liabilities		
Accounts receivable	(4,168,619)	(2,368,051)
Supplies inventory	46,330	(275,827)
Estimated third-party payor settlements	(1,051,819)	307,605
Prepaid expenses	(330,047)	330,997
Accounts payable	(294,265)	759,432
Accrued liabilities	1,005,971	565,077
Other long-term liabilities	(390,227)	-
Net cash from operating activities	$ 550,178	$ 10,663,432
SUPPLEMENTAL DISCLOSURE OF NONCASH INVESTING, CAPITAL, AND FINANCING ACTIVITIES		
Change in capital assets included in accounts payable	$ (3,516,060)	$ 1,416,137

See accompanying notes.

Note 1 – Reporting Entity and Summary of Significant Accounting Policies

Reporting entity – Public Hospital District No. 2 of Clallam County, Washington (dba Olympic Medical Center), serving Port Angeles and Sequim, Washington, and surrounding communities, is organized as a municipal corporation pursuant to the laws of the state of Washington.

Olympic Medical Center (the Medical Center) operates Olympic Memorial Hospital (the Hospital), a general acute-care facility that maintains 126 licensed beds including a birth center. The Medical Center has three divisions: the Hospital; Olympic Medical Physicians, which includes 15 physician clinics; and Olympic Medical Home Health, which provides home health care services. The Hospital division also includes Olympic Medical Imaging Centers, Olympic Medical Cancer Center, Olympic Medical Surgical Services, Olympic Medical Cardiac Services, Olympic Medical Physical Therapy and Rehabilitation, and Olympic Medical Laboratory. The majority of the Medical Center's patients live in Clallam County.

Use of estimates – The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.

Fund accounting – The Medical Center uses the proprietary fund method of accounting whereby revenue and expenses are recognized on the accrual basis.

Cash and cash equivalents – Cash and cash equivalents have original maturity dates of three months or less. For purposes of reporting cash flows, cash and cash equivalents include cash on hand, cash on deposit, and deposits in the local government investment pool. Cash and cash equivalents are included in the following lines on the statement of net position: cash, short-term investments, and assets limited as to use.

Supplies inventory – Supplies inventory, consisting of medicine and medical supplies, is valued at the lower of cost (computed on the first-in, first-out basis) or net realizable value.

Investments in debt securities – Investments in debt securities are reported at fair value except for investments in debt securities with maturities of less than one year at the time of purchase. These investments are reported at amortized cost. Interest, dividends, and gains and losses, both realized and unrealized, on investments in debt securities are included in nonoperating income when earned.

Capital assets – Capital asset acquisitions are recorded at cost. Contributed capital assets are reported at their estimated fair value at the time of their donation. Expenditures for maintenance and repairs are charged to operations as incurred. Betterments and major renewals are capitalized. It is the Medical Center's policy to capitalize assets that cost $2,000 or more and have a useful life of two years or greater.

Note 1 – Reporting Entity and Summary of Significant Accounting Policies (continued)

All capital assets other than land are depreciated or amortized using the straight-line method of depreciation using these asset lives:

Land improvements	5 – 25 years
Buildings and improvements	5 – 40 years
Fixed equipment	3 – 25 years
Movable equipment	2 – 20 years

Other long-term liabilities – The Medical Center has purchased claims-made liability insurance coverage that covers only asserted malpractice claims. The Medical Center recognizes expenses associated with reported claims and estimated claims incurred but not reported in the period in which the incidents are estimated to have occurred, rather than when a claim is asserted. Expenses associated with these incidents are based on historical actuarial assumptions of settlement costs and management estimates.

Risk management – The Medical Center is exposed to various risks of loss from torts; theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries and illness; natural disasters; medical malpractice; and, employee health, dental, and accident benefits. Commercial insurance coverage is purchased for claims arising from such matters. Settled claims have not exceeded this commercial coverage in any of the three preceding years.

Net position – Net position of the Medical Center is classified into four components. *Invested in capital assets, net of related debt* consists of capital assets net of accumulated depreciation and reduced by the balances of any outstanding borrowings used to finance the purchase or construction of those assets offset by any unspent proceeds of these borrowings. *Restricted expendable net positions* are noncapital net positions that must be used for a particular purpose, as specified by creditors, grantors, or contributors external to the Medical Center. *Restricted nonexpendable net position* equals the principal portion of permanent endowments. *Unrestricted net position* is the remaining net position that does not meet the definition of *invested in capital assets, net of related debt* or *restricted*. There were no restricted net positions as of December 31, 2017 and 2016.

