Washington State Department of Health

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

APPLICATION FOR CERTIFICATE OF NEED HOME HEALTH CARE PROJECTS

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: Terry Robertson, Chief Executive Officer **Date:** 10/05/2020	**Person To Whom Questions Regarding This Application Should Be Directed:** Leslie Palmer, Executive Director Josephine Caring Community, Josephine At Home 9901 272nd Pl NW Stanwood, WA 98292 **Telephone Number:** 360-386-3284
Legal Name of Applicant: Josephine Caring Community **Address of Applicant:** 9901 272nd Pl NW Stanwood, WA 98292 **Telephone Number: 360-629-2126**	**Type of Project (check all that apply):** [X] New Agency [ ] Existing Medicare Certified/Medicaid Eligible Agency Expanding into Different County [ ] Existing Licensed-Only Home Health Agency to Become Medicare Certified/Medicaid Eligible.
Project Summary: Establish a new Medicare-certified Home Health Agency in Snohomish County and Camano Island **Estimated capital expenditure: $5200**	

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 Josephine Caring Community.

B. For each licensed applicant, please provide the professional license number and specialty represented. If the license was not issued by Washington State, please identify the state it was issued.

Table1. Josephine Caring Community Professional Licenses

Name	Specialty	License/Provider ID & Number
Josephine Caring Community	Skilled Nursing	143
Josephine Caring Community	Assisted Living	569
Josephine Caring Community DBA Josie's Learning Center	Childcare Center	Provider ID: 4251 SSPS Provider Number: 113880

Please see Exhibit 1 for copies of above licenses.

C. 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.

While Josephine At Home is not an existing provider of home health services, we are located on the same campus as Josephine Caring Community:

Josephine At Home
9901 272nd Pl NW
Stanwood, WA 98292

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

Josephine At Home is a non-profit organization and subsidiary of Josephine Caring Community which is a non-profit organization operating under 501(c)(3) tax code.

Josephine Caring Community's Unique Business Identifier (UBI) registered with the Washington Secretary of State's Office is: 600-089-377

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

The owning entity will be the same as the applicant.

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

The operating entity will be the same as the applicant.

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

Please see Exhibit 2 for the Josephine Caring Community's organizational charts.

Exhibit 2 also provides an organizational chart to identify the relationship between Josephine Caring Community and Josephine At Home.

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

For over 112 years Josephine Caring Community has been a respected and award-winning regional partner in caring for all generations and nurturing *fullness of life*. The Josephine Caring Community campus, located at 9901-272nd PL NW Stanwood, WA 98292, offers direct access to a continuum of care:

- The Suites Senior Living – Assisted Living
- Saratoga Transitional Rehab – Short-term post hospital recovery or transitional therapy.
- The Meadows- 24/7 skilled nursing and memory care
- Josie's Learning Center - Our unique intergenerational activities center for children from 12 weeks to 12 years of age in classrooms throughout the facility

I. <u>For existing facilities</u>, identify the geographic primary service area.

Not applicable, Josephine At Home is not an existing provider of health services.

J. Identify the facility licensure/accreditation status.

Josephine At Home (JAH) is licensed as an In Home Services Agency to provide Home Health. The Josephine At Home credential number is HIS.FS.60923101.

While JAH is licensed to provide Home Health, the Agency has not been providing Home Health services while we seek Certificate of Need (Snohomish County and Camano Island) approval.

The current license is effective through 02/07/2022.

K. Is the applicant reimbursed for services under Medicare and Medicaid? List which ones.

Josephine At Home is a new Agency and not receiving reimbursement for services under Medicare and Medicaid. However, Josephine Caring Community does receive reimbursement for their inpatient skilled services under Titles XVIII and XIX of the Social Security Act

The Suites Senior Living also receives Medicaid Funding for clients who qualify for home and community services through Washington State Medicaid program.

L. If applicable, identify the medical director and provide his/her professional license number, and specialty represented.

Dr. James B. Grierson, MD is Josephine At Home's medical director.
Dr. Grierson's professional credential number is: MD00043397

Please see Exhibit 3 for a copy of the medical director's medical license.

M. If applicable, 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.

The Josephine At Home medical director is to be contracted with Josephine At Home.

Please see Exhibit 3 for a copy of the Medical Director Agreement.

N. <u>For existing facilities</u>, please provide the following information broken down by discipline (i.e., RN/LPN, OT, PT, home health aide, social worker, etc.) <u>for each county</u> currently serving:

1. **Total number of home health *visits* per year for the last three years; and**
2. **Total number of unduplicated home health *patients* served per year for the last three years.**

Not applicable, Josephine At Home is not an existing provider of home health services.

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.

The office address of the proposed facility is:

Josephine At Home
9901 272nd PL NW
Stanwood, WA 98292

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

Josephine At Home, a subsidiary of Josephine Caring Community, seeks to operate a Medicare and Medicaid certified home health agency to serve residents of Snohomish County and Camano Island.

C. List new services or changes in services represented by this project. In the following table, please indicate (by marking an 'X' in the appropriate column) which services would be provided directly by the agency and which services would be contracted.

Table 2. New Services Provided by the Project

	Direct	Contracted
Skilled Nursing	X	
Physical Therapy		X
Occupational Therapy		X
Speech Therapy		X
Medical Social Work	X	
Home Health Aide	X	
Medical Director		X
Respite Care	X	
IV Therapy		X
Other (list):		

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

The Josephine At Home project will serve all patients who meet Home Health eligibility and require such services in all of Snohomish County and Camano Island. By definition of Centers for Medicare & Medicaid Services (CMS), Home Health patients must meet the criteria for being homebound and able to receive intermittent skilled care. With an aging population in Snohomish County, and on Camano Island, the expectation supported by Medicare claims and other publicly reported data is that home health care utilization will continue to increase.

E. List the equipment proposed for the project:

1. **Description of equipment proposed; and**

Table 3. Capital Expenditures

Equipment	Estimated Price
Office Furniture	**$3,600**
Office Equipment	
Computer Equipment	**$1600**

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

   There will be no additional equipment, disposal or replacement costs for the project.

F. Provide drawings of proposed project:

1. **Single line drawings, *approximately to scale,* of <u>current</u> locations which identify current department and services; and**

   See Exhibit 4 for single line drawings and Josephine Caring Community facility map.

2. **Single line drawings, *approximately to scale,* of <u>proposed</u> locations which identify proposed services and departments; and**

   Josephine At Home's proposed location will be within the Josephine Caring Community's existing facility. Conference rooms, restrooms and reception are to be shared resources.

   Please see Exhibit 4.

3. **Total net and gross square feet of project.**

   Total net square feet: 678
   Total gross square feet: 886

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

Josephine At Home anticipates a date of February 1, 2021. The anticipated completion date of the project is April 1, 2021.

Josephine At Home has partnered with the Accreditation Commission for Health Care (ACHC) in seeking Home Health Accreditation.

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

Obtaining a Certificate of Need for a Home Health Agency is an important piece of our long-range business and financial plans. Through the Certificate of Need application, Josephine Caring Community will take another step improving continuity of care by providing physician directed home health care to those living in Snohomish County and Camano Island. The demand for home health from our existing skilled nursing facility and local partners remains high.

Long term, the Josephine At Home service line plans to expand to provide Home Care and Hospice. These plans will ensure continuity for patients and their families. As the health care landscape changes to value driven models, and data supports better outcomes when patients are able to obtain care in their home, Josephine is making evidence-based decisions to ensure we can meet and exceed the community's healthcare needs. COVID-19 has added additional evidence for both Josephine, and the nation, that significant changes must occur in how and where we deliver health care services.

Home Health Agencies are uniquely positioned to step-in and fill an even larger community need than originally foreseen. Josephine Caring Community will remain consistent in maintaining our current financial health by becoming Medicare and Medicaid certified so that we can continue to responsibly expand care across Snohomish County and Camano Island. In the past 112 years, Josephine has proven that by dedicating our organization to the wellbeing of our staff, seniors, rural residents and those that are vulnerable in our community, we are investing in a healthy future for all residents. Since 1908, Josephine Caring Community has provided care with *One Heart and Many Hands* and continues to celebrate *Fullness of Life* with our community centered service lines.

I. Provide documentation that the applicant has sufficient interest in the site or facility proposed. "*Sufficient interest*" shall mean any of the following:

1. **Clear legal title to the proposed site; or**
2. **A lease for at least one year with options to renew for not less than a total of three years; or**
3. **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. These agreements may be in draft form if all parties identified in the draft agreements provide a signed "Letter of Intent to finalize" the agreement.**

   The Snohomish County parcel numbers 32032400400700 and 32032400400701 and the related parcel information are located in Exhibit 5. Josephine Sunset Home is named as the legal owner of the Josephine Caring Community Facility and adjacent parcel.

   There was a facility and organizational name change in 2017 that is reflected in attached Exhibit 5.

III. PROJECT RATIONALE

A. Need (WAC 246-310-210)

1. Identify the proposed geographic service area.

Josephine At Home is proposing to provide Medicare and Medicaid certified Home Health services to both Snohomish County and Camano Island.

2. If the proposed service area is designated as a Medically Underserved Area (MUA) as defined by HCFA or a Health Professional Shortage Area (HPSA), please provide documentation verifying the designation

Snohomish County and Camano Island have areas designated as Medically Underserved. Snohomish County and Camano Island also have areas designated as Health Professional Shortage Areas.

Please see Exhibit 6 for additional supporting maps of the MUA and HPSA.

Discipline	MUA/P ID	Service Area Name	Designation Type	Primary State Name	County	Index of Medical Underservice Score	Status	Rural Status	Designation Date	Update Date
Primary Care	03687	Central Everett Service Area	Medically Underserved Area	Washington	Snohomish County, WA	61.9	Designated	Non-Rural	08/27/1992	02/01/1994
Primary Care	03688	West Edmonds Service Area	Medically Underserved Area	Washington	Snohomish County, WA	58.9	Designated	Non-Rural	08/27/1992	02/01/1994

https://data.hrsa.gov/tools/shortage-area/mua-find

Discipline	MUA/P ID	Service Area Name	Designation Type	Primary State Name	County	Index of Medical Underservice Score	Status	Rural Status	Designation Date	Update Date
Primary Care	03673	Camono Island Service Area	Medically Underserved Area	Washington	Island County, WA	51.2	Designated	Rural	11/19/1996	11/19/1996
Primary Care	03672	South Whidbey Service Area	Medically Underserved Area	Washington	Island County, WA	60.9	Designated	Rural	09/02/1994	09/02/1994

https://data.hrsa.gov/tools/shortage-area/mua-find

3. Identify and analyze the unmet home health service needs and/or other problems toward which this project is directed.

A. Identify the unmet home health needs of the patient population in the proposed service area. *Note that the unmet patient need should not include physical plant deficiencies and/or increase facility operating efficiencies.*

Utilizing the 1987 Washington State Health Plan need methodology offered by the Department for calculating home health need, we included summarization tables of each methodology step below.

Please see Exhibit 7 for the 1987 Washington State Health Plan need methodology utilized to calculate need.

Step 1: Identify the project's population in Snohomish County broken down by age cohorts (0-64; 65-79; 80+)

Table 4. Population by Age Cohort

Age Group	2021	2022	2023
0-64	714,416	718,158	721,919
65-79	95,379	97,312	99,267
80+	35,170	35,883	36,603

Step 2: Apply the estimates for home health use rates for each age cohort to derive projected patient visits in Snohomish County

Table 5. Projected Patients by Age Cohort

Age Group	Use Rate	2021	2022	2023
0-64	0.005	3572	3591	3610
65-79	0.044	4197	4282	4368
80+	0.183	6436	6567	6698

Step 3: Apply the estimates for projected patients for each age cohort to derive projected patient visits for Snohomish County

Table 6. Projected Visits by Age Cohort

Age Group	Number of Visits	2021	2022	2023
0-64	10	35,720	35,910	36,100
65-79	14	58,758	59,948	61,152
80+	21	135,156	137,907	140,658
Total		229,634	233,765	237,910

Step 4: Estimate home health agency need

Table 7. Estimated Agencies Needed

	2021	2022	2023
Total Estimated Patient Visits	229,634	233,765	237,910
Quotient of 10,000	10,000	10,000	10,000
Net Agencies Needed	22.96	23.37	23.79
Number of Agencies Needed	22	23	23

Net Need Assumptions:
In examining the existing home health agencies data provided by the Department against Medicare billing data in Snohomish County and Agency Sources of Patients for 2019, the following table summarizes an adjusted list of current Home Health Agencies. Of the collated list of agencies, adjustment rationale is listed under the exclusion column.

Table 8. Current Home Health Agencies Adjusted for Certificate of Need Approval and Service Areas Exclusions

Agency	Certificate of Need Approval	Exclusion
Alpha Nursing and Services	Yes	
Assured Home Health	Yes	
Brookdale Home Health	Yes	
Careage Home Health	No	Serves King County only
Eden Home Health	Yes	
Evergreen Home Care	Yes	
Gentiva Health Services	Yes	
Group Health Home Health & Hospice (aka Kaiser Permanente Continuing Care Services	Yes	HMO patient only, contracts with Assured
Harvard Partners	No	Staffing Agency
Jefferson Healthcare Home Health	Yes	Serves only Jefferson County only
Kindred At Home	Yes	
Kline Galland Home Health	Yes	Serves King County only
Memorial Home Care Services	Unknown	Serves Yakima County only
Providence Hospice and Home Care of Snohomish County	Yes	
Sea Mar Community Health Services	No	Does not provide Home Health
Signature Home Health	Yes	
Whidbey Health Home Health	Yes	Serves Whidbey Island only

Source: Please see Exhibit 8

Step 5: Subtract the existing number of home health agencies in a planning area

Table 9. Net Home Health Agency Need for Snohomish County Final Calculation

Home Health Agency Net Need (Snohomish County)	
Existing Home Health Agencies	17
Existing Medicare/Medicaid Certified Home Health Agencies	10
Projected Need for Home Health Agencies 2022	23
Net Need for Home Health Agencies in 2022	**13**

B. Identify the negative impact and consequences of unmet home health needs and deficiencies.

With a net need of thirteen home health agencies, Snohomish County and Camano Island are at risk of continued limitations in resident access to care, higher payor and patient costs, and poor health outcomes for those that develop complications or cannot find care in their area. Home Health services allow for patients to remain in their homes while receiving skilled care. Keeping patients at home, or discharging them from the hospital to their homes, reduces health care costs. It also reduces hospitalizations and fragmented care that can lead to poor health outcomes. The proposed project will improve continuity of care through increased access to care and serve the needs of a population that continues to increase.

4. 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.

Josephine At Home will serve home health eligible homebound Snohomish County and Camano Island residents. The applicant's Medicaid certification and large census of Medicaid patients in the skilled nursing facility and assisted living residences reflect the commitment to serving low-income members of the community. Recent and current Charity Care accounting records also reflect the intentionality of serving those who are unable to afford care.

Consistent with the Josephine Caring Community's Mission and Values, it is the policy of Josephine At Home to not discriminate against, exclude or treat differently any individuals accessing any Josephine At Home Program or Activity on any basis prohibited by local, state or federal laws, including but not limited to on the basis of race, color, national origin, age, disability, handicap, gender, gender identity, sexual orientation, or as those terms are defined under federal law and rules. Where applicable, federal statutory protections for religious freedom and conscience are applied. It is also Josephine At Home's policy to provide aids and language assistance services to individuals with a disability, handicap, or limited English proficiency who are accessing a Josephine At Home Program or Activity. Such services may include providing qualified bilingual/multilingual staff, qualified interpreters, and qualified translators.

According to the Snohomish County Community Health Assessment 2018, Snohomish County is less racially and ethnically diverse than the state. A smaller portion of the population is Hispanic (9.6% compared to 11.5% statewide) or Black (2.8% compared to 3.6% statewide). However, the Asian population makes up a larger percentage of the county than the state (9.9% compared to 7.7%).

Snohomish County is becoming more diverse over time. In 2000, 83.4% of the population was white. That number is now 71.4%. The figure below shows this data (with Hispanic people of all races combined).

Figure 1. 2018 Snohomish County Population by Race

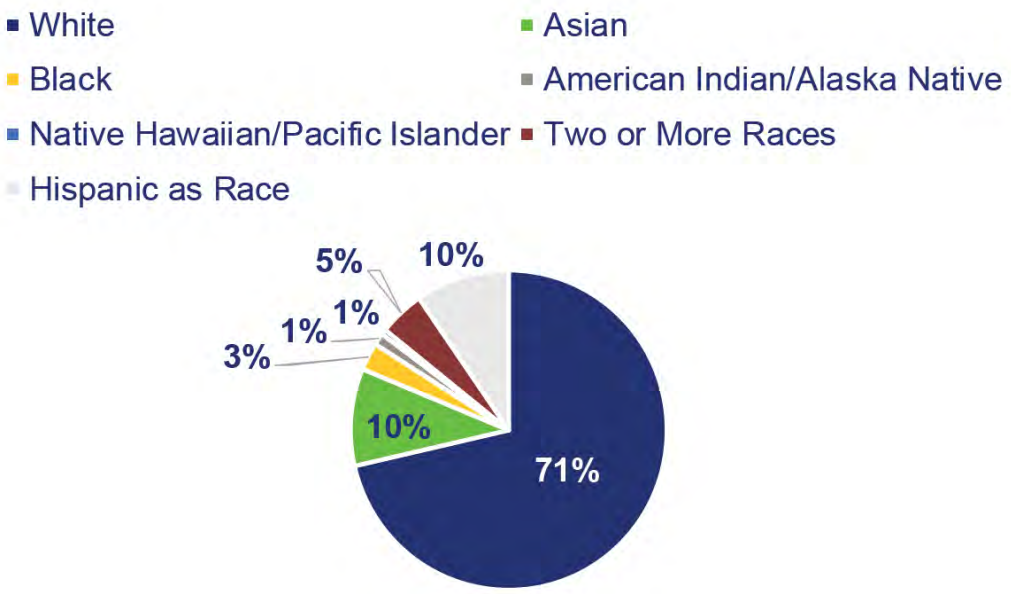


Table 10. Languages Spoken at Home by Adults and Children in Snohomish County

	Snohomish County	Washington	United States
Speak only English at home	80.0%	80.9%	78.7%
Speak Asian/Pacific Islander languages at home	7.2%	5.7%	3.5%
Speak Spanish at home	6.4%	8.4%	13.2%
Speak Indo-European languages at home	4.8%	3.9%	3.6%
Speak other languages at home	1.6%	1.1%	1.0%

Source: Snohomish County Community Health Assessment 2018

Due to the current pandemic, Josephine At Home is anticipating that a number of persons will prefer to receive some of their home health services via telehealth. Josephine At Home's electronic medical record (EMR) software and use of encrypted HIPAA compliant hardware, software and mobile devices will allow Josephine At Home to provide telehealth services. The convergence of COVID-19 and seasonal flu is anticipated to impact physician referrals to home health as the homebound eligibility definition has been revised. The revision expands the homebound eligibility to include those patients that have, "a confirmed or suspected COVID-19 diagnosis or if the patient has a condition that makes them more susceptible to contract COVID-19." *Source: Centers for Medicare & Medicaid Services (CMS)*

Please see Exhibit 9 for *Home Health Agencies: CMS Flexibilities to Flight COVID-19 released 9/8/20*

Below are Josephine Caring Communities current referral resources that Josephine At Home intends to maintain, and expand, upon.

Table 11. Expected Referral Sources

Referral Sources
Cascade Valley Hospital
Evergreen Hospital
Harborview
Island Hospital
Kindred Hospital
Multicare Tacoma
Northwest Hospital
Overlake Hospital
Providence Hospital Everett
Skagit Valley Hospital
St. Joseph Medical Center
Swedish Medical Center
United General Hospital
University of Washington Hospital
Physician Practices
Clinics
Assisted Living Facilities
Community
Family and Caregivers

5. <u>For existing facilities</u>, 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.

Not applicable, Josephine At Home is not an existing provider of health services.

6. **<u>For existing facilities</u>, please identify the number of patients currently receiving skilled services, broken down by type(s) of services (i.e., skilled nursing), by county served.**

Not applicable, Josephine At Home is not an existing provider of health services.

7. **Please provide utilization forecasts for the following, broken down by discipline (i.e., RN/LPN, OT, PT, social worker, etc.) <u>for each county</u> proposing to serve:**

   A. Total number of home health *visits* per year for the first three years; and
   B. Total number of unduplicated home health *patients* served per year for the first three years.