Operating revenues and expenses – The Medical Center's statement of revenues, expenses, and changes in net position distinguishes between operating and nonoperating revenues and expenses. Operating revenues result from exchange transactions associated with providing health care services—the Medical Center's principal activity. Nonoperating revenues, including taxes, grants, and contributions received for purposes other than capital asset acquisition, are reported as other operating revenues. Operating expenses are all expenses incurred to provide health care services.

Tax revenue for maintenance and operations – Property taxes are levied by the county on the Medical Center's behalf and are intended to finance the Medical Center's activities of the same calendar year. Amounts levied are based on assessed property values.

Note 1 – Reporting Entity and Summary of Significant Accounting Policies (continued)

Charity care – The Medical Center provides care to indigent patients who meet certain criteria under its charity care policies. Because the Medical Center does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue. Forgone revenue for charity care provided during 2017 and 2016, measured by the Medical Center's standard charges, was approximately $2,655,000 and $1,606,000, respectively.

Federal income tax – The Medical Center is a municipal corporation and is exempt from federal income tax.

Subsequent events – Subsequent events are events or transactions that occur after the statement of net position date but before financial statements are available to be issued. The Medical Center recognizes in the financial statements the effects of all subsequent events that provide additional evidence about conditions that existed at the date of the statement of net position, including the estimates inherent in the process of preparing the financial statements. The Medical Center's financial statements do not recognize subsequent events that provide evidence about conditions that did not exist at the date of the statement of net position but arose after the statement of net position date and before the financial statements are available to be issued.

The Medical Center has evaluated subsequent events through February 14, 2018, which is the date the financial statements are available to be issued.

Note 2 – Patient Service Revenue

Patient service revenue is recorded at established rates. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered. Preliminary settlements under reimbursement agreements with third-party payors are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

Reimbursement received from certain third-party payors is subject to audit and retroactive adjustment. Provision for possible adjustment as a result of audits is recorded in the financial statements. When reimbursement settlements are received, or when information becomes available with respect to reimbursement changes, any variations from amounts previously accrued are accounted for in the period in which the settlements are received or the change in information becomes available.

Note 2 – Patient Service Revenue (continued)

The Medical Center has arrangements with third-party payors that provide for payments to the Medical Center at amounts different from its established rates. 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 predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups (DRGs). Each DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that DRG. The Medical Center's classification of DRGs and the appropriateness of the related patient admission are subject to an independent review by a peer review organization. Most outpatient services to Medicare beneficiaries are paid prospectively based on ambulatory payment classifications (APCs). Physicians and other providers are paid on a fee schedule. The Hospital's cost reports have been reviewed and/or audited by the Medicare fiscal intermediary through 2014. Net revenue from the Medicare program totaled approximately $89,087,000 and $82,971,000 for 2017 and 2016, respectively. Unsecured net patient accounts receivable due from Medicare at December 31, 2017 and 2016, were approximately $6,779,000 and $5,905,000, respectively.

Medicaid – On July 1, 2005, a new inpatient Medicaid reimbursement methodology for all noncritical access Washington State governmental hospitals was implemented called "Certified Public Expenditures." Under this program, the Medical Center is paid for inpatient Medicaid services based on costs, including certain costs of uncompensated care. The estimated costs for inpatient care are calculated as a ratio of cost to charges from a base year (two years before the service year). Under the program, the Medical Center will be reimbursed the higher of the full cost of service or "baseline" reimbursement that would have been received based on the pre-July 1 inpatient payment system. Outpatient services are paid on a fee schedule or a percentage of allowed charges based on a ratio of the Medical Center's allowable operating expenses to total allowable revenue. Physicians and other providers are paid on a fee schedule. Net revenue from the Medicaid program totaled approximately $21,332,000 and $18,832,000 for 2017 and 2016, respectively. Unsecured net patient accounts receivable due from Medicaid at December 31, 2017 and 2016, were approximately $1,128,000 and $1,078,000, respectively.

The Medical Center has also entered into various payment arrangements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations.