Table 12. Projected Visit by Discipline and Year, 2021-2023

	2021	**2022**	**2023**
	Visits	**Visits**	**Visits**
RN	3504	4057	4272
PT	4164	4866	5193
HHA	311	343	344
OT	1716	2003	2141
ST	340	401	431
MSW	470	582	649
Total Visits	10,505	12,252	13,030
Unduplicated Patients	481	579	625

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

The following is a summary of financial assumptions utilized in the development of the budget Proforma and utilization forecast. All assumptions were developed using the Market Analysis (see Exhibit 8) data provided as a component of this application, home health industry standards and Generally Accepted Accounting Principles:

Balance Sheet

1. Accounts Receivable:
   a. Shown at Net
   b. DSO average 55-60 days
2. Property and Equipment
   a. Fixed assets for Office purchased during start-up phase in the first 60 days of fiscal 2021
   b. Computers, copiers and other tech equipment with exception to conference room setup will be through operating lease
3. Start-up Costs

a. Certain Costs identified and capitalized as an Intangible asset, amortized over 180 month period

4. Deposit – Office Space, one month rent
5. Accounts Payables
    a. Non-Payroll related costs 30 days from receipt of invoice with exception to those services provided by related party, Space Occupancy, insurance and IT related expenses
6. Related Party Line of Credit
    a. Provided by related party as needed

Income Statement

1. Revenues
    a. All revenues are shown at net reimbursement with exception to Charity which is presented at the average net Fee for Service Rate.
    b. Medicare
        i. Episodic reimbursement based on 30-day episodes as implemented by CMS effective January 1, 2020 under the Patient Driven Groupings Model (PDGM)
        ii. Reimbursement rate based average rate for other freestanding home health care agencies servicing the same service are of this agency.
        iii. Increase of 7.5% and 3.5% built into fiscal years 2022 and 2023.
    c. All Other Payers
        i. Fee for Service Reimbursement by service
        ii. Based on Washington State Health Care Authority rates effective July 1, 2020
        iii. $5 increase built into all professional services for fiscal years 2022 and 2023.
2. Expenses
    a. Salaries – Based on levels needed for expected volumes at the market compensation rates in the areas serviced by the agency.
        i. Increases to full time staff, both administrative and caregivers given in fiscal 2022 of 2%.
        ii. Caregivers are divided into two groupings, Salaries and Per Diem:
            1. Salaries are full time employed personnel
            2. Per Diem (also referred to Fee For Service staff) are 1099 independent contractors reimbursed at a per visit/hour rate.
    b. Fringe Benefits estimated at 30% for salaries covering statutory taxes, benefits and health insurance.
    c. Medical Supplies and Mileage expenses are determined at a per visit rate of $2.17 for Medical Supplies and $4.24 for Mileage.
    d. NonSalary Expenses are based on a percent of revenues
    e. Depreciation and Amortization calculated based on various office equipment and expenses using an average 10-year useful life for office equipment and 15 year useful life for start-up costs.

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

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

It was found after our analysis that there are 17 existing Home Health Agencies. Of those 17, only 10 were found to have Certificate of Need approval, have data supporting the ability to bill for services through Medicaid and Medicare and are able to serve Snohomish County. Reflected in Table 8, after the analysis of existing home health agency data provided by the Department against Medicare billing data in Snohomish County and Agency Sources of Patients for 2019, the following table summarizes an adjusted list of current Home Health Agencies.

Table 9. Home Health Agency net Need

Home Health Agency Net Need (Snohomish County)	
Existing Home Health Agencies	17
Existing Medicare/Medicaid Certified Home Health Agencies	10
Projected Need for Home Health Agencies 2022	23
Net Need for Home Health Agencies in 2022	**13**

Home care agencies that provide custodial care, and are not CN approved, do not meet home health agency requirements to provide skilled home health services per the Centers for Medicare & Medicaid Services (CMS) and Accreditation Commission for ealthcare ACHC .

Being a certified home health provider is a requirement for home health agencies to bill Medicare and Medicaid. Home health agency certification and accreditation are also a requirements for the insurances with which Josephine At Home plans to establish contracts.

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

Home health services are required to be provided in accordance with Medicare Home Health Conditions of Participation, which include ensuring initial assessments are performed either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date. Medicare certified home health agencies can monitor their individual timeliness through OASIS data, unfortunately this information is not currently publicly reported. However, in Home Health it is important to note that these results may be impacted by COVID-19 in 2020 and beyond due to new changes to the in-home services landscape.

Table 13. Timeliness of Care 2018

	2018 Speed of Admissions from Hospital Discharge to Home Health Agency (Medicare FFS)		
	0-1 Days	**0-2 Days**	**0-3 Days**
National Average	56%	78%	87%
Washington State Average	27%	53%	70%

Source: 2019 Providence Home Health & Services-Oregon d/b/a CN Application (Berg Data Solutions)

While there is evidence that some existing home health agencies in Snohomish County may provide timely care, the net need of 13 home health agencies analyzed that the available data may not be an accurate reflection in regards to patient access. The rationale being that with a net need as great as 13 agencies it would be assumed that timeliness of care, along with access, is an active challenge within Snohomish County. Serving patients in rural Snohomish County is a barrier to care, a point that Josephine At Home has familiarity with in relation to our skilled nursing facility and timely referrals. Some patients decline care, or are forced to move, in order to receive necessary healthcare as they age. Recruiting skilled staff in rural areas so that they may serve those same rural community members is a key objective for Josephine At Home.

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

The net need of 13 home health agencies was calculated using the Washington State Health Plan need methodology. The results support that there is no unnecessary duplication of services in Snohomish County.

. 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. The department uses the applicant's current or proposed status as a Medicare and Medicaid certified provider of service as part of its evaluation of question.

Josephine Caring Community has been serving Snohomish County and Camano Island for 112 years. Our commitment to serving those most vulnerable is supported in our commitment to Medicaid patients, our significant charity care and our formal non-discrimination policies that document our mission in serving the entirety of Snohomish County regardless of race, religion, disability, gender or income.

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

- **. Admissions policy; and**
- **. Charity care policy; and**
- **. Patient referral policy, if not addressed in admissions policy.**

Please see Exhibit 10 for the above policies

12. 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, there are no related special needs or circumstances.

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, there are no related special needs or circumstances.

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

Not applicable, there are no related special needs or circumstances.

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. If applicable, provide the proposed capital expenditures for the project. These expenditures should be broken out in detail and account for at least the following:

Table 1. Capital Expenditures

Equipment	Estimated Price
Office Furniture	**$3,600**
Office Equipment	
Computer Equipment	**$1600**

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

The capital expenditure for this project is limited to small equipment purchases and office equipement. These costs were based upon Josephine Caring Community's past experience in expanding services for the skilled nursing facility and assisted living as well as consultant's guidance.

3. Document the project impact on: (a) Capital costs (b) Operating costs and charges for health services.

The project's capital costs are small and do not have significant impact. The project's operating costs are expected industry standard amounts in which the Josephine Caring Community CEO has committed to supporting.

Please see Exhibit 11 for the Pro Forma Budget and Exhibit 12 for the Letter of Financial Support.

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

Table 14. Estimated Operating Revenue and Expenses

	FY 2021	FY 2022	FY 2023
Total Net Revenue	$1,587,000	$2,174,000	$2,479,000
Total Direct Expenses	$1,054,000	$1,256,000	$1,416,000
Gross Margin	$533,000	$918,000	$1,063,000
Percentage	*33.6%*	*42.2%*	*42.9%*
Total Indirect Expenses	$633,000	$844,000	$874,000
Net Profit (Loss)	(100,00)	74,000	189,000
Net Profit (Loss) %	-6.3%	3.4%	7.6%

5. Please note: according to revised HCFA regulations, home health agencies must have enough reserve funds (determined by an authorized fiscal intermediary) to operate <u>for three months after</u> becoming Medicare/Medicaid certified. Please provide the following information in relation to this requirement:

A. Provide the name and address of the fiscal intermediary you will be using to determine capitalization;

The Regional Home Health Intermediary address is noted below:

National Government Services, Inc.
Provider Enrollment
P.O. Box 6474
Indianapolis, IN 46207-7149

B. Provide a copy of the forms you are providing to the fiscal intermediary.

Josephine At Home's fiscal intermediary requires the Form 855 filing to be finalized within 60 days after initial filing. Completion and review of this application will take more than 60 days. Therefore; Josephine At Home would agree to submission of the form as a condition of receipt of a Certificate of Need.

6. 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.

Not applicable, as there is no financing for this project.

Please see Exhibit 12 for the Letter of Commitment from the Josephine Caring Community CEO.

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

   Please see Exhibit 12 for the Letter of Commitment from the Josephine Caring Community CEO.

8. **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.**

   Due to the unnecessary interest expense of financing, Josephine Home Health has elected to fund the agency with available cash.

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

   Please see Exhibit 11 for the Proforma budget that includes the balance sheets and expense and revenue statements for the first three years.

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

    There are no additional capital expenditures expected in the first three years.

11. **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.**

Table 15. Expected Payer Mix, Snohomish County %

Percent Payer Mix (Based on Budget Proforma Gross Revenue Projection)	FY 2021	FY 2022	FY 2023
Medicare	75.2%	79.2%	84.4%
Medicare Advantage	18.3%	15.5%	11.2%
Medicaid	0.1%	0.1%	0.5%
Commercial Insurance	5.4%	4.2%	3.3%
Charity	0.6%	0.7%	0.4%
Self-Pay	0.3%	0.2%	0.2%

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

    Please see Exhibit 11 for expense and revenue statements for Josephine Caring Community for the last three years.

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

Please see Exhibit 11 for cash flow statements for Josephine Caring Community for the last three years.

14. 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.

Please see Exhibit 11 for balance sheets detailing assets, liabilities, and net worth for Josephine Caring Community for the last three years.

15. 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.

Not applicable, Josephine At Home is not an existing provider of health services.

16. Provide anticipated costs and charges per visit broken down by discipline (i.e., RN/LPN, OT, PT, social worker, etc.) and by payer source.

Table 16.

	2021		2022		2023	
	Direct Cost	**Charge**	**Direct Cost**	**Charge**	**Direct Cost**	**Charge**
RN	$92.72	$200	$92.94	$200	$101.37	$200
PT	$105.84	$200	$107.91	$200	$105.76	$200
OT	$80	$150	$80	$150	$80	$150
ST	$75	$150	$75	$150	$75	$150
MSW	$75	$150	$75	$150	$75	$150
HHA	$25	$75	$25	$75	$25	$75

Charges = Nearest multiple of $50

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

Table 17. Staffing Input by FTE

Staffing Input by FTEs	FY 2021	FY 2022	FY 2023
Operations			
Nursing	3.83	4.35	4.78
Physical Therapy	3.71	4.50	4.97
Occupational Therapy	1.54	1.88	2.08
Speech Therapy	0.32	0.32	0.36
Medical Social Worker	0.20	0.25	0.29
Home Health Aides	0.35	0.43	0.48
Administrative			
Executive Director (Director/Administrator)	1.00	1.00	1.00
Supervisor of Clinical Services	1.00	1.00	1.00
Scheduling Coordinator	0.50	1.00	1.00
Intake Admissions	0.50	1.00	1.00
Marketing Exec	0.50	1.00	1.00

Admin Support	1.00	1.00	1.00

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

Once Medicare certification is attained, Josephine At Home anticipates that the majority of Josephine At Home patients will be Medicare and Medicaid enrollees. For home health services under the Patient Driven Groupings Model (PDGM) that was implemented in January 2020, Medicare will reimburse for services in a unit of 30-days. Reimbursement will be based on several categories which translate into 432 case-mix adjusted pay groups. While this will process will initially impact revenue, it is not a substantial issue due to robust reserves available to Josephine At Home.

The signed CEO letter of commitment can be found in Exhibit 12

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

1. Please provide the <u>current</u> and <u>projected</u> number of employees for the proposed project, using the following: Must be consistent with other areas of the CN application, Project Description etc.

Table 18. Current and Projected Employees

	Current FTE		Year 1		Year 2		Year 3	
Staff	FTE	Contracted	FTE	Contracted	FTE	Contracted	FTE	Contracted
RN	-	-	2.01	0.86	2.01	-	3.01	0.88
LPN	-	-	-	-	-	-	-	-
HH Aide	-	-	-	0.25	-	0.31	-	0.35
NURSING TOTAL	-	-	2.01	1.12	2.01	0.31	3.01	1.24
Admin	-	-	3.00	-	5.00	-	5.00	-
Medical Director	-	-	-	-	-	-	-	-
DNS	-	-	1.00	-	1.00	-	1.00	-
Business/Clerical	-	-	-	-	-	-	-	-
ADMIN. TOTAL	-	-	4.00	-	6.00	-	6.00	-
PT	-	-	1.51	1.16	2.01	1.31	2.01	1.56
OT	-	-	-	0.81	-	0.99	-	1.09
Speech Therapist	-	-	-	0.17	-	0.17	-	0.19
Med Social Work	-	-	-	0.09	-	0.11	-	0.12
Other (specify):	-	-	-	-	-	-	-	-
ALL OTHERS TOTAL	-	-	1.51	2.22	2.01	2.57	2.01	2.96

TOTAL STAFFING	-	-	7.52	3.34	10.02	2.89	11.02	4.20

Source: Financial Proforma Summary Years 2021-2023

2. Please provide your staff to visit ratio.

Table 19. Staff to Visit Ratio

Type of Staff	Staff / Visit Ratio
Skilled Nursing (RN & LPN)	4.75
Physical Therapist	5.00
Occupational Therapist	5.00
Medical Social Worker	4.00
Speech Therapist	5.00
Home Health Aide	7.00

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.

Josephine hired a nationally recognized home health consulting agency that sourced and reviewed the staffing data for accuracy and confirmed that the ratios meet both national and state standards of care.

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.

Josephine has been in operation in the same location for 112 years. We are the largest employer in Stanwood and Camano Island and are both familiar and adept in hiring qualified health manpower and management personnel. Due to our favorable reputation, opportunities for continuing education, scholarships, professional development and on-site child care services with an employee discount, we have not found recruitment and retention to be a challenge.

Job postings are listed on social media, posted internally and shared by word-of-mouth.

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

An in-service training plan can be found in Exhibits 14

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

A Quality Assessment and Performance Improvement Program (QAPI) has been developed.
Please see Exhibit 15

Quality Improvement: Josephine At Home will develop, implement, evaluate, and maintain an effective, ongoing, agency-wide, date driven Quality Assessment/Performance Improvement (QAPI) Program under the direction of the Executive Director and multidisciplinary QAPI Committee that evaluates and monitors the quality, safety and appropriateness of services provided by the agency. Josephine at Home's QAPI program will be ongoing, focused on client outcomes that are measurable, and have a written plan for the implementation in accordance with applicable state, federal and ACHC accreditation requirements. The committee will review and update or revise the plan of implementation at least quarterly or more often if needed. The QAPI program will provide key indicators of areas of risk management. The Josephine at Home QAPI Program activities will be incorporated into the overall Josephine Caring Community Performance Improvement Program and reported to the designated QAPI Committee, Professional Advisory Committee and Governing Body.

Please see Exhibit 15 for the Quality Assessment Performance Improvement Policy.

Customer Satisfaction: Josephine At Home's commitment to its clients, their caregivers, and the staff of the organization will be reflective of its philosophy and will be reviewed in light of Josephine At Home's own explicit and implicit commitment to provide excellent care/service to its clients. In accordance with Medicare requirements, Josephine At Home will monitor client/patient satisfaction through the administration and monitoring of Home Health Consumer Assessment of Healthcare Providers and Systems (HH-CAHPS) as part of the agency's Quality Assessment/Performance Improvement Program, and active client/patient satisfaction survey interviews. In addition, Josephine At Home will evaluate employee satisfaction and referral source/vendor satisfaction on an annual basis. All response data will be collected, analyzed and followed up as appropriate on an ongoing basis. A summary of findings and corrective actions taken will be made and reported quarterly as part of the QAPI Program.

Please see Exhibit 15 for the Customer Satisfaction Policy.

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

Josephine At Home's Office hours will be 8:00am to 5:00pm, Monday through Friday (excluding major holidays). Josephine At Home will provide 24/7 access to staff through an on-call service in which an RN will respond within one hour.

8. 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.

With Josephine Caring Community's 112 year growth in serving Snohomish County and Camano Island residents, we have formed an extensive network of ancillary and support services. Table. 10 reflects expected referral sources that we consider partners in our community. In addition to the Table 10. resources, Josephine At Home will expand on existing Josephine Caring Community resources that provide pharmacy and durable medical equipement.

9. **Explain the specific means by which the proposed project <u>will promote continuity</u> in the provision of health care to the defined population and <u>avoid unwarranted fragmentation</u> 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.**

Josephine At Home has provided health services to Snohomish County and Camano Island residents for 112 years. Existing ancillary and support resource relationship will be expanded upon, while it is predicted that new service relationships will also occur. Continuity of care will be achieved by reducing silos between agencies that refer, discharge or serve home health patients. By extending the continuum of care within Josephine Caring Community we will reduce fragmented care for patients transitioning to the post-acute care setting. Josephine At Home intends to deepen existing resource relationships while creating new healthcare partnerships to best service Snohomish County and Camano Island residents. As current and new relationships progress, Josephine At Home will create new service line agreements that are specific to the home health agency project.

10. **Fully describe any <u>history of the applicant entity and principles in Washington</u> 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.**

    a) **Have any of the applicants been adjudged insolvent or bankrupt in any state or federal court?**
    b) **Have any of the applicants been involved in a court proceeding to make judgment of insolvency or bankruptcy with respect to the applicant).**

Josephine Caring Community has no history with respect to criminal convictions, denial or revocation of a license to practice a health profession, or decertification as a provider of services in the Medicare or Medicaid program.

11. **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.**

Table 1. Josephine Caring Community Professional Licenses

Name	Specialty	License/Provider ID & Number
Josephine Caring Community	Skilled Nursing	143
Josephine Caring Community	Assisted Living	569
Josephine Caring Community DBA Josie's Learning Center	Childcare Center	Provider ID: 4251 SSPS Provider Number: 113880

Please see Exhibit 1 for copies of above licenses.

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

Josephine Caring Community has been in existence for 112 years and provided skilled nursing care to complex and vulnerable populations. We have continued to grow and expand services to meet patient and community needs based on evidence and data. Terry Robertson, Josephine Caring Community's CEO, has been leading Josephine for that past 12 years. He's developed new service lines, advanced existing services and has a vision to provide the entire continuum of care to all of Snohomish County and Camano Island. Terry Robertson's entire professional career has been in healthcare, beginning with a degree in healthcare administration received at Adventist Hospital in Chicago. For the past 35 years Terry has been committed to expanding the continuum of care for seniors and vulnerable populations through clinical and administrative excellence.

13. <u>For existing agencies</u>, 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.

Not applicable, Josephine At Home is not an existing provider of health services.

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

1. Identify the <u>exploration of alternatives</u> 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 spatial 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 outweighs each other by application of the decision-making criteria;**
- **Capital costs;**
- **Staffing impact.**

Should Josephine At Home not be approved for Home Health Certificate of Need, the project will be cancelled. An approved Certificate of Need is required for accreditation to receive payment through the Center of Medicare Services (CMS). Without CMS as a payor, the project is not financially feasible and will therefore be cancelled without alternative actions.

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

Medicare conditions of participation and available data on PDGM reimbursement are the basis of our proforma budget. The proforma budget will inform the initial start-up costs and staffing, while the ongoing financial reviews by the Board, CEO, Controller, Admissions and Josephine At Home Executive Director will meet regularily to establish revenue projections that align with the Medicare conditions of participation. That said, under PDGM there remains no cost caps.

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

Staff and system efficiencies are promoted through the use of SharePoint, a Microsoft Azure Cloud application that allows for a single source of data and workflow truth. SharePoint is an internal website that is a repository of all documentation, resources and links to the Josephine At Home policies, procedures and operational hyperlinks. This allows for all staff to be able to access the most

current Josephine information from any device (mobile, laptop or desktop). Josephine At Home also employs the use of Point Click Care for clinical documentation. Point Click Care utilizes CRM and data analytics that can be fed to dashboards. This allows for quick access to productivity metrics and detailed data sets that inform both management and clinical and non-clinical individual contributors. Training to the metrics occurs during onboarding and will be updated frequently in multiple modes of communications (monthly staff meetings, emails, on-demand training and resources through the applications of Relias and Point Click Care, Skills Training and annual reviews).

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.**

   Not applicable, the Josephine At Home project has not required any construction costs

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.**

   Not applicable, Josephine At Home will not have construction, renovation or expansion costs other than the low capital costs of what was outlined in Table 1. Alternative energy consumption is not a consideration for Josephine At Home due the office residing within an existing building of Josephine Caring Community.

Exhibit 1
Applicant Licenses

Washington State Department of Social & Health Services

Transforming lives

NURSING HOME LICENSE

License Number: 143 **First Issued: April 1, 1976**

Pursuant to the laws of the State of Washington and the Minimum Licensing Requirements of the Department of Social and Health Services, a license is hereby granted to

Josephine Caring Community

operated by Josephine Caring Community

to conduct and maintain at 9901 272ND PLACE NW

City of STANWOOD, Zip Code 98292 County of Snohomish State of Washington

A facility providing convalescent or chronic care, or both, for a period in excess of twenty-four consecutive hours, for 160 adults

This license shall be in force from the 1st day of February, 2020 through the 31st day of January, 2021 subject to revocation for due cause.

Candace Johnson

_____, Licensing Authority

NOTE: The department renewal of a license does not preclude the department from taking any action under RCW 18.51.060, based on inspection.

This license is not transferable, and is valid only for use by the corporation, partnership or individual(s) to whom it is issued and at the location above described.

Issued by Authority of Chapter RCW 18.51 and 74.46

Washington State Department of Social & Health Services

Transforming lives

ASSISTED LIVING FACILITY LICENSE

License Number: 569

Pursuant to the laws of the State of Washington and the Minimum Licensing Requirements of the Department of Social and Health Services, a license is hereby granted to

Josephine Caring Community

operated by Josephine Caring Community
to conduct and maintain at 9901 272nd Pl NW
City of Stanwood, Zip Code 98292 County of Snohomish State of Washington
a facility for the board and domiciliary care of 65 adults

This license shall be in force from the 1st day of October, 2019 through the 30th day of September, 2020 subject to revocation for due cause.

Candace Johnson

_____, Licensing Authority

NOTICE TO THE PUBLIC: Not all resident rooms and areas of this building are inspected or licensed by the state of Washington. A list of licensed rooms may be obtained from the assisted living facility licensee.