The following are the components of net patient service revenue for the years ended December 31:

	2017	2016
Gross patient service charges	$ 364,179,824	$ 328,380,845
Adjustments to patient service charges		
Contractual discounts	185,740,119	164,086,537
Provision for bad debts	2,313,127	2,583,038
Charity care	2,655,122	1,605,502
	190,708,368	168,275,077
Net patient service revenue	$ 173,471,456	$ 160,105,768

Note 3 – Deposits and Investments

The Board of Commissioners has internally designated assets to provide for capital improvements and other requirements. The carrying amounts of these, as well as other deposits and investments, are included in the Medical Center's statements of net position as follows:

	2017	2016
Cash	$ 4,517,648	$ 5,044,514
Short-term investments	353,699	351,277
Assets limited as to use		
Capital reserves	25,240,957	30,695,869
Reserve for accrued liabilities	1,713,928	1,722,268
Bond proceeds restricted for capital improvements	9,085,717	15,995,000
Total deposits and investments	$ 40,911,949	$ 53,808,928

Deposits – Deposits with financial institutions are either insured or collateralized. Deposits must be made with financial institutions qualified by the Washington Public Deposit Protection Commission (PDPC). The deposits of the Medical Center are covered by the Federal Deposit Insurance Corporation (FDIC). Collateral protection in excess of the FDIC limit is provided by the Washington PDPC, a multi-financial institution collateral pool. Pledged securities under the PDPC collateral pool are held by the PDPC's agent in the name of the collateral pool.

Investments – Eligible investments are only those securities and deposits authorized by statute. Eligible investments include:

- Obligations of the U.S. government
- Obligations of U.S. government agencies or government-sponsored corporations
- Obligations of Washington State and its agencies, or of other states and local governments in one of the three highest credit ratings of a nationally recognized rating organization
- Bankers' acceptances with the highest credit rating
- Commercial paper with the highest credit rating
- Repurchase agreements with collateral exceeding 102% of cost and consisting of authorized investments
- State Treasurer's local government investment pool
- Certificates of deposit with financial institutions qualified by the Washington Public Deposit Protection Commission

Note 3 – Deposits and Investments (continued)

Credit risk – Credit risk is the risk that an issuer or other counterparty to an investment will not fulfill its obligations. The Medical Center's investment policy limits the types of securities to those authorized by statute; therefore, credit risk is very limited. Obligations of the U.S. government and agencies are rated AAA by Standard and Poor's or Moody's credit rating organizations. Obligations of other states and local governments are rated A or higher by Standard and Poor's or Moody's and have one of the three highest ratings of nationally recognized rating organizations and are general obligations of those entities. The Medical Center's portfolio currently includes no bankers' acceptances or commercial paper.

The composition of investments, reported at fair value by investment type at December 31, 2017, and excluding unrestricted cash, short-term investments, and other assets limited as to use balances of $18,636,513 is as follows:

Investment Type	Quoted Prices in Active Markets for Identical Assets (Level 1)	Percentage of Totals
U.S. government agency obligations	$ 4,622,564	21%
State and local government obligations	17,652,872	79%
Total	$ 22,275,436	100%

The composition of investments, reported at fair value by investment type at December 31, 2016, and excluding unrestricted cash, short-term investments, and other assets limited as to use balances of $27,813,717, is as follows:

Investment Type	Quoted Prices in Active Markets for Identical Assets (Level 1)	Percentage of Totals
U.S. government agency obligations	$ 5,544,964	21%
State and local government obligations	20,450,247	79%
Total	$ 25,995,211	100%

Note 3 – Deposits and Investments (continued)

Custodial credit risk – Custodial credit risk is the risk that in the event of a failure of the counterparty, the Medical Center will not be able to recover the value of the investment or collateral securities that are in the possession of an outside party. All U.S. government, U.S. government agency, and state and local agency securities are held by the Medical Center's safekeeping custodian acting as an independent third party and carry no custodial credit risk. Cash deposits and certificates of deposit are collateralized by the State Collateral Pool that insures public deposits and carry no custodial credit risk. Deposits with the state investment pool are covered by the state's master custodial agreement and carry no custodial credit risk.

Concentration of credit risk – Concentration of credit risk is the risk of loss attributed to the magnitude of the Medical Center's investment in a single issuer. The Medical Center mitigates credit risk by limiting the percentage of the portfolio invested with any one issuer.

Interest rate risk – Interest rate risk is the risk that changes in interest rates of debt instruments will adversely affect the fair value of an investment. The Medical Center manages interest rate risk by having policy limitations on the maximum maturity of any one security and limits to 35% the percentage of the investment portfolio maturing in more than five years. As of December 31, 2017, the weighted-average maturity of the portfolio was less than five years.

Internally designated assets and bond proceeds are generally carried at fair market value. Internally designated assets, short-term investments, and bond proceeds are held in the following investments:

	2017	2016
U.S. government agency obligations	$ 4,622,564	$ 5,544,964
State and local government obligations	17,652,872	20,450,247
Local government investment pool	2,163,318	3,935,394
Cash and cash equivalents - LTGO bond proceeds	9,085,717	15,995,000
Certificates of deposit	2,869,830	2,838,809
	$ 36,394,301	$ 48,764,414

Note 4 – Capital Assets

Capital asset additions, retirements, and balances for the years ended December 31, 2017 and 2016, were as follows:

	Balance January 1, 2017	Additions	Sales and Retirements	Account Transfers	Balance December 31, 2017
ASSETS AT COST					
Land	$ 9,720,919	$ 109,211	$ -	$ -	$ 9,830,130
Land improvements	4,132,161	1,101	-	4,951,120	9,084,382
Buildings and improvements	93,372,210	116,860	977,075	15,003,613	107,515,608
Fixed equipment	24,008,029	-	-	9,348,888	33,356,917
Movable equipment	74,543,494	-	6,225,694	5,417,922	73,735,722
Construction in progress	27,864,885	9,230,640	-	(34,721,543)	2,373,982
	233,641,698	9,457,812	7,202,769	-	235,896,741
LESS ACCUMULATED DEPRECIATION					
Land improvements	2,426,966	388,979	-	-	2,815,945
Buildings and improvements	45,484,098	3,312,134	434,526	-	48,361,706
Fixed equipment	16,976,511	1,095,883	-	-	18,072,394
Movable equipment	49,853,533	5,259,269	6,152,866	-	48,959,936
	114,741,108	10,056,265	6,587,392	-	118,209,981
	$ 118,900,590	$ (598,453)	$ 615,377	$ -	$ 117,686,760

Note 4 – Capital Assets (continued)

	Balance January 1, 2016	Additions	Sales and Retirements	Account Transfers	Balance December 31, 2016
ASSETS AT COST					
Land	$ 9,720,919	$ -	$ -	$ -	$ 9,720,919
Land improvements	3,776,945	-	-	355,216	4,132,161
Buildings and improvements	91,469,741	-	238,680	2,141,149	93,372,210
Fixed equipment	22,786,852	-	-	1,221,177	24,008,029
Movable equipment	79,128,292	-	11,247,068	6,662,270	74,543,494
Construction in progress	9,127,829	29,116,868	-	(10,379,812)	27,864,885
	216,010,578	29,116,868	11,485,748	-	233,641,698
LESS ACCUMULATED DEPRECIATION					
Land improvements	2,259,834	167,132	-	-	2,426,966
Buildings and improvements	42,434,496	3,074,265	24,663	-	45,484,098
Fixed equipment	16,266,431	710,080	-	-	16,976,511
Movable equipment	56,250,364	4,791,428	11,188,259	-	49,853,533
	117,211,125	8,742,905	11,212,922	-	114,741,108
	$ 98,799,453	$ 20,373,963	$ 272,826	$ -	$ 118,900,590

The Medical Center recorded $421,000 and $394,000 of net capitalized interest in 2017 and 2016, respectively. The loss on disposal of assets of $599,333 and $260,839 as of December 31, 2017 and 2016, respectively, was included in the depreciation and amortization line on the statements of revenues, expenses, and changes in net position.

Note 5 – Long-Term Debt

During the second quarter of 2011, the Medical Center issued $10 million of debt directly with a bank. The debt has a 10-year term with fixed interest at 2.87% and is callable at the option of the Medical Center after five years or prior with a penalty. Principal and interest payments are due every six months with level payments, and the collateral for the debt is the Medical Center's revenues and tax levy.

During the fourth quarter of 2012, the Medical Center issued $10 million of debt directly with a bank. The debt has a seven-year term with fixed interest at 1.63% and is callable at the option of the Medical Center with a penalty. Principal and interest payments are due every six months with level payments, and the collateral for the debt is the Medical Center's revenues and tax levy.