NOTE: The department renewal of a license does not preclude the department from taking any action under RCW 18.20.115, based on inspection.
This license is not transferable, and is valid only for use by the corporation, partnership or individual(s) to whom it is issued and at the location above described.

Issued by Authority of Chapter RCW 18.20

4251
PROVIDER ID NUMBER

113880
SSPS PROVIDER NUMBER

WASHINGTON STATE DEPARTMENT OF EARLY LEARNING

Child Care Center
Full
Non-Expiring

In compliance with the laws of the State of Washington in meeting the licensing requirements of the Department of Early Learning (DEL), a child care license is hereby granted to the Child Care Center facility named below. **For information on the status of this license, call 1-866-482-4325 (or 1-866-48-check).**

Josephine Caring Community
DBA Josie's Learning Center

is licensed to maintain a Child Care Center located at 9901 272ND PLACE NW, city of STANWOOD, zip code 98292, county of Snohomish in the State of Washington for the care of children **between the ages of 1 month - 13 years but not to exceed 111 children.**
Limitations if any:

Classroom Name	Capacity		Classroom Name	Capacity		Classroom Name	Capacity
Infant	8		Room 4 Preschool	10		Montessori	20
Waddlers	7		Room 2 Preschool	10		Room 3 Toddler	7
Room 5 Pre-K	10		Room 6 Pre-K	10		ECEAP	20
School Age	30						

This license is issued on April 15, 2015 Dated: May 14, 2018 at Bellingham, Washington.

Wendy Lin
DEL Licensor Signature
WENDY LIN
425-740-6874
Telephone Number

Brittney Cyr, MSW
DEL Licensing Supervisor Signature
Brittney Cyr
360-714-4162
Telephone Number

Notice: This license is not transferable, and is valid only for use by the individual (s) to whom it is issued and at the location described.
Issued by Authority of Chapter 43.215 Revised Code of Washington. 10.9.4.1 Center License
Rev. 6.2014

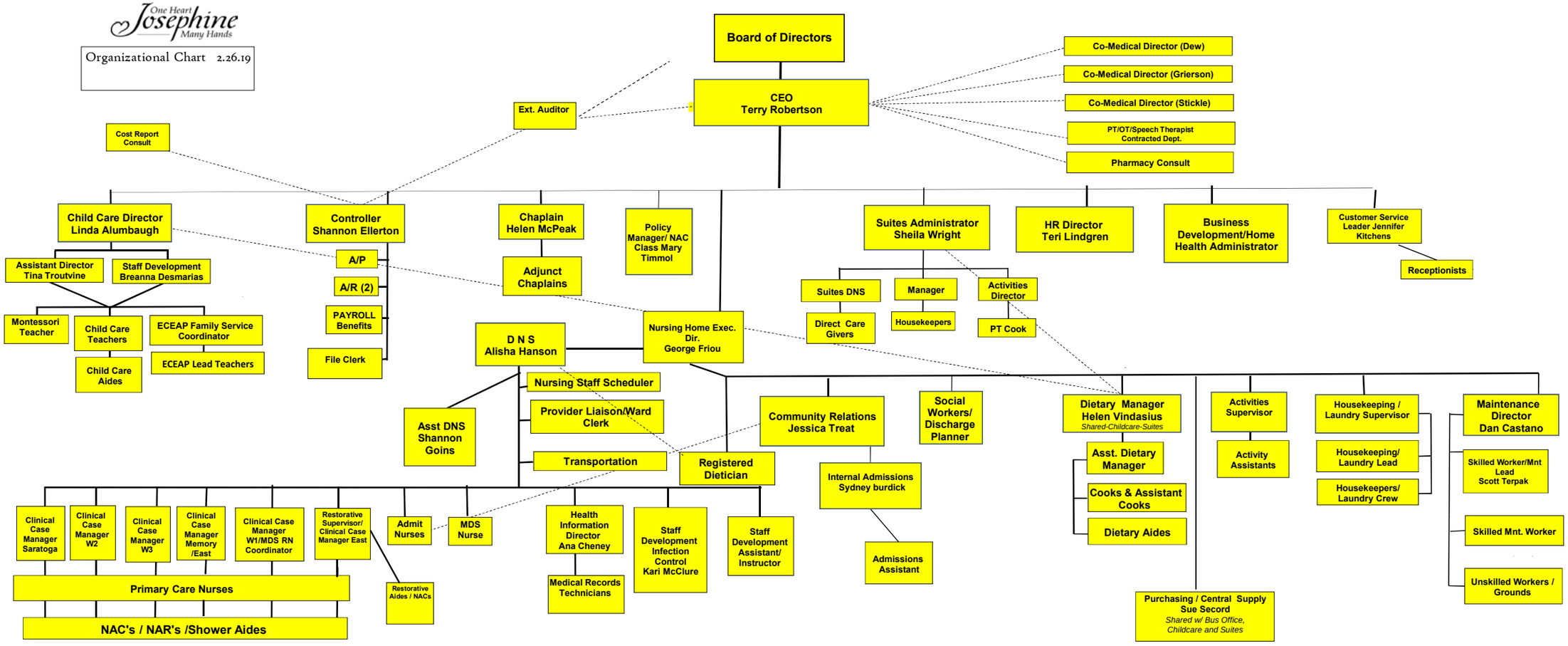
Washington State Department of Early Learning

Exhibit 2

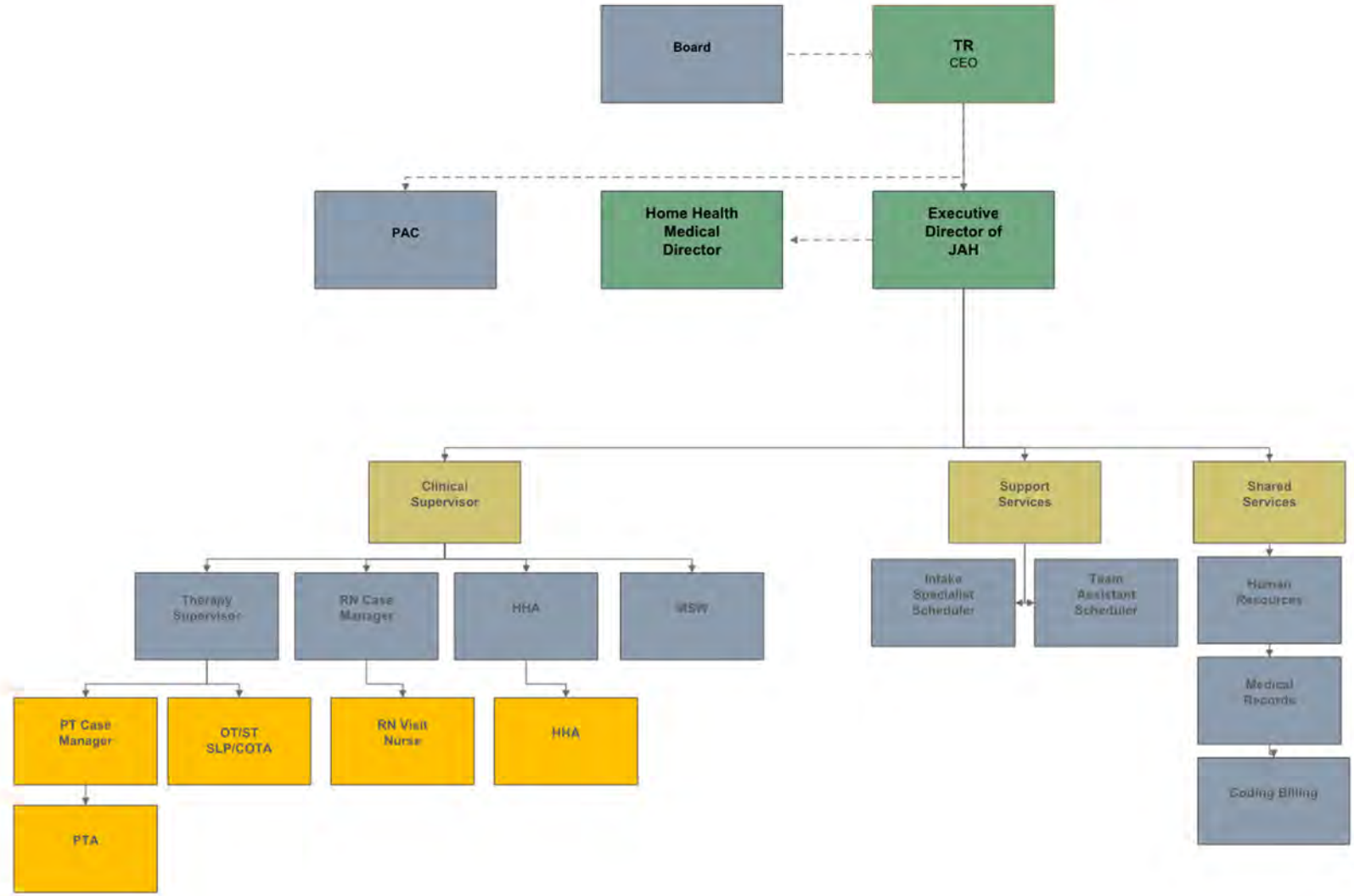
Organizational Charts

One Heart Josephine Many Hands

Organizational Chart 2.26.19



Josephine
at Home
The Josephine Caring Community



*Patients are able to access any Josephine At Home Staff.

Exhibit 3

JAH Medical Director License

JAH Medical Director Agreement

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
Olympia, Washington 98504

4/2/2020

Subject: Credential Verification

To Whom It May Concern:

This verifies the status of the Physician And Surgeon License for Grierson, James B.

This site is a Primary Source for Verification of Credentials.

Credential Number:	MD00043397
Credential Type:	Physician And Surgeon License
First Credential Date:	03/17/2004
Last Renewal Date:	04/22/2019
Credential Status:	ACTIVE
Current Expiration Date:	07/11/2021
Enforcement Action:	No

The Washington Department of Health presents this information as a service to the public.

The absence or presence of information in this system does not imply any recommendation, endorsement, or guarantee of competence of any health care professional, the mere presence of such information does not imply a practitioner is not competent or qualified.

This site provides disciplinary actions taken and credentials denied for failure to meet qualifications. If the Enforcement Action is listed as a No, there has been no disciplinary action. It allows viewing and downloading of related legal documents since July 1998. Contact our Public Disclosure Office at pdro@doh.wa.gov for information on actions before July 1998. This information comes directly from our database. It is updated daily.

MEDICAL DIRECTOR AGREEMENT

This **MEDICAL DIRECTOR AGREEMENT** (the "Agreement") is made into this 28th day of August 2020, by **Josephine At Home, a subsidiary of Josephine Caring Community**, a Washington Non-Profit Corporation, (hereinafter "Agency" or "Josephine At Home") and Dr. James Grierson (hereinafter "Consultant", "Physician" or "Medical Director").

RECITALS:

A. Agency provides medical care and treatment to patients including provision of home care services; and
B. Agency is responsible for patient care and may not delegate overall administrative and supervisory responsibilities. Agency administrative and supervisory responsibilities are solely those of the CEO and Executive Director.
C. Agency has determined that the retention of a physician to provide professional medical direction relating to home care services as the Medical Director of Agency is in the best interest of patients, the community, and Agency; and
D. Physician is duly licensed to practice medicine in the state where the Agency operates and has expertise in the provision of home care services; and
E. Agency and Physician mutually desire to enter into this Agreement, which will facilitate the delivery of home care services in Agency through the provision of Physician's medical director Services.

NOW, THEREFORE, for good and valuable consideration, the receipt and sufficiency of which is acknowledged by the parties, the parties agree as provided above and as follows:

1. **DEFINITIONS:** For purposes of this Agreement, the following terms shall have the meanings ascribed thereto unless clearly required by the context in which such term is used.
    a. Agency Policies. The term "Agency Policies" shall meant the established policies, practices, and procedures of the Agency, adopted, approved, or amended by the Agency pursuant to normal procedure.
    b. Medical Director Services. The term "Medical Director Services" shall mean those certain services listed in Section 2.3 herein.
    c. Patients. The term "Patients" shall mean the patients of the Agency.
    d. Term. The term "Term" shall mean the contract period provided for under the Agreement.
2. **COVENANTS OF PHYSICIAN**
    a. Appointment of Physician. Agency hereby appoints Physician as Medical Director of Agency, and Physician accepts such an appointment, to provide administrative services for Agency in accordance with the terms of this Agreement and in accordance with 45 C.F.R. 484.14(d)

    b. Qualifications of Physician. Physician must at all times during the Term of this Agreement (i) hold a valid and unrestricted license to practice medicine in the state in which the Agency is located, and (ii) be fully capable and qualified, in accordance with

good medical practice, to provide Medical Director Services as required by the Agreement. In providing services under the Agreement, the Physician may not have been (i) Denied Medicare or Medicaid enrollment; (ii) Been excluded or terminated from any federal health care program or Medicaid; (iii) Had Medicare or Medicaid billing privileges revoked; or (iv) Been debarred from participating in any government program.

c. Duties of the Physician. Physician shall be available for consultant relating to the delivery of home care services ("Program") at the Agency and shall provide the following Medical Director Services:
   1. **Quality Improvement.** Physician will participate in quality improvement /utilization review processes, review and update protocols periodically and make recommendations to improve quality of Program services.
   2. **Education/Program Development**. Physician agrees to be utilized to teach assessment skills to the Program clinical staff, develop new patient care protocols and assist/review development of staff and patient education materials.
   3. **Executive/Administrative Consultant**. Physician will serve on the Professional Advisory Committee (PAC) in order to provide medical perspective to administrative decision making and help articulate the mission, goals, and policies of the Program. The functions of the PAC are to establish and annually review the Program's policies governing the scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications and Program evaluation.
   4. **Community Liaison.** The Physician agrees to intervene in the case of physician/Program problems and will advocate for home care to the physician community. Community Liaison duties do not include marketing Program to other physicians or referral sources.
   5. **Health Policy/Regulation.** Physician agrees to provide medical input or interpretation of social, political, regulatory or economic factors that impact patient care or the Program and act as a physician spokesperson and resource in representing the Program position in dealing with regulatory or accrediting organizations.
   6. **Ethical Issues Consultant.** Physician agrees to participate in the development of ethical policies and decisions and provide medical input on patient care issues of an ethical nature.
   7. **Planning.** Participate in the planning and development activities for the Program.
   8. **Medical Records.** Monitor the maintenance, retention and required confidentiality of records and information associated with patient care in the Program.
   9. **Miscellaneous Activities.** In addition, Physician shall perform such other administrative duties as may from time to time be agreed to between Physician and the Agency. Physician shall perform the duties described in this Section in accordance with Agency Policies.
   10. **Financial Obligation.** Physician shall not have the right or authority to, and hereby expressly covenants to, enter into a contract in the name of Agency, or otherwise bind Agency in any way to any financial obligation, without the express written

consent of the Agency. Physician shall hold Agency harmless from any loss attributable to a violation of this covenant.

11. **Reports and Records.** Physician shall prepare such reports relating to the provision of Medical Director Services as are reasonably requested by Agency. The ownership and right of control of all reports, and supporting documents submitted to or by Physician shall exclusively with Agency.
12. **Confidentiality of Information**. Physician agrees to keep confidential and not to use or to disclose to others either during the Term or during any other period of association with Agency extending beyond the Term and for a period of six (6) years thereafter, except as expressly consented to in writing by Agency, any secrets or proprietary information, patient lists, marketing programs, or trade secrets of Agency (which shall be deemed to include all provisions of this Agreement), or any matter or thing ascertained by Physician through Physician's association with Agency, the use or disclosure or which matter or thing might reasonably be construed to be contrary to the best interest of the Agency. Physician further agrees that should this Agreement be terminated, Physician will neither take nor retain without prior written authorization from Agency, any papers, policies, forms, patient lists, fee documentation, patient records, quality improvement materials, files or other documents or copies thereof or other confidential information of any kind belonging to the Agency pertaining to patients or to Agency's business, sales, financial condition or products,. Physician will comply with all applicable privacy and security regulations as specified in Health Insurance Portability and Accountability Act of 1996 (HIPAA) and subsequent rules. Physician is not to share protected information with any third parties unless there is a stated need to share the information with an identified third party. Physician agrees to abide by all state and federal law relevant to the confidentiality of patient identifiable health information including but not limited to HIPAA. Any such protected information will be destroyed or returned to the Agency according to Agency policy. Without limiting other possible remedies to Agency for the breach of this covenant, Physician agrees that injunctive or other equitable relief shall be available to enforce this covenant, such relief to be without the necessity of posting a bond, cash or otherwise. Physician further agrees that if any restriction contained in this Section is held by any account of competent jurisdiction to be unenforceable or unreasonable, a lesser restriction shall be enforced in its place and remaining restrictions contained herein shall be enforced independently of each other.
13. **Exclusivity and Protection of Proprietary Information**. Physician shall not provide similar Medical Director Services for any other Agency without prior written consent of the Agency. Further, Physician acknowledges that the manner of operating the Program is proprietary information of the Agency. Nothing herein shall prohibit Physician from engaging in the regular practice of medicine (inclusive of care plan oversight) and /or Physician's participation in clinical consultation services for non-competing business or industries, nor shall it obligate Physician to direct referrals of medical business to a particular provider.

3. COVENANTS OF AGENCY

a. Amount of Compensation. In consideration of the Medical Director Services rendered each month by Physician pursuant to this Agreement, Agency shall pay to Physician the amount of $1500 per month. Physician agrees that such amount shall be Physicians sole compensation for Medical Director Services furnished pursuant to this Agreement. No other financial, or other forms of incentives, bonuses or kick-backs shall be allowable under this Agreement. Physicians provision of professional medical services to patients, regardless of whether the patient is also a patient of agency, and the compensation therefore, shall not be governed by this Agreement.

4. Terms And Termination of Agreement

a. Term. This Agreement shall be effective as of the Effective Date for the term of one (1) year therefrom; subject however to Sections b. through e. hereof. This Agreement will be automatically renewed annually by the parties for additional one-year terms unless terminated pursuant to this Article 4. This Agreement will be reviewed annually by the Agency.

b. Immediate Termination for Cause by Agency. Agency may, as its option, terminate this Agreement immediately by written notice to Physician upon the occurrence of any of the following event: (i) Physician failure to meet any of the qualifications set forth in this Section 2; (ii) failure of the Physician to fulfill duties set forth in Section 2, (iii) the death or disability of the Physician; or (iv) failure of the Physician to attend scheduled PAC meetings without at least a 2 hour notice.

c. Termination. At any time during the term of this Agreement, either party mat terminate this Agreement without cause upon the giving of thirty (30) days advance written notice to the other party.

d. Termination or Notice for Default. In the event that either party shall give written notice to the other that such other party has breached a material provision in this Agreement (other than specified in Section b. above), and such breach remains uncorrected for a period of (10) days after receipt of such written notice, the party giving such notice may, at its option, after the expiration of the aforesaid ten (10) day period, terminate the Agreement immediately.

e. Termination Due to Legislative or Administrative Changes. This Agreement is intended to comply with all relevant state and federal statutes and regulations relating to the delivery of Program services and to the reimbursement of Program services under the Medicare, Medicaid, or other third-party payor programs and the deferral statutes and regulations governing entities exempt from federal taxation. In the event that there shall be: (i) a change is statutes, regulations or instructions relating to the Medicare, Medicaid, or other third-party payor programs, or the exemption of entities form federal taxation, including a change in the interpretation or enforcement thereof of government agencies; (ii) the adoption of any new legislation or regulations applicable to this Agreement; or (iii) the initiation of an enforcement action by a government entity with respect to legislation , regulations or instruction applicable to this Agreement any of which affects the continuing viability or legality of this Agreement, then both parties agree to negotiate in good faith to amend the Agreement to conform with the existing

laws or regulations. If Agreement cannot be reached with respect to such amendments within (30) days after the effective date of such change, adoption, enforcement, or notice (or such earlier time as may be required by such legislation or regulations), then either party may terminate this Agreement by written notice to the other party. Physician agrees to reimburse Agency for any payment that is determined by a court or government agency to be illegal.

5. MISCELLANEOUS
    a. Status of Physician. It is expressly acknowledged by the parties hereto that Physician, in performing Physician duties and obligations under this Agreement, is an "independent contractor" and nothing in this Agreement is intended nor shall be construed to create an employer/employee relationship, a joint venture relationship, or to allow Agency to exercise control or direction over the manner or method by which Physician performs the services which are the subject matter of this Agreement; provided, always, that the services to be furnished hereunder by Physician shall be provided in a manner consistent with the Program Policies, the standard governing such services, and the provisions of this Agreement. Physician understands and agrees that, unless otherwise required under the applicable federal income tax laws or the term of any agreement between Agency and the Internal Revenue Service, (i) Physician shall not be treated as an employee for federal tax purposes; (ii) Agency will not withhold on behalf of Physician pursuant to this Agreement any sums for income tax, unemployment insurance, social security, retirement benefits, or any other withholding pursuant to any law or requirement of any governmental body relating to Physician, or make available to Physician any of the benefits afforded to employees of Agency; (iii) all of such payments, withholdings, and benefits, if any, are the sole responsibility of Physician; and (iv) Physician will indemnify and hold harmless Agency from any and all loss or liability arising with respect to such payments, withholdings, or benefits, if any.
    b. Benefit. This Agreement shall be binding upon and operate for the benefit of the parties and their respective heirs, executors, administrators, assigns and legal representatives.
    c. Applicable Law. This Agreement shall be deemed to have been made in the State of Washington and shall be governed by the laws of the State of Washington without regard to the laws pertaining to choice law. In the even a party in this Agreement must bring suite to enforce the terms of this Agreement, jurisdiction and venue shall lie exclusively in Snohomish County, Washington.
    d. Amendment. No modification of any of the provision of the provisions hereof shall be binding upon either the Physician or Agency unless it is in writing and signed by the Party against whom such modification is sought to be enforced/
    e. Severability. If any term, covenant, or condition of this Agreement, or the application therof to any person or circumstance, shall be invalid or unenforceable, the remainder of this Agreement, and the application of any term or provision to persons or circumstances other than those as to which it is held invalid or unenforceable, shall not be affected thereby, and all other terms shall be valid and enforceable to the fullest extent permitted by the law.

MEDICAL DIRECTOR AGREEMENT

Agency	**Physician**
Terry Robertson **CEO**	**Dr. James Grierson, MD**
IN WITNESS WHEREOF, the parties have executed and entered into this Agreement this 28th day of August 2020.	

Exhibit 4

Applicant Facility Map
Single Line Drawing

JOSEPHINE CAMPUS MAP

Saratoga Transitional Rehab — The Josephine Caring Community

The Meadows Nursing Care — The Josephine Caring Community

The Suites Senior Living — The Josephine Caring Community

Josie's Learning Center — The Josephine Caring Community

Josephine at Home — The Josephine Caring Community

PICNIC SHELTER

The Meadows Nursing Care
MEMORY CARE RESIDENTS

Memory Care Nurses Station

737 738 739 CM MEDS DINING 740 741
MEMORY CARE RESIDENTS
736 H DAY ROOM T STOR SHOWER S.U. C.U. MECH 743 742

735 734 733 732 731 730 729 727 726 724 722 720
RESTORATIVE T CM OXY SHOWER STOR STOR BOILER
THE MEADOWS EAST 2 UNIT

812 811 810 809 808 807 806 805 804 803 802 SHOWER S.S. MEDS H E

REHAB GYM
BATH S.T. T
563 564 561 562 559 560 557 558 555 556 553 S.U. C.U. 828 826 824 822 CM S.U. C.U. 551 549 M.R. 547 546 545 544 543 542 541
SARATOGA REHAB UNIT

Saratoga Transitional Rehab
ENTRANCE

WEST PARKING LOT

TRASH ENCLOSURE

Josie's Learning Center
PLAY YARD

West 2 & 3 Nurses Station

East 1& 2 Nurses Station

602 604 606 608 610 612 MED CM OXY SHOWER STOR STOR BOILER Day Room PORCH

The Meadows Nursing Care
EAST ENTRANCE

H STOR 827 CONF CM STAFF ED T T DAY ROOM

JLC Rm #2 JLC Rm #3 601 603 605 607 609 611 H S.U. C.U. T S.S. 712 711 710 709 708 707 706 705 704 703 702 701 T H E
THE MEADOWS EAST 1 UNIT

D.N.S 529 528 527 526 525 524 523 522 521 Day Room

SARATOGA COURTYARD

Josie's Learning Center
PLAY YARD

MAIN. BUILDING

Saratoga Nurses Station

West 1 Nurses Station

GEN

ELECT LAUNDRY C.U. oxy SHOWER 540 538 536 534 532 530 T OXY S
WEST 1 UNIT
T H 539 537 535 533 531 MEDS C.U. H 505 503 501 Comm Room

509 511 SHOWER JLC Rm #4

S.U. 510 512 514 VENDING MACHINE 516 518 504 502 BEAUTY SHOP M.D. OFFICE CM SIT AREA CHAP-LAIN ACT. DIR

CHAPEL

DINING ROOM

GREENHOUSE COURTYARD

CATERING CLOSET STOR PRAYER CHAPEL

115 116 117 114 118 113 119 112 120 111 121 122 123 124 STOR E S T S ELE E.E.R.
DECK OFFICE LOUNGE LOBBY DINING ROOM

S.U. CENT. SUPPLY DCP OFFICE CENT. SUPPLY COURTYARD

BOILER STORAGE

ACTIVITY CENTER CONF. RM MECH ELEC STOR HELIUM DISP MAT E CSL/HK T T

AT HOME STOR

GIFT SHOP T T STOR STAFF LOUNGE KITCHEN

DECK JLC PLAY YARD

WIC OFFICE T JLC Rm #5 CLO JLC WADDLER COPY ADMIT REC JLC INFANTS

You Are Here

LOBBY

VISITOR ENTRANCE

JLC OFF. T T

MAIN ENTRANCE

Josie's Learning Center
PRESCHOOL CHILDCARE

VISITORS PARKING LOT

Josie's Learning Center
MONTESSORI

Josie's Learning Center
MONTESSORI PLAY YARD

Josephine at Home

The Suites Senior Living
ENTRANCE

110 MED OFFICE 109 101 108 102 107 103 104 106 105

SECOND FLOOR BUSINESS OFFICES

PHONE ROOM STORAGE STORAGE ELEVATOR CONF ROOM STAFF SCHED T CRD HR MD OFFICE MDS
BUSINESS OFFICE T STOR POLICY MEDICAL RECORDS T STORAGE PAYROLL CEO

9901 272nd Place NW

THE SUITES SECOND FLOOR

217 218 216 220 219 215 221 214 222 223 213 224 225 226 227 LAUNDRY ELE MEDIA ROOM 2B 2A
212 ATRIUM CLO BATH 211 FAMILY ROOM 231 230 229 228 201 DECK 210 202 209 203 208 204 205 207 206

Exits
T Toilets
Stairs
Nurses Station

N W E S

Josephine Caring Community
One Heart. Many Hands.

FIRE EXTINGUISHER HERE

YOU ARE HERE

EXIT

Exhibit 5

Josephine Caring Community Name Change Documentation

Josephine Caring Community Parcel Information

August 15, 2017

Internal Revenue Service
Exempt Organizations Determinations
Room 4024
PO Box 2508
Cincinnati, OH 45201

RE: Change of Name – Exempt Organization
Request of Affirmation Letter

I hereby report a name change for the Exempt Organization listed below. Attached is a copy of the Articles of Amendment bearing the proof of filing stamp by the State of Washington. Please send an Affirmation Letter that reflects the new name.

EIN:	91-0570870
Prior Name:	Evangelical Lutheran Church in America Josephine Sunset Home Inc.
New Name:	Josephine Caring Community
Our address is unchanged:	9901 272nd PL NW Stanwood, WA 98292-7449

Sincerely,

Ernest Fosse, Chair
Board of Directors
Josephine Caring Community

Articles of Amendment
Section 3 Attachment
Josephine Sunset Home
600 089 377
Amendment adopted: 4/28/2017

Article I
Name

1.1 The institution is a Washington non-profit corporation known as ~~"JOSEPHINE SUNSET HOME INC" doing business as "Josephine"~~ "Josephine Caring Community."

IRS Department of the Treasury
Internal Revenue Service

OGDEN UT 84201-0046

In reply refer to: 0625747877
Sep. 22, 2017 LTR 2520 0
91-0570870 000000 00
00005856
BODC: TE

JOSEPHINE CARING COMMUNITY
9901 272ND PL NW
STANWOOD WA 98292-7449

017609

Taxpayer Identification Number: 91-0570870

Dear Taxpayer:

Thank you for the inquiry dated Aug. 15, 2017.

We have changed the name on your account as requested. The number shown above is valid for use on all tax documents.

If you need forms, schedules, or publications, you may get them by visiting the IRS website at www.irs.gov or by calling toll-free at 1-800-TAX-FORM (1-800-829-3676).

If you have any questions, please call us toll free at 1-877-829-5500.

If you prefer, you may write to us at the address shown at the top of the first page of this letter.

Whenever you write, please include this letter and, in the spaces below, give us your telephone number with the hours we can reach you. Also, you may want to keep a copy of this letter for your records.

Telephone Number ( )_____ Hours_____

Sincerely yours,

Shane N. Painter
Dept. Manager, Entity

Enclosure(s):
Copy of this letter

Office of the Secretary of State
Corporations & Charities Division

Washington Nonprofit Corporation

See attached detailed instructions

☑ Standard Filing Fee $20.00

☐ Filing Fee with Expedited Service $70.00

This Box For Office Use Only

05/31/17 3468399-001
$20.00 K
Ba: 3513176

FILED
SECRETARY OF STATE
MAY 31, 2017
STATE OF WASHINGTON

UBI Number: 600 089 377

ARTICLES OF AMENDMENT

Chapter 24.03 RCW

SECTION 1

NAME OF CORPORATION: *(as currently recorded with the Office of the Secretary of State)*

Josephine Sunset Home

SECTION 2

ARTICLES OF AMENDMENT WERE ADOPTED BY: *(please check and complete one of the following)*

☑ The amendment was adopted by a meeting of members held: (Date) 4/28/2017
A quorum was present at the meeting and the amendment received at least two-thirds of the votes which members present or represented by proxy were entitled to cast.

☐ The amendment was adopted by a consent in writing and signed by all members entitled to vote.

☐ There are no members that have voting rights. The amendment received a majority vote of the directors at a board meeting held: (Date) _____

SECTION 3

AMENDMENTS TO ARTICLES ON FILE: *(if necessary, attach additional information)*

See attached

SECTION 4

EFFECTIVE DATE OF ARTICLES OF AMENDMENT: *(please check one of the following)*

☑ Upon filing by the Secretary of State

☐ Specific Date: _____ *(Specified effective date must be within 30 days AFTER the Articles of Amendment have been filed by the Office of the Secretary of State)*

SECTION 5

SIGNATURE: *(see instructions page)*

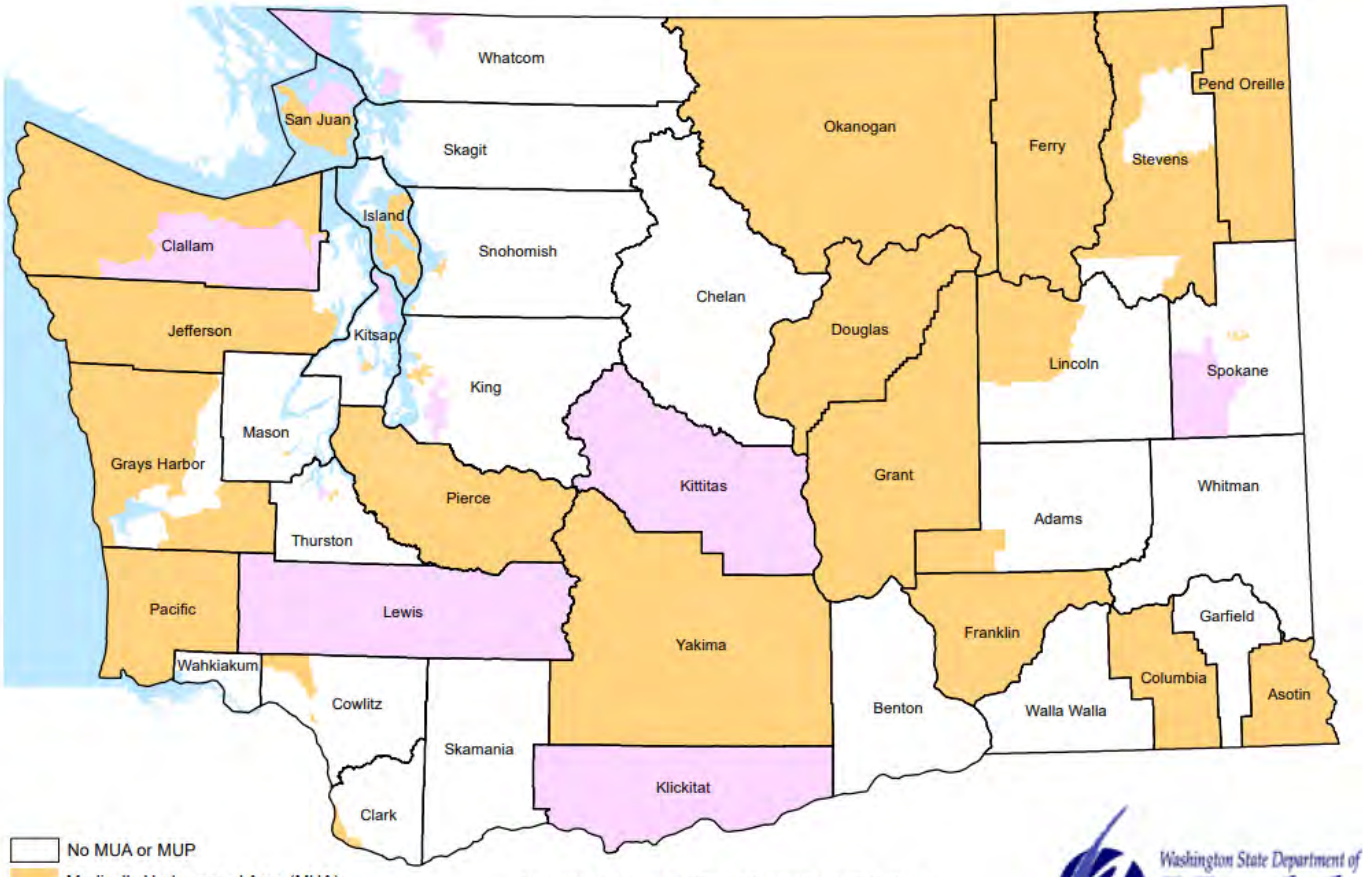
This document is hereby executed under penalties of perjury, and is, to the best of my knowledge, true and correct.

x Signature	Printed Name and Title	Date	Phone
Irene M. Nelson	Irene M. Nelson Secretary	5-16-17	206-949-1435

Exhibit 6

Medically Underserved Area Map
Health Professional Shortage Area Map

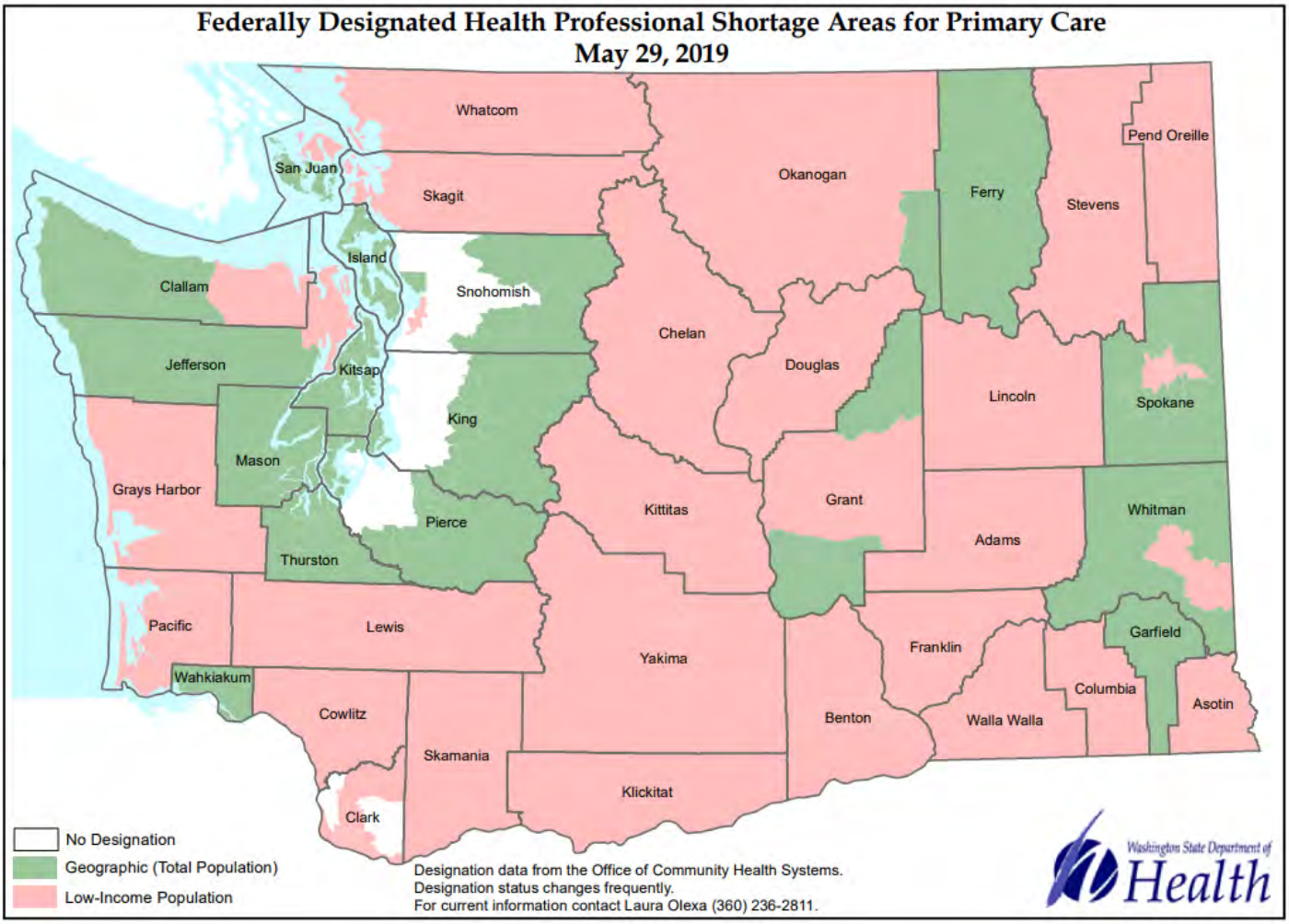
Medically Underserved Area & Medically Underserved
May 29, 2019



Designation data from the Office of Community Health Systems.
Designation status changes frequently.
For current information contact Laura Olexa (360) 236-2811.

Washington State Department of Health

Federally Designated Health Professional Shortage Areas for Primary Care
May 29, 2019



Designation data from the Office of Community Health Systems.
Designation status changes frequently.
For current information contact Laura Olexa (360) 236-2811.

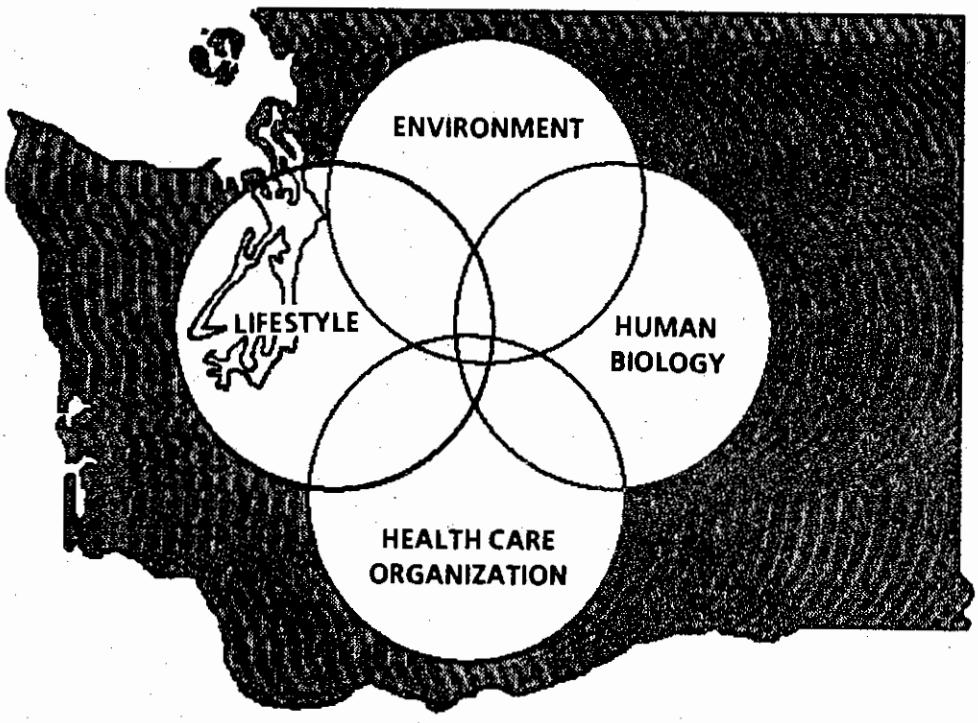
Washington State Department of Health

Exhibit 7

1987 Washington State Health Plan
Need Methodology

Clean Copy

WASHINGTON STATE HEALTH PLAN



VOLUME 2: PERFORMANCE STANDARDS FOR HEALTH FACILITIES AND SERVICES

Adopted by the State Health Coordinating Council
January 21, 1987

Approved by Governor Booth Gardner
May 12, 1987

WASHINGTON STATE HEALTH PLAN

VOLUME 2: PERFORMANCE STANDARDS FOR HEALTH FACILITIES AND SERVICES

Adopted by the State Health Coordinating Council
January 21, 1987

Approved by Governor Booth Gardner
May 12, 1987

STATE HEALTH COORDINATING COUNCIL (SHCC)

MEMBERS

Ward C. Miles, M.D. (Chair)
Retired physician
Olympia

Lorraine Berndt, C.N.A.*
Home health agency director
Longview

Vivian M. Caver
Community agency director
Seattle

James R. Click
Insurance executive
Mountlake Terrace

Harold Clure, M.D.
Physician
Anacortes

Leona Dater
Union representative
Spokane

Dewey Desler
Council of governments director
Bellingham

Victor Dirksen
Hospital district superintendent
Port Townsend

Carolyn Ghilarducci*
Volunteer
Tacoma

Frank Hungate, Ph.D.
Researcher
Richland

Eldon E. Jacobsen, Ph.D.
Retired professor
Ellensburg

Herbert T. Kubota
Businessman
Metaline Falls

Jerald L. Liskey
Laboratory director
Walla Walla

Jeanne Miller*
High school teacher
Brewster

Carlos Olivares
Farm workers clinic director
Yakima

Joanne C. Peterson
Home health agency director
Moses Lake

George Reis
Retired psychologist
Hoodsport

Bonnie Sandahl, C.R.N.
Nurse practitioner
Alderwood Manor

Vincent L. Stevens*
University dean
Cheney

Alvin J. Thompson, M.D.
Physician
Seattle

EX-OFFICIO MEMBERS

Joanne Brekke
State Representative
Seattle

Lorraine Wojahn
State Senator
Tacoma

Jule Sugarman
Department of Social and
Health Services Director
Olympia

Chair
State Hospital Commission
Olympia

James T. Krajek
Veterans Administration
medical center director
Bellevue

---

* Former member

SHCC/REGIONAL HEALTH COUNCIL PLAN DEVELOPMENT COMMITTEE

Carolyn Ghilarducci (Chair)
Volunteer
Tacoma

Lorraine Berndt, C.N.A.
Home health agency director
Longview

James R. Click
Insurance executive
Mountlake Terrace

Bill Ferguson
Regional health council
representative
Ilwaco

Pat Herda
Regional health council
representative
Chewelah

Frank Hungate, Ph.D.
Researcher
Richland

Jeanne Miller
High school teacher
Brewster

Mary Ruud
Regional health council
representative
Sprague

Vincent Stevens
University dean
Cheney

Josephine Tamayo-Murray
Regional health council
representative
Redmond

Alvin J. Thompson, M.D.
Physician
Seattle

John Vornbrock
Regional health council
representative
Yakima

TECHNICAL STAFF

STATE HEALTH
COORDINATING COUNCIL

Verne Gibbs, SHCC
Executive Director

Mike Dickey, Health
Planning Administrator

Adrienne Alexander, Plan
Development Coordinator

Dan Rubin, Data and
Analysis Lead

Lucille Phillips,
Health Planner

Barbara Perkins,
Health Planner

Joe Campo,
Data Specialist

REGIONAL
HEALTH COUNCILS

Linda Lockwood, Puget Sound
Health Systems Agency (HSA)

Debby Peterman,
Puget Sound HSA

Phil Rothman, Southwest
Washington HSA

Bob Hughes, Central
Washington HSA

Jim Sullivan, Central
Washington HSA

Bob Russell, Eastern
Washington HSA

Janis Sigman, Eastern
Washington HSA

STATE OF WASHINGTON
OFFICE OF THE GOVERNOR

OLYMPIA
98504-0413

BOOTH GARDNER
GOVERNOR

May 15, 1987

Ward C. Miles, M.D., Chair
State Health Coordinating Council
Mail Stop OB-43F
Olympia, Washington 98504

Dear Mr. Miles:

I am pleased to approve the State Health Plan (SHP) developed by the State Health Coordinating Council under the provisions of the State Health Planning and Resources Development Act (RCW 70.38). This document presents ambitious and worthy objectives for the improvement of health status and development of health services in the state. Executive agencies should take appropriate steps within available resources to assure that their policies are consistent with the directions set forth in this plan.