Note 5 – Long-Term Debt (continued)

During the fourth quarter of 2013, the Medical Center entered into a $20 million debt agreement directly with a bank. The debt has a 25-year term with fixed interest at 3.69% through November 30, 2023, at which point the bank has the option to tender the bond without premium or penalty. For the period beginning December 1, 2023, the bond shall bear interest at 3.69% plus or minus .00675% for each one basis point variance in the 10-year U.S. Treasury Constant Maturity Note rate or other applicable Index Rate as defined by the bank. Principal and interest payments are due every six months with level payments, and the collateral for the debt is the Medical Center's revenues and tax levy.

During the fourth quarter of 2016, the Medical Center entered into a $20 million debt agreement directly with a bank. The debt has a 25-year term with fixed interest at 3.04% through December 1, 2026, at which point the bank has the option to tender the bond without premium or penalty. For the period beginning December 2, 2026, the bond shall bear interest at 3.04% plus or minus .00675% for each one basis point variance in the 10-year U.S. Treasury Constant Maturity Note rate or other applicable Index Rate as defined by the bank. Principal and interest payments are due every six months with level payments, and the collateral for the debt is the Medical Center's revenues and tax levy.

Principal and interest repayments on long-term debt are as follows:

	Principal	Interest
2018	$ 1,574,438	$ 1,301,716
2019	1,624,251	1,251,909
2020	1,526,552	1,201,134
2021	1,556,954	1,150,445
2022	1,325,695	1,100,892
2023 - 2026	31,819,657	10,445,211
	$ 39,427,547	$ 16,451,307

The schedule of long-term debt activity for the years ended December 31, 2017 and 2016, is as follows:

	Balance December 31, 2016	Additions	Reductions	Balance December 31, 2017	Principal Amounts Due Within One Year	Interest Amounts Due Within One Year
Long-term debt						
LTGO Bond 2011	$ 3,355,604	$ -	$ (2,244,473)	$ 1,111,131	$ 270,728	$ 30,371
LTGO Bond 2012	2,422,205	-	(2,131,302)	290,903	144,255	4,212
LTGO Bond 2013	19,172,303	-	(578,487)	18,593,816	599,463	680,633
LTGO Bond 2016	20,000,000	-	(568,303)	19,431,697	559,992	586,500
Total long-term debt	$ 44,950,112	$ -	$ (5,522,565)	$ 39,427,547	$ 1,574,438	$ 1,301,716
Other liabilities						
Other long-term liabilities	$ 1,454,740	$ -	$ (390,227)	$ 1,064,513	$ -	$ -

Note 5 – Long-Term Debt (continued)

	Balance December 31, 2015	Additions	Reductions	Balance December 31, 2016	Principal Amounts Due Within One Year	Interest Amounts Due Within One Year
Long-term debt						
LTGO Bond 2011	$ 6,338,163	$ -	$ (2,982,559)	$ 3,355,604	$ 633,066	$ 97,714
LTGO Bond 2012	5,828,848	-	(3,406,643)	2,422,205	792,399	39,397
LTGO Bond 2013	19,726,552	-	(554,249)	19,172,303	577,940	702,155
LTGO Bond 2016	-	20,000,000	-	20,000,000	568,303	578,189
Total long-term debt	$ 31,893,563	$ 20,000,000	$ (6,943,451)	$ 44,950,112	$ 2,571,708	$ 1,417,455
Other liabilities						
Other long-term liabilities	$ 1,454,740	$ -	$ -	$ 1,454,740	$ -	$ -

Note 6 – Property Taxes

The County Treasurer acts as an agent to collect property taxes levied in the county. Taxes are levied annually, on January 1, on property values listed as of the prior May 31. Assessed values are established by the county assessor at 100% of fair market value. A reevaluation of all property is required every four years.

Taxes are due in two equal installments on April 30 and October 31. Collections are distributed monthly by the County Treasurer.

The Medical Center is permitted by law to levy up to $0.75 per $1,000 of assessed valuation for general purposes. The Washington State Constitution and Washington State Law, RCW 84-55-010, limit the rate. The Medical Center may also levy taxes at a lower rate. Additional amounts of tax need to be authorized by a vote of the residents of Clallam County.

For 2017, the Medical Center's regular levy was $.56822 per $1,000 of assessed valuation. The Medical Center received $4,570,000 from the County for the regular levy and revenues related to the harvest of timber within the community. For 2016, the Medical Center's regular levy was $0.58708 per $1,000 of assessed valuation. The Medical Center received $4,423,000 from the County for the regular levy and revenues related to the harvest of timber within the community.