The content of the State Health Plan has been developed over many months, and there are areas where recent events require an update of the situation described in Volume 1 of the Plan:

Acquired Immune Deficiency syndrome (AIDS). The plan was developed before the scope and severity of the AIDS problem was fully recognized. I am confident that the SHCC, the Department of Social and Health Services and other responsible entities will expand their consideration of this important issue.

Conditions in correctional institutions. The overcrowding of correctional institutions referred to in the plan is mitigated by the opening of a a new state correctional facility at Clallam Bay.

Prenatal Care. Significant movement toward the plan's prenatal care goal has been made in recent months due to legislative action to appropriate additional funds for expansion of the program as I had requested. This action demonstrates the high priority placed on this goal by both the executive branch and the legislature.

Basic health care. Progress also has been made toward the plan's goal of equitable access to health care and the provision of a basic level of health services to all state residents as a result of pending legislative action on the Basic Health Care Plan (House Bill 477).

I want to thank the members of the state Health Coordinating Council and the many health care consumers and providers around the state who contributed to the development of this State Health Plan. Your continuing interest and involvement will help us to develop an efficient and effective health care system and to seek ways to improve the health status of state residents.

Sincerely,

Booth Gardner

Booth Gardner
Governor

0214m

CONTENTS

(5) Any Type A or Type B CCRC proposing a nursing home project may, at its discretion, designate it as an application against the special statewide pool of CCRC nursing home beds established under the Nursing Home Bed Need Projection Method (General Provision (f) ii and Step 2). No single project shall be considered simultaneously under both the CCRC statewide bed pool and the bed allocation of the Nursing Home Planning Area in which the project is located.

d. Home Health Agencies (HH)

Home health agency means an entity coordinating or providing the organized delivery of home health services.

Home health services means the provision of nursing services along with at least one other therapeutic service or with a supervised home health aide service to ill or disabled persons in their residences on a part-time or intermittent basis, as approved by a physician.

(1) The performance standards policies presented below are interim. The health planning system shall evaluate these standards and revise them as necessary, when data on the costs and use of home health services in the state are available.

(2) The following home health planning areas in each health planning region shall be used to determine population requirements for home health services:

Health Planning Region I

(a) Clallam/West Jefferson
(b) Whatcom
(c) Skagit
(d) San Juan
(e) Island (minus Camano Island)
(f) East Jefferson
(g) Snohomish/Camano Island
(h) King
(i) Pierce
(j) Kitsap

Health Planning Region II

(a) Grays Harbor/Pacific
(b) Thurston/Mason
(c) Lewis
(d) Cowlitz/Wahkiakum
(e) Clark/Skamania/Klickitat

Health Planning Region III

(a) Okanogan
(b) Chelan/Douglas
(c) Kittitas/Yakima
(d) Grant
(e) Benton/Franklin

Health Planning Region IV

(a) Ferry/Stevens/Pend Oreille
(b) Lincoln/Adams
(c) Spokane
(d) Walla Walla/Columbia
(e) Garfield/Asotin/Whitman

(3) The total annual number of home health visits needed in a home health planning area in the next year shall be estimated using the Interim Home Health Agency Need

Estimation Method described below. As utilization data become available, estimates used in this method shall be evaluated and adjusted.

(People under 65 x .005) x 10 visits
+ (People 65-79 x .044) x 14 visits
+ (People 80+ x .183) x 21 visits

= TOTAL VISITS

(4) The appropriate number of home health agencies in each home health planning area shall be determined based on the following policies:

(a) For planning purposes ten thousand (10,000) home health agency visits shall be considered to be the target minimum operating volume for a home health agency.

(b) Two home health agencies may be permitted in each home health planning area to allow competition and consumer choice. Where the projected aggregate need is less than 10,000 visits per year, the burden of proof shall be on a proposed new home health agency to demonstrate that competing agencies will result in greater levels of efficiency, effectiveness and equity in such an environment. In this regard, they shall address at least the considerations in Policies (5)(a)-(g) below.

(c) The maximum number of home health agencies permitted in a home health planning area shall not exceed the number of agencies derived by dividing the visits estimated under Step 3 above by the number 10,000.*

(d) For the purpose of determining the need for additional home health agencies in a home health planning area, existing home health agencies in the planning area are those agencies which can serve the area without further state approval and which provide service use and cost data requested by the health planning system.

(5) Considerations for which preference may be given in reviewing competing proposals to meet a limited need in a planning area are presented below. Preference shall be given to the project that meets the greatest number of the following criteria for preference:

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*Note: Fractional numbers derived under this calculation would be rounded down to the nearest whole number.

(a) The proposed agency will meet state certification requirements.

(b) The proposed agency will serve either directly or through formal agreements with other providers the entire planning area in which it is proposed to be located.

(c) The proposed agency has a written policy and budget to serve clients without regard to their source of payment.

(d) The agency has a lower charge per visit compared to similarly-organized agencies providing comparable services in the home health planning area. "Organization" refers to whether the agency is freestanding or hospital-based.

(e) The agency assures continuity of care by having documented formal linkages to other levels of care.

(f) The agency has arrangements to provide charity care to clients who are unable to pay for services.

(g) The agency demonstrates a mechanism for measuring and responding to community concerns.

e. Hospice Services (HS)

Hospice means a private or public agency or part thereof that administers or provides hospice care.

Hospice care means care supervised by the attending physician and provided by the hospice to the terminally ill. Hospice care is primarily palliative or medically necessary care provided by a hospice multidisciplinary team with care available 24 hours per day 7 days a week.

Hospice multidisciplinary teams means a team of individuals that provides or supervises care and services offered by the hospice and that is composed of at least a physician (consultant), registered nurse, social worker, and a pastoral, spiritual or other counselor.

Hospice services are provided in a coordinated program of care organized for the purpose of providing palliative and supportive care which is designed to meet the psychosocial, psychological, and spiritual needs of patients and their families (which includes those persons related by blood, marriage, or other significant relationship as designated by the patient). Bereavement services are an essential part of hospice care.

Exhibit 8

Net Need Sources

Table. 8

Public Disclosure Request - Organizations

Lists the Credential #, Credential Status, First Issuance Date, Effective Date, Expiration Date, Facility Name, Site and Mailing Addresses, Counties, and Emails, Site Phone # and Secretary of State #. 07/21/17

Filtered By:

Boards = All Boards

Credential Type = IHS - In Home Services Agency License

Credential Status = ACTIVE,ACTIVE IN RENEWAL,ACTIVE NOT RENEWABLE,ACTIVE ON PROBATION,ACTIVE PRINT LICENSE,ACTIVE PROVISIONAL,ACTIVE WITH CONDITIONS,ACTIVE WITH RESTRICTIONS,APPROVED

Run Date = 9/22/2020

Number of records = 444

Credential #	Status	First Issuance Date	Effective Date	Expiration Date	Facility Name	Site Attention	Site Address 1	Site Address 2	Site City	Site State	Site Zip Code	Site County	Site Email Address	Site Phone #	Mail Attention	Mail Address1	Mail Address2	Mail City	Mail State	Mail Zip	Mail County	Mail Email Address	Secretary of State #	Contact Name	Contact Email
IHS.FS.00000201	ACTIVE		03/01/2020	02/28/2022	A and B Healthcare and Staffing		1025 S 320th St Ste 101		Federal Way	WA	98003-5348	King	abhomecare@msn.com	(253) 874-3333		1025 S 320th St Ste 101		Federal Way	WA	98003-5348	King	abhomecare@msn.com	602084431	A and B Healthcare and Staffing Inc	abhomecare@msn.com
IHS.FS.60844133	ACTIVE	06/28/2018	06/29/2019	06/28/2021	A and K Health Care Services LLC		13810 Tukwila International Blvd		Tukwila	WA	98168-3169	King	kadracadey80@gmail.com	(206) 489-8775		13810 Tukwila International Blvd		Tukwila	WA	98168-3169	King	kadracadey80@gmail.com	604165084	A and K Health Care Services LLC	kadracadey80@gmail.com
IHS.FS.60428919	ACTIVE	11/07/2013	02/01/2020	01/31/2022	A Better Solution In-Home Care		9522 271st St NW		Stanwood	WA	98292-8095	Snohomish		(360) 629-4510		9522 271st St NW		Stanwood	WA	98292-8095	Snohomish		603336872	SC Beholdings LLC	shawn@abettersolutionhc.com
IHS.FS.00000039	ACTIVE	01/01/2003	12/01/2018	11/30/2020	A Helping Hand		2407 6th Ave		Tacoma	WA	98406-7703	Pierce	steven@ahelpinghandnw.com	(206) 686-7440		2407 6th Ave		Tacoma	WA	98406-7703	Pierce	steven@ahelpinghandnw.com	602319233	A Helping Hand Inc	kim.m@ahelpinghandnw.com
IHS.FS.60803191	ACTIVE	03/27/2019	03/28/2020	03/27/2022	A Kind Heart Home Care Services		23005 76th Ave W		Edmonds	WA	98026-8701	Snohomish	winnah@akindheartinc.com	(206) 795-3399		23005 76th Ave W		Edmonds	WA	98026-8701	Snohomish	winnah@akindheartinc.com	602556238	A Kind Heart Inc.	winnah@akindheartinc.com
IHS.FS.00000219	ACTIVE		02/01/2020	01/31/2022	A-One Home Care		3114 Oakes Ave		Everett	WA	98201-4406	Snohomish	lmblack117@yahoo.com	(425) 252-8518		3114 Oakes Ave		Everett	WA	98201-4406	Snohomish	lmblack117@yahoo.com	601083955	A-One Medical Services Inc	lmblack117@yahoo.com
IHS.FS.00000218	ACTIVE		11/01/2019	10/31/2021	A.N.S.		1029 Main St		Lewiston	ID	83501-1841	Nez Perce	bierb@ansidaho.com	(208)746-3050		1029 Main St		Lewiston	ID	83501-1841	Nez Perce	bierb@ansidaho.com	601741653	Alternative Nursing Services	beierb@ansidaho.com
IHS.FS.60721619	ACTIVE	01/27/2017	01/28/2020	01/27/2022	AAging Better In-Home Care		1014 N Pines Rd Ste 110		Spokane Valley	WA	99206-6144	Spokane	bweaver@aagingbetter.com	(509) 464-2344		1014 N Pines Rd Ste 110		Spokane Valley	WA	99206-6144	Spokane	bweaver@aagingbetter.com	604057599	AAging Better In-Home Care LLC	bweaver@aagingbetter.com
IHS.FS.60901837	ACTIVE	03/11/2019	03/12/2020	03/11/2022	ABOVE Home Health		2962 Limited Ln NW Ste A		Olympia	WA	98502-4550	Thurston	nr98502@gmail.com	(443) 691-8922		2962 Limited Ln NW Ste A		Olympia	WA	98502-4550	Thurston	nr98502@gmail.com	604285791	ABOVE Home Health LLC	care@abovehh.com
IHS.FS.00000111	ACTIVE	01/01/2005	06/01/2020	05/31/2022	AccentCare of Washington		7100 Fort Dent Way Ste 275		Tukwila	WA	98188-7500	King	reenecowan@accentcare.com	(206) 748-7648		7100 Fort Dent Way Ste 275		Tukwila	WA	98188-7500	King	reenecowan@accentcare.com	602508224	AccentCare of Washington Inc	reenecowan@accentcare.com
IHS.FS.60034694	ACTIVE	09/25/2008	09/26/2019	09/25/2021	Accredo Health Group		22623 68th Ave S		Kent	WA	98032-1981	King	CorporateLicensing@AccredoHealth.com	(800) 647-2448		22623 68th Ave S		Kent	WA	98032-1981	King	lisa.diogo@accredohealth.com	601780032	Accredo Health Group Inc	Scott.Borland@AccredoHealth.com
IHS.FS.60631350	ACTIVE	03/15/2016	03/16/2019	03/15/2021	Acti-Kare Responsive In-Home Care		6431 NE Bothell Way Ste C		Kenmore	WA	98028	King	veronica.griffiths26@gmail.com			PO Box 2496		Woodinville	WA	98072-2496	King		603562836	Alpha Omega In Home Care Services LLC	vgriffiths@actikare.com
IHS.FS.00000205	ACTIVE	07/01/2002	01/01/2019	12/31/2020	Addus HomeCare		1121 N Argonne Rd Ste 210		Spokane Valley	WA	99212-2686	Spokane	mark.robinson@addus.com			2300 Warrenville Rd Ste 100		Downers Grove	IL	60515-1717	DuPage		601299559	Addus Healthcare Inc	natlcontracts@addus.com
IHS.FS.00000206	ACTIVE		02/29/2020	02/28/2022	Advanced Health Care		9116 Gravelly Lake Dr SW Ste B1		Tacoma	WA	98499-3148	Pierce	rbode@advanced-healthcare.com	(253)475-7744		9116 Gravelly Lake Dr SW Ste B1		Tacoma	WA	98499-3148	Pierce	rbode@advanced-healthcare.com	600527451	Advanced Health Care Inc	jferguson@advanced-healthcare.com
IHS.FS.60796898	ACTIVE	10/11/2017	09/01/2020	08/31/2022	Advanced Home Health Northwest of Wenatchee		681 Okanogan Ave Ste B		Wenatchee	WA	98801-3461	Chelan		(509) 665-7384		681 Okanogan Ave Ste B		Wenatchee	WA	98801-3461	Chelan		604052952	Wenatchee Home Health LLC	tcampbell@prestigecare.com
IHS.FS.00000156	ACTIVE	01/01/2006	01/01/2020	12/31/2021	AdvisaCare		4250 Aurora Ave N Ste A-108		Seattle	WA	98103-7396	King	lskogen@advisacare.com	(253) 922-5501		4234 Cascade Rd SE		Grand Rapids	MI	49546-8384	Kent	kjensen@advisacare.com	602586915	Advisacare Healthcare Solutions Inc	kjensen@advisacare.com
IHS.FS.60876117	ACTIVE	08/30/2018	08/31/2019	08/30/2021	Agape Healthcare Services LLC		240 Auburn Way S Ste 2A		Auburn	WA	98002-5452	King	agapehealthcareservicesllc@gmail.com	(253) 329-2441		240 Auburn Way S Ste 2A		Auburn	WA	98002-5452	King	agapehealthcareservicesllc@gmail.com	604046953	Agape Healthcare Services LLC	agapehealthcarenw@gmail.com
IHS.FS.60919147	ACTIVE	02/25/2019	02/26/2020	02/25/2022	Agape Home Care, LLC		1417 179th St SW		Lynnwood	WA	98037-4019	Snohomish	agapeeldercare@gmail.com	(425) 314-8120		1417 179th St SW		Lynnwood	WA	98037-4019	Snohomish	agapeeldercare@gmail.com	602954173	Agape Manor LLC	agapeeldercare@gmail.com
IHS.FS.60908890	ACTIVE	11/01/2018	11/02/2019	11/01/2021	Agape In Home Care		2018 156th Ave NE		Bellevue	WA	98007-3825	King	tim@agapeihc.com	(206) 790-7733		2018 156th Ave NE		Bellevue	WA	98007-3825	King	tim@agapeihc.com	604325894	Agape In Home Care LLC	tim@agapeihc.com
IHS.FS.60534639	ACTIVE	12/15/2015	12/16/2018	12/15/2020	Agape Pediatric In-Home Therapy		925 Stevens Dr Ste 1E		Richland	WA	99352-3523	Benton	alow@agapetherapywa.com	(509) 942-8474		1107 Bridle Dr		Richland	WA	99352-9687	Benton	alow@agapetherapywa.com	603437255	Agape Therapy Services PLLC	office@agapetherapywa.com
IHS.FS.60953087	ACTIVE	05/26/2020	05/26/2020	05/26/2021	Agilosi Home Care Services, LLC		10002 Aurora Ave N Ste 36 PMB 282		Seattle	WA	98133-9348	King	joshveve@agilosihc.com	(206) 353-8816		10002 Aurora Ave N Ste 36 PMB 282		Seattle	WA	98133-9348	King	joshveve@agilosihc.com	603367354	Agilosi Home Care Services, LLC	joshveve@agilosihc.com
IHS.FS.60620780	ACTIVE	04/20/2016	04/21/2019	04/20/2021	All About You Care LLC		5710 200th St SW Apt 107		Lynnwood	WA	98036-6254	Snohomish				PO Box 2142		Everett	WA	98213-0142	Snohomish		603531123	All About You Care LLC	sambakah@comcast.net
IHS.FS.00000226	ACTIVE		09/01/2020	08/31/2022	All Ways Caring HomeCare		924 S Pines Rd Ste 100		Spokane Valley	WA	99206-5423	Spokane	lbalo@rescare.com	(509) 847-0300		924 S Pines Rd Ste 100		Spokane Valley	WA	99206-5423	Spokane	lbalo@rescare.com	601882866	Res Care Washington Inc	valerieoliver@rescare.com
IHS.FS.60531646	ACTIVE	02/10/2015	12/01/2018	11/30/2020	Alleva Home Care		1420 5th Ave Ste 2200		Seattle	WA	98101-1346	King		(206) 957-1365		1420 5th Ave Ste 2200		Seattle	WA	98101-1346	King		603347061	Alleva Home Care	nisons@allevahomecare.org
IHS.FS.00000204	ACTIVE		06/01/2020	05/31/2022	Alliance Nursing		14615 NE North Woodinville Way Ste 108		Woodinville	WA	98072-8492	King	heathern@alliancenursing.com	(425) 483-3303		14615 NE North Woodinville Way Ste 108		Woodinville	WA	98072-8492	King	heathern@alliancenursing.com	601209611	Alliance Nursing Inc	heathern@alliancenursing.com
IHS.FS.60270777	ACTIVE	04/20/2012	04/21/2019	04/20/2021	Almost Angels Home Care Agency		5612 Ocean Beach Hwy Ste 102		Longview	WA	98632-6215	Cowlitz	elaine@almostangelshomecare.com	(360) 846-2393		5612 Ocean Beach Hwy Ste 102		Longview	WA	98632-6215	Cowlitz	elaine@almostangelshomecare.com	603156952	Almost Angels Home Care Agency LLC	almostangels1@gmail.com
IHS.FS.60793191	ACTIVE	09/07/2017	12/01/2018	11/30/2020	Alpha Home Health		10530 19th Ave SE Ste 201		Everett	WA	98208-4282	Snohomish	admin@islandshh.com	(360) 299-1302		10530 19th Ave SE Ste 201		Everett	WA	98208-4282	Snohomish	admin@islandshh.com	604158700	Glacier Peak Healthcare Inc.	admin@islandshh.com
IHS.FS.61032013	ACTIVE	04/21/2020	04/21/2020	04/21/2021	Alpha Hospice		10530 19th Ave SE Ste 201		Everett	WA	98208-4282	Snohomish	admin@islandshh.com	(360) 299-1302		10530 19th Ave SE Ste 201		Everett	WA	98208-4282	Snohomish	admin@islandshh.com	604158700	Glacier Peak Healthcare Inc.	admin@islandshh.com
IHS.FS.60134307	ACTIVE	03/04/2010	03/05/2019	03/04/2021	Always Best Care Senior Services		10324 Canyon Rd E Ste 208		Puyallup	WA	98373-1013	Pierce	pnatsiopoulos@abc-seniors.com	(253) 534-9596		10324 Canyon Rd E Ste 208		Puyallup	WA	98373-1013	Pierce	pnatsiopoulos@abc-seniors.com	602867285	Advocates Organizational Consulting LLC	pnatsiopoulos@abc-seniors.com
IHS.FS.60432843	ACTIVE	03/13/2014	03/14/2019	03/13/2021	Amada Senior Care		1135 3rd Ave Ste S101		Longview	WA	98632-3204	Cowlitz	chris.c@amadaseniorcare.com	(360) 952-3100		1135 3rd Ave Ste S101		Longview	WA	98632-3204	Cowlitz	chris.c@amadaseniorcare.com	603313862	Honor Senior Care LLC	kimberlee.c@amadaseniorcare.com
IHS.FS.61035006	ACTIVE	03/02/2020	03/02/2020	02/20/2022	Amedisys Home Health		1800 136th Pl Ste 100		Bellevue	WA	98005-2343	King	patricia.goff@amedisys.com	(425) 800-5557		1800 136th Pl Ste 100		Bellevue	WA	98005-2343	King	patricia.goff@amedisys.com	602749954	Amedisys Washington LLC	
IHS.FS.00000214	ACTIVE		12/01/2018	11/30/2020	American Healthcare Services		504 Broadway # A		Seattle	WA	98122-5394	King	americanhcs@gmail.com	(206) 839-1070		504 Broadway # A		Seattle	WA	98122-5394	King	americanhcs@gmail.com	602023107	American Healthcare Services Inc	americanhcs@gmail.com
IHS.FS.00000215	ACTIVE		09/01/2018	08/31/2020	Amicable Health Care		15220 32nd Ave S Ste B		Seatac	WA	98188-2179	King	adesoye@amicablehealth.net	(206) 246-0550		15220 32nd Ave S Ste B		Seatac	WA	98188-2179	King	adesoye@amicablehealth.net	601788680	Amicable Health Care Inc	support@amicablehealth.net
IHS.FS.60268554	ACTIVE	04/03/2012	04/04/2019	04/03/2021	Angel Senior Care		8512 N Wall St		Spokane	WA	99208-6164	Spokane	vaughn@angelseniorcare.org	(509) 326-4357		8512 N Wall St		Spokane	WA	99208-6164	Spokane	vaughn@angelseniorcare.org	603165643	Guardian Angel Home Care LLC	vaughn@angelseniorcare.com
IHS.FS.60776502	ACTIVE	09/21/2017	09/22/2020	09/21/2022	Angel Services		917 Crestview Dr		Selah	WA	98942-8866	Yakima	saintpatricksbaby@yahoo.com	(509) 480-1271		917 Crestview Dr		Selah	WA	98942-8866	Yakima	saintpatricksbaby@yahoo.com	603494553	Latour Melissa K and Nathan K	saintpatricksbaby@yahoo.com
IHS.FS.60403728	ACTIVE	03/11/2014	03/12/2019	03/11/2021	Annies Loving Care Agency		3709 146th St SE		Mill Creek	WA	98012-4261	Snohomish	info@anneslovingcare.com	(206) 550-8564		3709 146th St SE		Mill Creek	WA	98012-4261	Snohomish	info@anneslovingcare.com	603203094	Goni Silvana A and Ignatius Reza	info@anneslovingcare.com
IHS.FS.60135615	ACTIVE	03/04/2010	03/05/2019	03/04/2021	Anthony Care, LLC		5317 Atchinson Dr SE		Olympia	WA	98513-4532	Thurston	operations@anthonycare.com	(360) 918-1701		5317 Atchinson Dr SE		Olympia	WA	98513-4532	Thurston	operations@anthonycare.com	602970331	Anthony Care, LLC	operations@anthonycare.com
IHS.FS.60528197	ACTIVE	01/15/2015	01/16/2020	01/15/2022	Apogee Home Care		6009 Capitol Blvd SW Ste 103A		Tumwater	WA	98501-5295	Thurston	sarah@apogeehcp.com			PO Box 331		Aberdeen	WA	98520-0084	Grays Harbor		603432759	Apogee Healthcare Professionals LLC	sarah@apogeehcp.com
IHS.FS.00000221	ACTIVE		10/01/2020	09/30/2022	Apria Healthcare LLC		17890 NE Airport Way Ste 170		Portland	OR	97230-5397	Multnomah			Attn: Clinical Services - Licensing	26220 Enterprise Ct		Lake Forest	CA	92630-8405	Orange	ruth.bindrup@apria.com	600599301	Apria Healthcare LLC	Patricia.Mahon@apria.com
IHS.FS.00000222	ACTIVE		05/01/2020	04/30/2022	Apria Healthcare LLC		5102 20th St E Ste 103		Fife	WA	98424-1996	Pierce	patricia.mahon@apria.com		Attn: Clinical Services-Licensing	26220 Enterprise Ct		Lake Forest	CA	92630-8405	Orange		600599301	Apria Healthcare LLC	Patricia.Mahon@apria.com
IHS.FS.00000223	ACTIVE		05/01/2020	04/30/2022	Apria Healthcare LLC		411 E North Foothills Dr Ste 200		Spokane	WA	99207-2106	Spokane	ruth_bindrup@apria.com		Attn: Clinical Services - Licensing	26220 Enterprise Ct		Lake Forest	CA	92630-8405	Orange	ruth.bindrup@apria.com	600599301	Apria Healthcare LLC	Patricia.Mahon@apria.com
IHS.FS.00000227	ACTIVE		10/01/2019	09/30/2021	Ashley House		33811 9th Ave S		Federal Way	WA	98003-6707	King	kmaaz@ashleyhousekids.com	(253) 533-9050		33811 9th Ave S		Federal Way	WA	98003-6707	King	kmaaz@ashleyhousekids.com	601101059	The Ashley House	kmaaz@ashleyhousekids.com
IHS.FS.60497952	ACTIVE	09/10/2014	07/01/2020	06/30/2022	Assured Home Health		6100 219th St SW Ste 440		Mountlake Terrace	WA	98043-2222	Snohomish	lra@lchgroup.com			PO Box 51266		Lafayette	LA	70505-1266			603404396	LHCG LXIII LLC	dana.nelson@lhcgroup.com
IHS.FS.60214206	ACTIVE	04/01/2011	04/02/2020	04/01/2022	Assured Home Health		111 W North River Dr Ste 205		Spokane	WA	99201-3204	Spokane	lra@lchgroup.com			PO Box 51266		Lafayette	LA	70505-1266			603060013	Spokane Home Care Services LLC	justin_mathiason@chs.net
IHS.FS.60109573	ACTIVE	11/02/2009	11/03/2018	11/02/2020	Assured Home Health		111 W North River Dr Ste 204		Spokane	WA	99201-3204	Spokane	jodi.bordelon@lhcgroup.com			PO Box 51266		Lafayette	LA	70505-1266			602938091	Northeast Washington Home Health Inc	lra@lhcgroup.com
IHS.FS.60092413	ACTIVE	06/01/2012	06/01/2020	05/31/2022	Assured Home Health and Hospice		1417 S Pioneer Way		Moses Lake	WA	98837-2458	Grant	jodi.bordelon@lhcgroup.com			PO Box 51266		Lafayette	LA	70505-1266	Lafayette		602910663	Washington HomeCare and Hospice of Central Basin LLC	jodi.bordelon@lhcgroup.com
IHS.FS.00000229	ACTIVE		11/01/2019	10/31/2021	Assured Home Health and Hospice		1821 Cooks Hill Rd Ste 201 (Hospice)	1821 Cooks Hill Rd Ste 200(Home Health)	Centralia	WA	98531	Lewis	lra@lhcgroup.com			PO Box 51266	1821 Cooks Hill Rd Ste 200(Home Health)	Lafayette	LA	70505-1266			601741674	Northwest Healthcare Alliance Inc	jodi.bordelon@lhcgroup.com
IHS.FS.60097245	ACTIVE	07/14/2009	10/01/2019	09/30/2021	Astria Home Health		7 S 10th Ave		Yakima	WA	98902-3318	Yakima	ladonna_chambard@chs.net	(509) 575-5093		7 S 10th Ave		Yakima	WA	98902-3318	Yakima	ladonna_chambard@chs.net	602922173	Yakima HMA Home Health LLC	ladonna.chambard@hma.com
IHS.FS.60724314	ACTIVE	02/14/2017	02/15/2020	02/14/2022	Astria Sunnyside Home Health		812 Miller Ave Ste A		Sunnyside	WA	98944-2377	Yakima	brian.gibbons@astria.health	(509) 837-1375		812 Miller Ave Ste A		Sunnyside	WA	98944-2377	Yakima	brian.gibbons@astria.health	604060329	Sunnyside Home Health	brian.gibbons@astria.health
IHS.FS.60303710	ACTIVE	08/24/2012	08/25/2019	08/24/2021	At Home With Country Meadows		12169 Country Meadows Ln NW		Silverdale	WA	98383-9550	Kitsap		(360) 692-4480		12169 Country Meadows Ln NW		Silverdale	WA	98383-9550	Kitsap		603195296	Sante ILF Op Co LLC	kgeiger@encorecommunities.com
IHS.FS.00000099	ACTIVE	01/01/2004	11/01/2019	10/31/2021	Athena Home Care Services		7909 NE 13th Ave		Vancouver	WA	98665-9602	Clark	annie@athenahomecare.com			PO Box 65070		Vancouver	WA	98665-0003	Clark		602407472	Athena Home Care Services Inc	annie@athenahomecare.com
IHS.FS.60973773	ACTIVE	08/27/2019	08/28/2020	08/27/2022	Atomic Home Health		6204 Westport Ln		Pasco	WA	99301-7802	Franklin	atomichomehealth1@yahoo.com	(509) 528-1512		6204 Westport Ln		Pasco	WA	99301-7802	Franklin	atomichomehealth1@yahoo.com	604459750	Atomic Home Health, LLC	atomichomehealth1@yahoo.com
IHS.FS.00000231	ACTIVE		12/01/2019	11/30/2021	Avail Home Health		4706 W Nob Hill Blvd		Yakima	WA	98908-3744	Yakima	sheris@availhome.com	(509) 966-8000		4706 W Nob Hill Blvd		Yakima	WA	98908-3744	Yakima	sheris@availhome.com	601065245	Avail Home Health Inc	sheris@availhome.com
IHS.FS.00000344	ACTIVE		06/01/2020	05/31/2022	Aveanna Healthcare		1120 N Mullan Rd Ste 206		Spokane Valley	WA	99206-4074	Spokane	rseignemartin@pediatricohomecare.net		Attn: Licensing	400 Interstate North Pkwy SE Ste 1600		Atlanta	GA	30339-5047	Cobb		602135267	Pediatric Home Care, Inc	mglockling@ihpnet.com
IHS.FS.00000423	ACTIVE		07/01/2020	06/30/2022	Aveanna Healthcare		9105 NE Highway 99 Ste 202 Bldg A		Vancouver	WA	98665-8974	Clark	credentialing@aveanna.com			400 Interstate North Pkwy SE Ste 1600		Atlanta	GA	30339-5047	Cobb		601648771	Pediatric Services of America Inc	credentialing@aveanna.com
IHS.FS.00000422	ACTIVE		06/01/2020	05/31/2022	Aveanna Healthcare		9105 NE Highway 99 Ste 202 Bldg A		Vancouver	WA	98665-8974	Clark	credentialing@aveanna.com			400 Interstate North Pkwy SE Ste 1600		Atlanta	GA	30339-5047	Cobb		601648771	Pediatric Services of America Inc	credentialing@aveanna.com
IHS.FS.60510592	ACTIVE	11/25/2014	11/26/2019	11/25/2021	Aveanna Healthcare		7602 Bridgeport Way W Ste 2B		Lakewood	WA	98499-2415	Pierce	credentialing@aveanna.com			400 Interstate North Pkwy SE Ste 1600		Atlanta	GA	30339-5047	Cobb		601648771	Pediatric Services of America Inc	credentialing@aveanna.com

Public Disclosure Request - Organizations

Lists the Credential #, Credential Status, First Issuance Date, Effective Date, Expiration Date, Facility Name, Site and Mailing Addresses, Counties, and Emails, Site Phone # and Secretary of State #. 07/21/17