Property taxes are recorded as receivables when levied. Because state law allows for sale of property for failure to pay taxes, no estimate of uncollectible taxes is made.

Note 7 – Employee Benefit Plans

The Medical Center has a defined contribution pension plan covering substantially all qualified employees. All qualified employees may participate in the Medical Center's retirement plan. The employer's annual contribution is set by the plan documents. The Medical Center's liability under the plan is limited to its annual contribution. It is the Medical Center's policy to currently fund pension costs accrued under this plan.

The Medical Center has deferred compensation plans created in accordance with Internal Revenue Code Section 457 and Revenue Code Section 403(b). The plans are available to eligible employees and permit them to defer a portion of their salary until withdrawn in future years. The Medical Center makes contributions based on a percentage of certain employees' compensation. The deferred compensation is not available to employees until termination, retirement, death, or unforeseeable emergency. The Medical Center fully funds all compensation deferred under the plan agreements through deposits.

Contributions to the employee benefit plans from both the Medical Center and employees totaled approximately $9,386,000 in 2017 and $8,251,000 in 2016.

Note 8 – Collective Bargaining Agreements

At December 31, 2017, the Medical Center had a total of approximately 1,421 employees. Of this total, approximately 906 are covered by collective bargaining agreements.

Note 9 – Contingencies

Litigation – The Medical Center is involved in litigation arising in the ordinary course of business. Based on consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect on the Medical Center's future financial position or results from operations.

Compliance with laws and regulations – The Medical Center is subject to many complex federal, state, and local laws and regulations. Compliance with these laws and regulations is subject to government review and interpretation, and unknown or unasserted regulatory actions. Government activity with respect to investigations and allegations regarding possible violations of these laws and regulations by health care providers, including those related to medical necessity, coding, and billing for services, has increased significantly. Violations of these laws can result in large fines and penalties, sanctions on providing future services, and repayment of past patient service revenues. The Medical Center has implemented a voluntary corporate compliance program, which includes guidance for all Medical Center employees' adherence to applicable laws and regulations. Management believes any actions that may result from investigations of noncompliance with laws and regulations will not have a material effect on the Medical Center's future financial position or results of operations.

Note 10 – Concentration of Credit Risk

The Medical Center grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors at December 31, 2017 and 2016, was as follows:

	2017	2016
Medicare	46%	44%
Medicaid	11%	12%
Other third-party payors	30%	30%
Patients	13%	14%
	100%	100%

Note 11 – Disclosures About Fair Value of Financial Instruments

The following methods and assumptions were used to estimate the fair value of each class of financial instrument for which it is practicable to estimate that value:

Cash equivalents and short-term investments – The carrying amount reported on the statements of net position approximates fair value.

Assets limited as to use – The carrying amount approximates the fair values of investments. The fair values are estimated based on quoted market prices, if available, or estimated using quoted market prices of similar investments.

Accounts payable and accrued expenses – The carrying amount reported on the statements of net position for accounts payable and accrued expenses approximates fair value.

Estimated third-party payor settlements – The carrying amount reported on the statements of net position for estimated third-party payor settlements approximates fair value.

Long-term debt – The Medical Center is not able to estimate the fair value of its bonds because there is no trading of the bonds in secondary markets to establish a current fair value, as the bonds were privately placed with a financial institution.

Note 12 – Operating Leases

The Medical Center leases certain facilities and equipment under operating lease arrangements. The following is a schedule by year of future minimum lease payments as of December 31, 2017:

2018	$	287,038
2019		268,233
2020		251,294
2021		241,130
2022		241,130
2023 - 2027		566,851
Total minimum lease payments	$	1,855,677

Rent expense on operating leases for 2017 and 2016 was $331,000 and $273,000, respectively.

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Report of Independent Auditors on Internal Control over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*

To the Board of Commissioners
Public Hospital District No. 2 of Clallam County, Washington
dba Olympic Medical Center

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of Public Hospital District No. 2 of Clallam County, Washington, dba Olympic Medical Center (the Medical Center) as of and for the year ended December 31, 2017, and the related notes to the financial statements, which collectively comprise the Medical Center's basic financial statements, and have issued our report thereon dated February 14, 2018.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered the Medical Center's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Medical Center's internal control. Accordingly, we do not express an opinion on the effectiveness of the Medical Center's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the Medical Center's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Everett, Washington
February 14, 2018


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