IHS.FS.61029809	ACTIVE	03/12/2020	03/12/2020	03/12/2021	B'Zoe Home Care Giving Services		17842 85th Pl NE		Bothell	WA	98011-1879	King	bzoehomecare@gmail.com			PO Box 50462		Bellevue	WA	98015-0462	King			603024728	B'Zoe Inc.	bzoehomecare@gmail.com
IHS.FS.00000232	ACTIVE		05/01/2020	04/30/2022	Bayview Retirement Community / Bayview Home Care		11 W Aloha St		Seattle	WA	98119-3743	King	jhart@bayviewmanor.org	(206) 284-7330		11 W Aloha St		Seattle	WA	98119-3743	King	jhart@bayviewmanor.org	578047760	Bayview Manor Homes	pyeo@bayviewseattle.org
IHS.FS.60674651	ACTIVE	08/22/2016	11/06/2019	08/22/2020	Beam for Seniors - Capital Place		700 Black Lake Blvd SW		Olympia	WA	98502-5086	Thurston	syliva-greene@beamforseniors.com	(360) 352-5056		700 Black Lake Blvd SW		Olympia	WA	98502-5086	Thurston	syliva-greene@beamforseniors.com	603610163	Beam Senior Care LLC	legal@holidaytouch.com
IHS.FS.00000233	ACTIVE		12/01/2019	11/30/2021	Beneficial In-Home Care Inc		706 N Maple St		Spokane	WA	99201-1873	Spokane		(509) 323-0390		706 N Maple St		Spokane	WA	99201-1873	Spokane		602022142	Beneficial In-Home Care Inc	jdivilbiss@comcast.net
IHS.FS.60828742	ACTIVE	02/07/2018	06/10/2019	06/09/2021	Best Adult Care HCA LLC		15564 8th Ave NE		Shoreline	WA	98155-6239	King	yavuukhulan68@yahoo.com	(206) 364-2140		15564 8th Ave NE		Shoreline	WA	98155-6239	King	yavuukhulan68@yahoo.com	604185001	Best Adult Care LLC	yavuukhulan68@yahoo.com
IHS.FS.60966822	ACTIVE	07/22/2020	07/22/2020	07/22/2021	Bethany Home Health LLC		1902 120th Pl SE Ste 201		Everett	WA	98208-6292	Snohomish	josephs@bethanynw.org	(425) 365-0549		1902 120th Pl SE Ste 201		Everett	WA	98208-6292	Snohomish	josephs@bethanynw.org	604419812	Bethany Home Health LLC	josephs@bethanynw.org
IHS.FS.60796599	ACTIVE	03/30/2018	03/31/2019	03/30/2021	Beyond Homecare LLC		14816 Tukwila International Blvd Ste 104		Tukwila	WA	98168-4329	King	beyondthehomecare@gmail.com	(206) 427-0108		10912 SE 250th Ct Unit B		Kent	WA	98030-6856	King		604158085	Beyond Homecare LLC	beyondhomecares@gmail.com
IHS.FS.60823718	ACTIVE	01/28/2019	01/29/2020	01/28/2022	Bobbi's Way In-Home Health Care		512 Cascade Ave Ste 100		Hood River	OR	97031-2126	Hood River	kcasey@bobbiswayinhomehealthcare.com	(541) 436-4515		1767 12th St Ste 324		Hood River	OR	97031-9531	Hood River		604121488	Bobbi's Way In-Home Health Care LLC	kcasey@bobbiswayinhomehealthcare.com
IHS.FS.60934498	ACTIVE	06/20/2019	06/21/2020	06/20/2022	Brightstar Care		120 15th St SE Ste 202		Puyallup	WA	98372-3796	Pierce	hayley.jones@brightstarcare.com			PO Box 112407		Tacoma	WA	98411-2407	Pierce		604341044	Haylo Care Inc.	hayley.jones@brightstarcare.com
IHS.FS.60298698	ACTIVE	09/13/2012	09/14/2019	09/13/2021	BrightStar Care N Seattle		14300 Greenwood Ave N Ste D		Seattle	WA	98133-6872	King	Kathy.Lyons@brightstarcare.com	(206) 777-1190		14300 Greenwood Ave N Ste D		Seattle	WA	98133-6872	King	Kathy.Lyons@brightstarcare.com	603190438	MKL Services LLC	Kathy.Lyons@brightstarcare.com
IHS.FS.60653551	ACTIVE	07/11/2016	07/12/2019	07/11/2021	BrightStar Care South Puget Sound		116 Lee St SE Ste C		Tumwater	WA	98501-6722	Thurston	shelly.forest@brightstarcare.com	(360) 915-6183		116 Lee St SE Ste C		Tumwater	WA	98501-6722	Thurston	shelly.forest@brightstarcare.com	603584297	S Forest Inc.	shelly.forest@brightstarcare.com
IHS.FS.60532952	ACTIVE	01/15/2015	05/01/2020	04/30/2022	Brookdale Home Health		19009 33rd Ave W Ste 330		Lynnwood	WA	98036-4741	Snohomish	donnis.evans@brookdale.com			111 Westwood Pl Ste 400		Brentwood	TN	37027-5057	Williamson		603462319	Brookdale Home Health LLC	jmcglasson@brookdale.com
IHS.FS.60770635	ACTIVE	07/31/2017	08/01/2020	07/31/2022	Building Blocks Pediatric Therapy		2261 Deer Pointe Dr		Clarkston	WA	99403-5005	Asotin	jamielarsen@buildingblockspt.com	(509) 499-3483		2261 Deer Pointe Dr		Clarkston	WA	99403-5005	Asotin	jamielarsen@buildingblockspt.com	603470216	Building Blocks Pediatric Therapy LLC	jamielarsen@buildingblockspt.com
IHS.FS.60823021	ACTIVE	02/23/2018	02/24/2019	02/23/2021	Capital Homecare Cooperative		407 4th Ave E Ste 201		Olympia	WA	98501-1108	Thurston	president@capitalhomecare.com			PO Box 6307		Olympia	WA	98507-6307	Thurston		604019139	Capital Homecare Cooperative	admin@capitalhomecare.coop
IHS.FS.60896224	ACTIVE	01/31/2019	02/01/2020	01/31/2022	Care and Care Healthcare LLC		11900 NE 1st St Ste 300		Bellevue	WA	98005-3049	King	info@newlighthealthcare.us	(425) 214-7467		11900 NE 1st St Ste 300		Bellevue	WA	98005-3049	King	info@newlighthealthcare.us	604233493	Care and Care Healthcare LLC	carehealthcare@gmx.com
IHS.FS.60442813	ACTIVE	03/31/2014	04/01/2019	03/31/2021	Care at Home of WA, Inc		5634 37th Ave SW		Seattle	WA	98126-2834	King	vanessa@careathomeseattle.com	(206) 937-3100		5634 37th Ave SW		Seattle	WA	98126-2834	King	vanessa@careathomeseattle.com	603345692	Care at Home of Washington Inc	vanessa@careathomeseattle.com
IHS.FS.60794508	ACTIVE	02/20/2018	02/21/2019	02/20/2021	Care Indeed Inc.		Lincoln Square South	10400 NE St	Seattle	WA	98101	King	deeb@careindeed.com			890 Santa Cruz Ave	10400 NE St	Menlo Park	CA	94025-4641	San Mateo		604155613	Care Indeed Inc.	deeb@careindeed.com
IHS.FS.00000241	ACTIVE		01/01/2020	12/31/2021	Care Plus Home Health and Training		1950 Pottery Ave Ste 160		Port Orchard	WA	98366-2593	Kitsap				3377 Bethel Rd SE #107, PMB 195		Port Orchard	WA	98366	Kitsap		602336066	Care Plus Home Health Inc	mycareplus@msn.com
IHS.FS.60016733	ACTIVE	07/09/2009	07/10/2019	07/09/2021	Care to Stay Home		12810 E Nora Ave Ste A-1		Spokane Valley	WA	99216-1045	Spokane	jayne@caretostayhome.com	(509) 340-1359		12810 E Nora Ave Ste A-1		Spokane Valley	WA	99216-1045	Spokane	jayne@caretostayhome.com	602808712	RJ Care Services LLC	rob@caretostayhome.com
IHS.FS.60103446	ACTIVE	06/17/2010	06/18/2019	06/17/2021	Careage At Home		14450 NE 29th Pl Ste 106		Bellevue	WA	98007-3697	King		(425) 519-1265		14450 NE 29th Pl Ste 106		Bellevue	WA	98007-3697	King		602869769	Careage At Home LLC	hvirani@careagehealth.com
IHS.FS.60007888	ACTIVE		10/01/2019	09/30/2021	Careage Home Health		14450 NE 29th Pl Ste 106		Bellevue	WA	98007-3697	King		(425) 519-1265		14450 NE 29th Pl Ste 106		Bellevue	WA	98007-3697	King		602727471	Careage Home Health LLC	tevans@careagehealthpierce.com
IHS.FS.60848148	ACTIVE	06/26/2018	06/27/2019	06/26/2021	Careage Home Health		4924 109th St SW		Lakewood	WA	98499-6822	Pierce	shayes@careage.com	(253) 240-4601		4924 109th St SW		Lakewood	WA	98499-6822	Pierce	shayes@careage.com	602727471	Careage Home Health LLC	tevans@careagehealthpierce.com
IHS.FS.00000243	ACTIVE		01/01/2019	12/31/2020	Careforce		19401 40th Ave W Ste 205		Lynnwood	WA	98036-5613	Snohomish	dmeinken@careforce.com	(425) 712-1999		19401 40th Ave W Ste 205		Lynnwood	WA	98036-5613	Snohomish	dmeinken@careforce.com	601903788	Careforce Inc	dmeinken@careforce.com
IHS.FS.60848537	ACTIVE	09/05/2018	09/06/2019	09/05/2021	Caregivers 4 Mom and Dad		1522 Bishop Rd # A		Chehalis	WA	98532-8710	Lewis	caregivers4mom.dad@gmail.com	(360) 996-4465		1522 Bishop Rd # A		Chehalis	WA	98532-8710	Lewis	caregivers4mom.dad@gmail.com	604206883	Kitchen, Betty Jo	caregivers4mom.dad@gmail.com
IHS.FS.00000244	ACTIVE		10/01/2019	09/30/2021	Caregivers Home Health Inc		622 E Front St		Port Angeles	WA	98362-3320	Clallam				PO Box 3157		Port Angeles	WA	98362-0341	Clallam		601738632	Caregivers Home Health Inc	accounting@caregiversonline.com
IHS.FS.60716334	ACTIVE	01/24/2017	08/22/2019	08/21/2021	Caring Hearts (DBA: Nova Lengkong)		1100 Bellevue Way NE Ste 8A-376		Bellevue	WA	98004	King	caringheartsdba@outlook.com	(425) 499-1880		1100 Bellevue Way NE Ste 8A-376		Bellevue	WA	98004	King	caringheartsdba@outlook.com	604026029	Nova Lengkong dba Caring Hearts	caringheartsdba@outlook.com
IHS.FS.61048466	ACTIVE	04/07/2020	04/07/2020	04/07/2021	Caring Hearts Agency		1537 Sacajawea Ave		Richland	WA	99352-8678	Benton	sherriparker59@hotmail.com	(509) 520-5922		1537 Sacajawea Ave		Richland	WA	99352-8678	Benton	sherriparker59@hotmail.com	603178327	Caring Hearts Agency LLC	sherriparker59@hotmail.com
IHS.FS.60576376	ACTIVE	09/18/2015	09/19/2020	09/18/2022	Casa Bella Home Care Services		3250 Airport Way S Ste 314		Seattle	WA	98134-2167	King				3250 Airport Way S Ste 314		Seattle	WA	98134-2167	King		603506512	Ellebron LLC	casabellahomecare@gmail.com
IHS.FS.00000246	ACTIVE		11/01/2018	10/31/2020	Cascade Home Care		1611 N State St		Bellingham	WA	98225-4602	Whatcom	gbeanblossom@ccssite.org	(360) 594-4216		1611 N State St		Bellingham	WA	98225-4602	Whatcom	gbeanblossom@ccssite.org	601139109	Cascade Connections	gbeanblossom@ccssite.org
IHS.FS.00000247	ACTIVE		09/01/2019	08/31/2021	Catholic Community Services		1323 Yakima Ave		Tacoma	WA	98405-4457	Pierce	PeterN@ccsww.org			PO Box 1235		Tacoma	WA	98401-1235	Pierce		601098379	Catholic Community Services of Western Washington	PeterN@ccsww.org
IHS.FS.00000248	ACTIVE		11/01/2019	10/31/2021	CDM Caregiving Services		2300 NE Andresen Rd		Vancouver	WA	98661-7310	Clark	info@cdmcaregiving.org	(360) 896-9695		2300 NE Andresen Rd		Vancouver	WA	98661-7310	Clark	info@cdmcaregiving.org	601135827	CDM Services	hjurczak@cdmltc.org
IHS.FS.00000250	ACTIVE		01/01/2020	12/31/2021	Central Washington Hospital Home Care Services		731 N Chelan Ave		Wenatchee	WA	98801-2026	Chelan	rebecca.davenport@confluencehealth.org		Attn: Compliance/Facility Licensing	PO Box 489		Wenatchee	WA	98807-0489	Chelan		048006501	Central Washington Health Services Assn	dixie.randall@cwhs.com
IHS.FS.61061395	ACTIVE	05/12/2020	05/12/2020	05/12/2021	CH Home Service LLC		6824 69th Pl NE		Marysville	WA	98270-7798	Snohomish	chhomeservicellc18@gmail.com	(425) 467-0123		6824 69th Pl NE		Marysville	WA	98270-7798	Snohomish	chhomeservicellc18@gmail.com	604304937	CH Home Service LLC	chhomeservicellc18@gmail.com
IHS.FS.00000456	ACTIVE		04/01/2020	03/31/2022	Chaplaincy Health Care		2108 W Entiat Ave		Kennewick	WA	99336-3000	Benton		(509) 783-7416		1480 Fowler St		Richland	WA	99352-4717	Benton	info@chaplaincyhealthcare.org	601128829	Tri-Cities Chaplaincy	info@tricitieschaplaincy.org
IHS.FS.60997294	ACTIVE	12/20/2019	12/20/2019	12/20/2020	Cherry Blossom Care		5614 73rd Ave NE		Marysville	WA	98270-8950	Snohomish	cherryblossominhomecare@gmail.com	(206) 326-0062		5614 73rd Ave NE		Marysville	WA	98270-8950	Snohomish	cherryblossominhomecare@gmail.com	602511451	Sahara Adult Family Home Inc.	balli196920@gmail.com
IHS.FS.00000252	ACTIVE		12/01/2019	11/30/2021	Chesterfield Health Services		703 Columbia St Ste 200		Seattle	WA	98104-1965	King	stella@chesterfieldhealth.com	(206) 838-6050		703 Columbia St Ste 200		Seattle	WA	98104-1965	King	stella@chesterfieldhealth.com	601701883	Chesterfield Services Inc	stella@chesterfieldhealth.com
IHS.FS.60506466	ACTIVE	11/26/2014	11/27/2019	11/26/2021	CHI Franciscan Health at Home		2901 Bridgeport Way W		University Place	WA	98466-4614	Pierce		(253) 543-7026		2901 Bridgeport Way W		University Place	WA	98466-4614	Pierce		603418789	CHI National Home Care	denise.hauck@chs.trihealth.com
IHS.FS.00000253	ACTIVE		10/01/2019	09/30/2021	Childrens Country Home		14643 NE 166th St		Woodinville	WA	98072-9013	King	diane@childrenscountryhome.org	(425) 806-9453		14643 NE 166th St		Woodinville	WA	98072-9013	King	diane@childrenscountryhome.org	601751853	Childrens County Home	diane@childrenscountryhome.org
IHS.FS.60959298	ACTIVE	02/25/2020	02/25/2020	02/25/2021	Childress Nursing Services		1015 Blaine Ave NE Unit A		Renton	WA	98056-8722	King	quianac@childressnursing.com	(206) 310-5101		PO Box 2031		Renton	WA	98056-0031	King		604143753	Childress Nursing Services LLC	quianac@childressnursing.com
IHS.FS.60450347	ACTIVE	04/24/2014	04/25/2019	04/24/2021	Chinook Home Health Care LLC		3311 W Clearwater Ave Ste C110		Kennewick	WA	99336-2944	Benton				3311 W Clearwater Ave Ste C110		Kennewick	WA	99336-2944	Benton		603355235	Chinook Home Health Care LLC	johannah@chinookhomehealthcare.com
IHS.FS.60064617	ACTIVE	02/01/2020	02/01/2020	01/31/2022	Circle Of Life Caregiver Cooperative		1155 N State St Ste 525		Bellingham	WA	98225-5045	Whatcom	joannmcnerthney@circleofifeco-op.com	(360) 647-1537		1155 N State St Ste 525		Bellingham	WA	98225-5045	Whatcom	joannmcnerthney@circleofifeco-op.com	602760033	Circle Of Life Caregiver Cooperative	kris@circleoflife.coop
IHS.FS.60899656	ACTIVE	10/02/2018	10/03/2019	10/02/2021	CLT at Home LLC		15640 NE Fourth Plain Blvd Ste 206		Vancouver	WA	98682-5141	Clark	connie.thompson@cltathome.com	(360) 713-6560		15640 NE Fourth Plain Blvd Ste 206		Vancouver	WA	98682-5141	Clark	connie.thompson@cltathome.com	604315524	CLT at Home LLC	connie.thompson@cltathome.com
IHS.FS.00000258	ACTIVE		10/01/2019	09/30/2021	Coastal Community Action Program		101 E Market St		Aberdeen	WA	98520-5208	Grays Harbor	info@coastalcap.org	(360) 533-5100		101 E Market St		Aberdeen	WA	98520-5208	Grays Harbor	info@coastalcap.org	600169316	Coastal Community Action Program	info@coastalcap.org
IHS.FS.60875683	ACTIVE	07/11/2018	07/12/2020	07/11/2022	Columbia River Home Health		7105 W Hood Pl Ste B201		Kennewick	WA	99336-6714	Benton	admin@columbiariverhh.com	(509) 591-4459		7105 W Hood Pl Ste B201		Kennewick	WA	99336-6714	Benton	admin@columbiariverhh.com	604283032	Iron Bridge Healthcare, Inc.	admin@columbiariverhh.com
IHS.FS.60203382	ACTIVE	02/14/2011	02/15/2020	02/14/2022	ComForCare Home Care		6407 NE 117th Ave Ste B		Vancouver	WA	98662-5520	Clark	vancouverwa@comforcare.com			PO Box 823155		Vancouver	WA	98682-0066	Clark		603058050	Captura 22 Inc	
IHS.FS.60917916	ACTIVE	03/06/2019	03/07/2020	03/06/2022	Comforcare Seattle/Bellevue		312 N 85th St # 102		Seattle	WA	98103-3659	King	scollins@comfortcare.com	(206) 347-3030		312 N 85th St # 102		Seattle	WA	98103-3659	King	scollins@comfortcare.com	604314544	Homestewards LLC	scollins@comforcare.com
IHS.FS.60918240	ACTIVE	01/25/2019	01/25/2020	01/25/2022	Comfort and Caring Home Care		5705 Evergreen Way		Everett	WA	98203-6030	Snohomish	jjagne@chccare.org			PO Box 2801		Everett	WA	98213-0801	Snohomish		604333009	Jagne, Jankeh	jjagne@cnccare.org
IHS.FS.60639401	ACTIVE	03/24/2017	03/25/2020	03/24/2022	Comfort At Home Homecare LLC		12330 Roosevelt Way NE Apt 202		Seattle	WA	98125-4845	King	frework68@gmail.com			PO Box 75512		Seattle	WA	98175-0512	King		603567992	Comfort At Home Home Care LLC	frework68@gmail.com
IHS.FS.60453361	ACTIVE	04/07/2014	04/08/2019	04/07/2021	Comfort Keepers		2958 Limited Ln NW Ste B		Olympia	WA	98502-4577	Thurston	cindyadkins@comfortkeepers.com	(360) 742-3773		2958 Limited Ln NW Ste B		Olympia	WA	98502-4577	Thurston	cindyadkins@comfortkeepers.com	603368158	Banda Enterprises LLC	cindyadkins@comfortkeepers.com
IHS.FS.00000260	ACTIVE		07/01/2019	06/30/2021	Comfort Keepers		1204 N Mullan Rd		Spokane Valley	WA	99206-4053	Spokane	bookkeeping@cksponkane.com	(509) 484-2345		1204 N Mullan Rd		Spokane Valley	WA	99206-4053	Spokane	bookkeeping@cksponkane.com	602161002	Davenkaren Enterprises Inc	darcyantles@comfortkeepers.com
IHS.FS.00000259	ACTIVE		06/01/2019	05/31/2021	Comfort Keepers		500 S 336th St Ste 204		Federal Way	WA	98003-6389	King	kimsanchez@comfortkeepers.com	(253) 945-1400		500 S 336th St Ste 204		Federal Way	WA	98003-6389	King	kimsanchez@comfortkeepers.com	602202259	Bianchi Home Care Inc	kimsanchez@comfortkeepers.com
IHS.FS.00000011	ACTIVE	01/01/2003	02/01/2020	01/31/2022	Comfort Keepers #438		3256 Chico Way NW		Bremerton	WA	98312-1322	Kitsap	kitsap@comfortkeepers.com	(360) 373-5678		3256 Chico Way NW		Bremerton	WA	98312-1322	Kitsap	kitsap@comfortkeepers.com	602252968	Woolford Services LLC	gm@woolfordsvcs.com
IHS.FS.60761607	ACTIVE	07/20/2018	07/21/2019	07/20/2021	Comforters Companions LLC		4231 L Pl NE		Auburn	WA	98002-7798	King	isioma.oluwabiyi@yahoo.com.uk	(206) 708-9773		4231 L Pl NE		Auburn	WA	98002-7798	King	isioma.oluwabiyi@yahoo.com.uk	604087630	Comforters Companions LLC	isioma.oluwabiyi@yahoo.co.uk
IHS.FS.60547198	ACTIVE	06/05/2015	06/06/2020	06/05/2022	Community Home Health and Hospice		3102 NE 134th St		Vancouver	WA	98686-2628	Clark				3102 NE 134th St		Vancouver	WA	98686-2628	Clark		601066671	Community Home Health and Hospice	cari.clizbe@chhh.org
IHS.FS.00000262	ACTIVE		05/01/2020	04/30/2022	Community Home Health and Hospice CHHH Community Home Care Hnsnice		1035 11th Ave		Longview	WA	98632-2505	Cowlitz	sdalton@chhh.org			PO Box 2067		Longview	WA	98632-8189	Cowlitz		601066671	Community Home Health and Hospice	cari.clizbe@chhh.org
IHS.FS.60304414	ACTIVE	07/30/2012	07/31/2019	07/30/2021	Community Support Solutions Inc		6628 212th St SW Ste 102		Lynnwood	WA	98036-7355	Snohomish	sean@cssow.org			PO Box 956		Conway	WA	98238-0901	Skagit		602355027	Community Support Solutions Inc	sean@cssow.org
IHS.FS.00000081	ACTIVE	01/01/2004	05/01/2019	04/30/2021	Companion Care		18680 142nd Ave NE		Woodinville	WA	98072-8521	King	merri@companioncareofwa.com	(425) 488-7575		18680 142nd Ave NE		Woodinville	WA	98072-8521	King	merri@companioncareofwa.com	602374888	Companion Care Incorporated	payroll@companioncareofwa.com
IHS.FS.60951079	ACTIVE	08/21/2019	08/21/2019	08/21/2020	Compassion First Healthcare LLC		9905 S 220th St		Kent	WA	98031-8113	King	compassionfirsthealthcare@gmail.com	(619) 371-8022		9905 S 220th St		Kent	WA	98031-8113	King	compassionfirsthealthcare@gmail.com	604258096	Compassion First Healthcare LLC	compassionfirsthealthcare@gmail.com
IHS.FS.60694750	ACTIVE	07/17/2018	07/18/2019	07/17/2021	Compassionate Senior Care LLC		11802 4th Ave W Apt D229		Everett	WA	98204-4949	Snohomish	chenny.t@gmail.com	(425) 626-5895		11802 4th Ave W Apt D229		Everett	WA	98204-4949	Snohomish	chenny.t@gmail.com	603603605	Compassionate Senior Care LLC	chenny.t@gmail.com
IHS.FS.00000264	ACTIVE		06/01/2019	05/31/2021	Concerned Citizens		945 S Forks Ave		Forks	WA	98331-9173	Clallam	lindamiddleton@concernedcitizensnw.org	(360) 374-9340		PO Box 1787		Forks	WA	98331-1787	Clallam		600600536	Concerned Citizens	lindamiddleton@concernedcitizensnw.org
IHS.FS.61058934	ACTIVE	06/25/2020	06/25/2020	06/25/2021	Continuum Care of King LLC		33305 1st Way S Ste B207		Federal Way	WA	98003-4554	King	sstern@continuumhospice.com			1000 SE Everett Mall Way Ste 402		Everett	WA	98208-2814	Snohomish		604361067	Continuum Care of King LLC	ckeith@continuumhospice.com

Public Disclosure Request - Organizations

Lists the Credential #, Credential Status, First Issuance Date, Effective Date, Expiration Date, Facility Name, Site and Mailing Addresses, Counties, and Emails, Site Phone # and Secretary of State #. 07/21/17

IHS.FS.61010090	ACTIVE	11/12/2019	11/12/2019	11/12/2020	Continuum Care of Snohomish LLC		1000 SE Everett Mall Way Ste 402		Everett	WA	98208-2814	Snohomish	info@continuumhospice.com	(425) 961-9500		1000 SE Everett Mall Way Ste 402		Everett	WA	98208-2814	Snohomish	info@continuumhospice.com	604173856	Continuum Care of Snohomish LLC	sstern@continuumhospice.com
IHS.FS.00000265	ACTIVE		02/29/2020	02/28/2022	Coram CVS/Specialty Infusion Services		14935 NE 87th St Ste 101		Redmond	WA	98052-2046	King	erik.heikkenen@coramhc.com			1 Cvs Dr # MC1160		Woonsocket	RI	02895-6146	Providence		601617839	Coram Alternate Site Services Inc	mclicensing@cvscaremark.com
IHS.FS.60277946	ACTIVE	03/20/2012	03/21/2019	03/20/2021	Coram CVS/Specialty Infusion Services		5511 E 3rd Ave		Spokane Valley	WA	99212-0726	Spokane	jodie.holba@coramhc.com	(303) 672-8631	Licensing Dept	1 Cvs Dr # MC1160		Woonsocket	RI	02895-6146	Providence		601617839	Coram Alternate Site Services Inc	mclicensing@cvscaremark.com
IHS.FS.00000266	ACTIVE		07/01/2020	06/30/2022	Coram Specialty Infusion Services, Inc.		7358 SW Durham Rd		Portland	OR	97224-7307	Washington	erik.heikkenen@coramhc.com	(303) 672-8631	Attn: Licensure and Certification	1 Cvs Dr # MC1160		Woonsocket	RI	02895-6146	Providence	erik.heikkenen@coramhc.com	601617839	Coram Alternate Site Services Inc	mclicensing@cvscaremark.com
IHS.FS.60852239	ACTIVE	04/24/2018	03/24/2019	03/23/2021	Critical Nurse Staffing LLC		295 Bradley Blvd Ste 101		Richland	WA	99352-4486	Benton	jamie.sharpe@cnscares.com	(509) 735-6440		1114 N 1st St Ste 200		Grand Junction	CO	81501-2150	Mesa		603144046	Critical Nurse Staffing LLC	jamie.sharpe@cnscares.com
IHS.FS.60871359	ACTIVE	07/31/2018	08/01/2019	07/31/2021	D.C.S. LLC		24502 98th Ave S		Kent	WA	98030-0004	King	johnnyandrewdavidson@gmail.com	(206) 619-1466		24502 98th Ave S		Kent	WA	98030-0004	King	johnnyandrewdavidson@gmail.com	604208996	D.C.S, LLC	johnnyandrewdavidson@gmail.com
IHS.FS.60907239	ACTIVE	01/09/2020	01/09/2020	01/09/2021	Day by Day Nursing Services		3241 34th Ave W		Seattle	WA	98199-2614	King	daybydaynursing@gmail.com			PO Box 99506		Seattle	WA	98139-0506	King		602489076	Jimenez, Angelina Espiritu	daybydaynursing@gmail.com
IHS.FS.60665846	ACTIVE	09/16/2016	09/17/2019	09/16/2021	Dementia Care Solutions		620 N Argonne Rd Ste 2		Spokane Valley	WA	99212-2792	Spokane	dementiacares14@gmail.com	(509) 443-4985		620 N Argonne Rd Ste 2		Spokane Valley	WA	99212-2792	Spokane	dementiacares14@gmail.com	603427263	Gladyannas LLC	nkbeach27@gmail.com
IHS.FS.60626874	ACTIVE	02/29/2016	03/01/2019	02/28/2021	Denali Care Services LLC		31620 23rd Ave S Ste 201		Federal Way	WA	98003-5132	King		(206) 212-6488		31620 23rd Ave S Ste 201		Federal Way	WA	98003-5132	King		603552157	Denali Care Services LLC	denalicare@gmail.com
IHS.FS.60876098	ACTIVE	09/20/2018	09/21/2019	09/20/2021	Dependable Staffing and Home Health Services		33305 1st Way S Ste B100		Federal Way	WA	98003-4545	King	madhuri@dependablestaffingagency.com	(888) 221-5151		33305 1st Way S Ste B100		Federal Way	WA	98003-4545	King	madhuri@dependablestaffingagency.com	602308469	Dependable Staffing Agency LTD	madhuri@dependablestaffingagency.com
IHS.FS.60803573	ACTIVE	12/04/2017	12/05/2018	12/04/2020	Divine Home Health Care Inc.		4555 NE 66th Ave		Vancouver	WA	98661-3181	Clark	mjonesrn11@gmail.com	(360) 341-2561		2210 W Main St Ste 107 #314		Battle Ground	WA	98604-4232	Clark		604169784	Divine Home Health Care Inc.	mjonesrn11@gmail.com
IHS.FS.60639353	ACTIVE	04/01/2016	04/02/2019	04/01/2021	DOTNE Home Care LLC		1020 A St SE Ste 6		Auburn	WA	98002-6063	King	dotnehomecare@gmail.com	(253) 737-5207		1020 A St SE Ste 6		Auburn	WA	98002-6063	King	dotnehomecare@gmail.com	603569557	DOTNE Home Care LLC	dotnehomecare@gmail.com
IHS.FS.60651755	ACTIVE	09/06/2016	09/07/2019	09/06/2021	Eden Home Care		316 E McLeod Rd Ste 101		Bellingham	WA	98226-6491	Whatcom	tnickolas@empres.com			4601 NE 77th Ave Ste 300		Vancouver	WA	98662-6736	Clark		603591861	EmpRes Home Care of Bellingham LLC	astrickland@empres.com
IHS.FS.60871865	ACTIVE	11/21/2018	11/22/2019	11/21/2021	Eden Home Health		Parkade Plaza, 733 7th Ave Ste 110		Kirkland	WA	98033	King	legal@empres.com			4601 NE 77th Ave Ste 300		Vancouver	WA	98662-6736	Clark		604069995	Eden Home Health of King County, LLC	legal@empres.com
IHS.FS.61014910	ACTIVE	03/12/2020	03/12/2020	03/12/2021	Eden Home Health		13305 E Trent Ave		Spokane Valley	WA	99216-1266	Spokane	legal@empres.com			4601 NE 77th Ave Ste 300		Vancouver	WA	98662-6736	Clark		604331802	Eden Home Health of Spokane County, LLC	legal@empres.com
IHS.FS.60491681	ACTIVE	07/24/2014	11/01/2018	10/31/2020	Eden Home Health		316 E McLeod Rd Ste 101		Bellingham	WA	98226-6491	Whatcom	tnickolas@empres.com			4601 NE 77th Ave Ste 300		Vancouver	WA	98662-6736	Clark		603375240	Empres Home Health of Bellingham LLC	pgroth@empres.com
IHS.FS.60001472	ACTIVE	02/28/2008	03/01/2019	02/28/2021	EKL Health		14941 NE 147th Ct		Woodinville	WA	98072-9010	King	eklhealth@yahoo.com	(425) 408-0008		14941 NE 147th Ct		Woodinville	WA	98072-9010	King	eklhealth@yahoo.com	602788240	EKL Health LLC	eklhealth@yahoo.com
IHS.FS.00000228	ACTIVE		07/01/2019	06/30/2021	Elder Options Affordable Home Care		872 15th Ave		Longview	WA	98632-2321	Cowlitz		(360) 636-1000		872 15th Ave		Longview	WA	98632-2321	Cowlitz		601823634	Retirement Resources Inc	nancy@elderoptions.org
IHS.FS.00000110	ACTIVE	01/01/2005	07/01/2020	06/30/2022	Elfin Services		7305 NE 4th Plain Blvd Ste B		Vancouver	WA	98662-7148	Clark	s.polkow@elfinservices.com	(360) 883-3569		7305 NE 4th Plain Blvd Ste B		Vancouver	WA	98662-7148	Clark	s.polkow@elfinservices.com	602152619	Elfin Services Inc	s.polkow@elfinservices.com
IHS.FS.60179243	ACTIVE	08/26/2010	08/27/2019	08/26/2021	Elite Elder Care INC		21812 NE 104th St		Vancouver	WA	98682-9772	Clark	eec.victoria@gmail.com			PO Box 873718		Vancouver	WA	98687-3718	Clark		603018774	Elite Elder Care Inc	eec.victoria@gmail.com
IHS.FS.00000276	ACTIVE		08/01/2019	07/31/2021	Elite Home Care Agency		14040 NE 8th St Ste 101		Bellevue	WA	98007-4122	King	elitehcl@msn.com	(425)957-2002		14040 NE 8th St Ste 101		Bellevue	WA	98007-4122	King	elitehcl@msn.com	602043172	Elite International LLC	elitezel@gmail.com
IHS.FS.60384078	ACTIVE	06/06/2013	05/01/2020	04/30/2022	Elite Home Health and Hospice		1370 Bridge St		Clarkston	WA	99403-2332	Asotin				PO Box 736		Clarkston	WA	99403-0736	Asotin		603266008	Alpowa Healthcare Inc	sosburn@elitehhh.com
IHS.FS.60817754	ACTIVE	04/16/2018	09/16/2019	04/16/2021	Elite Homecare Staffing Solutions LLC		4600 16th St E Apt B207		Fife	WA	98424-2668	Pierce	kariukimercy4@gmail.com	(253) 397-9058		4600 16th St E Apt B207		Fife	WA	98424-2668	Pierce	kariukimercy4@gmail.com	604185363	Elite Homecare Staffing Solutions LLC	elitess19@gmail.com
IHS.FS.60833183	ACTIVE	08/21/2019	08/22/2020	08/21/2022	Ellendee Healthcare Agency LLC		7200 W Nob Hill Blvd Ste 8		Yakima	WA	98908-1928	Yakima	ellendeeservices@gmail.com	(509) 899-7069		PO Box 8257		Yakima	WA	98908-0257	Yakima		604214724	Ellendee Healthcare Agency LLC	ellendeeservices@gmail.com
IHS.FS.60922864	ACTIVE	02/21/2019	02/22/2020	02/21/2022	Encore Home Health		12169 Country Meadows Ln NW		Silverdale	WA	98383-9550	Kitsap	ficek@santepartners.com	(360) 271-1873		12169 Country Meadows Ln NW		Silverdale	WA	98383-9550	Kitsap	ficek@santepartners.com	603567231	Encore Home Health, LLC	mhalverson@encorecommunities.com
IHS.FS.61090266	ACTIVE	08/14/2020	08/14/2020	08/14/2021	Enebray Care Services LLC		19306 8th Ave W		Lynnwood	WA	98036-4943	Snohomish	enebraycare@gmail.com			3715 196th St SW Unit 2695		Lynnwood	WA	98036-3227	Snohomish		604626116	Enebray Care Services LLC	enebraycare@gmail.com
IHS.FS.60689285	ACTIVE	01/09/2017	01/10/2020	01/09/2022	Energy Employee Home Health Services		5219 W Clearwater Ave Ste 7C		Kennewick	WA	99336-1914	Benton	admin@eehhs.com			12345 Lake City Way NE # 2163		Seattle	WA	98125-5401	King		603599255	Energy Employee Home Health Services LLC	admin@eehhs.com
IHS.FS.61055889	ACTIVE	05/21/2020	05/21/2020	05/21/2021	Enlightenment Home Care LLC		3609 Apollo St SE		Lacey	WA	98503-7135	Thurston	enlightenmenthomecare@gmail.com			PO Box 3007		Lacey	WA	98509-3007	Thurston		604581418	Enlightenment Home Care LLC	mrs.s.gay73@gmail.com
IHS.FS.60521160	ACTIVE	12/22/2014	12/23/2019	12/22/2021	Envision Home Health		1818 S Union Ave Ste 1A		Tacoma	WA	98405-1953	Pierce				1818 S Union Ave Ste 1A		Tacoma	WA	98405-1953	Pierce		603282417	Envision Home Health of Washington LLC	michele.gill@envhh.com
IHS.FS.60952486	ACTIVE	06/06/2019	06/07/2020	06/06/2022	Envision Hospice		402 Black Hills Ln SW Ste 402B		Olympia	WA	98502-8145	Thurston	roberta.carl@envhh.com	(360) 350-4875		402 Black Hills Ln SW Ste 402B		Olympia	WA	98502-8145	Thurston	roberta.carl@envhh.com	604174080	Envision Hospice of Washington, LLC	michele.gill@envhh.com
IHS.FS.60542868	ACTIVE	08/21/2015	03/08/2019	03/07/2021	Estelita Su Homecare		5701 Seaview Ave NW Apt 401		Seattle	WA	98107-3358	King		(206) 510-8902		5701 Seaview Ave NW Apt 401		Seattle	WA	98107-3358	King		603363998	Miraluna SU Ventures LLC	ms.miraluna@gmail.com
IHS.FS.00000278	ACTIVE		01/01/2020	12/31/2021	Evergreen Health		11800 NE 128th St Ste 200		Kirkland	WA	98034-7211	King		(425) 899-3300		11800 NE 128th St Ste 200		Kirkland	WA	98034-7211	King		600068426	King County Public Hospital District #2	
IHS.FS.60340573	ACTIVE	06/25/2013	06/26/2020	06/25/2022	Evergreen In Home Care LLC		17126 SE 29th Pl		Bellevue	WA	98008-5600	King				17126 SE 29th Pl		Bellevue	WA	98008-5600	King		603266773	Evergreen In Home Care LLC	evergreeninhomecare@gmail.com
IHS.FS.00000184	ACTIVE	01/01/2007	12/01/2019	11/30/2021	Everhome Healthcare		23607 Highway 99 Ste 3C		Edmonds	WA	98026-9272	Snohomish	jestrada@everhomehealthcare.com	(425) 275-5858		23607 Highway 99 Ste 3C		Edmonds	WA	98026-9272	Snohomish	jestrada@everhomehealthcare.com	602693339	CHC Services LLC	jestrada@chcservices.com
IHS.FS.60720360	ACTIVE	02/22/2017	02/23/2020	02/22/2022	Executive Care		13636 NE 100th Ct		Kirkland	WA	98033-5240	King	aarti.bindlish@gmail.com			10500 Valley View Rd Ste 101		Bothell	WA	98011-3206	King		604044968	Bindlish Home Care LLC	aarti.bindlish@executivehomecare.com
IHS.FS.60938634	ACTIVE	02/20/2019	02/20/2019	10/31/2020	Family First Senior Care		521 N Argonne Rd Ste B103		Spokane Valley	WA	99212-2867	Spokane	info@familyfirstseniorcare.com	(509) 326-5525		521 N Argonne Rd Ste B103		Spokane Valley	WA	99212-2867	Spokane	info@familyfirstseniorcare.com	604248455	VillagePlan Care Options LLC	william@villageplan.com
IHS.FS.60236440	ACTIVE	01/03/2012	01/04/2019	01/03/2021	Family Best Care LLC		11661 SE 1st St Ste 203		Bellevue	WA	98005-3526	King	info@familybestcare.com	(425) 647-8510		11661 SE 1st St Ste 203		Bellevue	WA	98005-3526	King	info@familybestcare.com	602703464	Family Best Care LLC	info@familybestcare.com
IHS.FS.00000008	ACTIVE	01/01/2002	01/01/2020	12/31/2021	Family Care Services		501 E McLoughlin Blvd		Vancouver	WA	98663-3356	Clark	scott@familycareser.com	(360)546-5566		501 E McLoughlin Blvd		Vancouver	WA	98663-3356	Clark	scott@familycareser.com	602242773	Family Care Services Inc	
IHS.FS.60857773	ACTIVE	05/23/2018	08/01/2019	07/31/2021	Family Resource Home Care		10700 Meridian Ave N Ste 215		Seattle	WA	98133-9008	King	jeff.wiberg@fhccares.com	(206) 545-1092		10700 Meridian Ave N Ste 215		Seattle	WA	98133-9008	King	jeff.wiberg@fhccares.com	604180775	Geras LLC	jeffw@familyrhc.com
IHS.FS.61028960	ACTIVE	12/13/2019	12/13/2019	11/30/2021	Fedelta Care Solutions		155 NE 100th St Ste 200		Seattle	WA	98125-8015	King	smeyer@fedeltahomecare.com	(206) 362-2366		155 NE 100th St Ste 200		Seattle	WA	98125-8015	King	smeyer@fedeltahomecare.com	602891532	Fedelta Home Care LLC	smeyer@fedeltahomecare.com
IHS.FS.60722673	ACTIVE	05/15/2017	05/16/2020	05/15/2022	Fidelity HomeCare		12720 NE 97th Pl		Kirkland	WA	98033-5200	King	heryhlee@yahoo.com			PO Box 295		Mountlake Terrace	WA	98043-0295	Snohomish		604072838	Fidelity Home Care LLC	heryhlee@yahoo.com
IHS.FS.60890417	ACTIVE	10/10/2018	10/11/2019	10/10/2021	Find Us at Home		1220 Main St Ste 400		Vancouver	WA	98660-2963	Clark	loren@finadusathomewa.com	(360) 989-9197		1220 Main St Ste 400		Vancouver	WA	98660-2963	Clark	loren@finadusathomewa.com	603152363	Find Us at Home LLC	mariann@findusathomewa.com
IHS.FS.00000283	ACTIVE		06/01/2019	05/31/2021	First Choice In-Home Care		15015 Main St Ste 209		Bellevue	WA	98007-5224	King	jim@fcihc.com	(425) 747-5000		15015 Main St Ste 209		Bellevue	WA	98007-5224	King	jim@fcihc.com	602154094	First Choice In-Home Care Inc	jim@fcihc.com
IHS.FS.60513347	ACTIVE	01/20/2015	01/21/2020	01/20/2022	First Light Home Care - South Sound		921 Lakeridge Way SW Ste 203		Olympia	WA	98502-6081	Thurston		(360) 489-1621		921 Lakeridge Way SW Ste 203		Olympia	WA	98502-6081	Thurston		603431168	The Fidelis Group Inc.	slane@firstlighthomecare.com
IHS.FS.60972682	ACTIVE	12/04/2019	12/04/2019	12/04/2020	First Light Homecare of Spokane and Coeur d'Alene		916 W Ironwood Dr Ste 4		Coeur D Alene	ID	83814-4927	Kootenai	mzastrow@firstlighthomecare.com	(208) 758-8090		916 W Ironwood Dr Ste 4		Coeur D Alene	ID	83814-4927	Kootenai	mzastrow@firstlighthomecare.com	604447606	3 and 1, LLC	mzastrow@firstlighthomecare.com
IHS.FS.00000287	ACTIVE		05/01/2020	04/30/2022	Franciscan Hospice and Pallative Care		2901 Bridgeport Way W		University Place	WA	98466-4614	Pierce		(253) 534-7064		2901 Bridgeport Way W		University Place	WA	98466-4614	Pierce		278002934	Franciscan Health System	karenlea@chifranciscan.org
IHS.FS.60417479	ACTIVE	11/06/2013	11/07/2018	11/06/2020	Freedom Independent Living Home Care Inc		14813 41st Ave W		Lynnwood	WA	98087-5574	Snohomish	ron@freedomhomecare.info	(425) 221-9848		14813 41st Ave W		Lynnwood	WA	98087-5574	Snohomish	ron@freedomhomecare.info	603318465	Freedom Independent Living Home Care Inc	ron@freedomhomecare.info
IHS.FS.60379608	ACTIVE	06/07/2013	06/01/2020	05/31/2022	Frontier Home Health and Hospice		800 Jasmine St Ste 2		Omak	WA	98841-9501	Okanogan	jgessford@frontierhhh.com	(509) 422-8621		800 Jasmine St Ste 2		Omak	WA	98841-9501	Okanogan	jgessford@frontierhhh.com	603286069	Frontier Home Health and Hospice LLC	jgessford@frontierhhh.com
IHS.FS.60379644	ACTIVE	06/07/2013	06/01/2020	05/31/2022	Frontier Home Health and Hospice		800 Jasmine St Ste 2		Omak	WA	98841-9501	Okanogan	jgessford@frontierhhh.com	(509) 422-8621		800 Jasmine St Ste 2		Omak	WA	98841-9501	Okanogan	jgessford@frontierhhh.com	603286069	Frontier Home Health and Hospice LLC	jgessford@frontierhhh.com
IHS.FS.00000275	ACTIVE		08/01/2019	07/31/2021	Full Life Care		800 Jefferson St Ste 620		Seattle	WA	98104-2421	King		(206) 467-7033		800 Jefferson St Ste 620		Seattle	WA	98104-2421	King		601132013	Full Life Care	renamf@fulllifecare.org
IHS.FS.60961245	ACTIVE	06/03/2020	06/03/2020	06/03/2021	Fullcare at Home L.L.C.		14536 31st Ave NE		Shoreline	WA	98155-7518	King	fullcareathome@gmail.com	(206) 458-4066		14536 31st Ave NE		Shoreline	WA	98155-7518	King	fullcareathome@gmail.com	604422918	Fullcare at Home L.L.C.	redietm87@gmail.com
IHS.FS.60603640	ACTIVE	12/04/2015	12/05/2018	12/04/2020	Generations Home Care		6430 Tacoma Mall Blvd Ste 201		Tacoma	WA	98409-6727	Pierce	jtg@generationshomecare.org	(253) 693-4092		6430 Tacoma Mall Blvd Ste 201		Tacoma	WA	98409-6727	Pierce	jtg@generationshomecare.org	603231064	Madrona Peak LLC	jtg@generationshomecare.org
IHS.FS.60720687	ACTIVE	03/19/2018	03/20/2019	03/19/2021	Goldencare Home Health Agency		10126 NE 141st Pl		Kirkland	WA	98034-5281	King	laurabidnan@live.com	(206) 372-9712		10126 NE 141st Pl		Kirkland	WA	98034-5281	King	laurabidnan@live.com	604042902	Goldencare Agency LLC	laurabidnan@live.com
IHS.FS.61078336	ACTIVE	08/03/2020	08/03/2020	08/03/2021	Goldencare Homecare LLC		13415 117th Avenue Ct E		Puyallup	WA	98374-3173	Pierce	goldencarehomecare@gmail.com	(206) 331-8589		13415 117th Avenue Ct E		Puyallup	WA	98374-3173	Pierce	goldencarehomecare@gmail.com	604582142	Goldencare Homecare LLC	goldencarehomecare@gmail.com
IHS.FS.00000078	ACTIVE	01/01/2004	04/01/2019	03/31/2021	Good To Be Home Care		8903 Gravelly Lake Dr SW		Tacoma	WA	98499-3149	Pierce	mail@goodtobehomecare.com	(253) 588-4344		8903 Gravelly Lake Dr SW		Tacoma	WA	98499-3149	Pierce	mail@goodtobehomecare.com	602374948	Good To Be Home Care LLC	mail@goodtobehomecare.com
IHS.FS.60332097	ACTIVE	02/13/2013	02/14/2020	02/13/2022	Griswold Home Care		4 102nd Ave NE		Bellevue	WA	98004-5621	King	ken.krajewski@griswoldhomecare.com			PO Box 22		Bellevue	WA	98009-0022	King		602420741	SK Management Services, LLC	ken.krajewski@griswoldhomecare.com
IHS.FS.60266397	ACTIVE	03/07/2012	03/08/2019	03/07/2021	Guardian Home Care		3560 Bridgeport Way W Ste 3A		University Place	WA	98466-4446	Pierce	paulette.f@amadaseniorcare.com	(253) 881-0014		3560 Bridgeport Way W Ste 3A		University Place	WA	98466-4446	Pierce	paulette.f@amadaseniorcare.com	603163787	Guardian Home Care Inc	paulette.f@amadaseniorcare.com
IHS.FS.60259579	ACTIVE	04/20/2012	04/21/2019	04/20/2021	Guest Home Care		7704 63rd Dr NE		Marysville	WA	98270-3328	Snohomish	brucevisitor@gmail.com	(425) 268-7988		7704 63rd Dr NE		Marysville	WA	98270-3328	Snohomish	brucevisitor@gmail.com	601397763	Guest Bruce G	brucevisitor@gmail.com
IHS.FS.61049854	ACTIVE	04/13/2020	04/13/2020	04/13/2021	Hanford Home Health		78058 Country Heights Dr		Kennewick	WA	99338-5036	Benton	charminern@gmail.com			78058 Country Heights Dr		Kennewick	WA	99338-5036	Benton	charminern@gmail.com	604556661	Atomic Health Management PLLC	charminern@gmail.com
IHS.FS.60992210	ACTIVE	11/26/2019	11/26/2019	11/26/2020	Happy Quest LLC		1400 112th Ave SE Ste 100		Bellevue	WA	98004-6901	King	sammy19@happyquest.com			2018 156th Ave NE		Bellevue	WA	98007-3825	King		604463658	Happy Quest LLC	sammuelmakathimo18@gmail.com
IHS.FS.60892797	ACTIVE	04/16/2019	04/17/2020	04/16/2022	Harbor Health Solutions LLC		2417 Pacific Ave SE Ste D		Olympia	WA	98501-2052	Thurston	equip1@live.com	(360) 952-5252		2417 Pacific Ave SE Ste D		Olympia	WA	98501-2052	Thurston	equip1@live.com	604292668	Harbor Health Solutions LLC	equip1@live.com
IHS.FS.00000306	ACTIVE		09/01/2019	08/31/2021	Harbors Home Health and Hospice		201 7th St		Hoquiam	WA	98550-2506	Grays Harbor	joel@myhhhh.org	(360) 532-5454		201 7th St		Hoquiam	WA	98550-2506	Grays Harbor	joel@myhhhh.org	600437574	Harbors Home Health and Hospice	joel@myhhhh.org
IHS.FS.00000153	ACTIVE	01/01/2006	10/01/2019	09/30/2021	Harvard Partners Home Health		1606 8th Ave N		Seattle	WA	98109-3006	King	contact@harvardpartners.org	(425) 822-6979		1606 8th Ave N		Seattle	WA	98109-3006	King	contact@harvardpartners.org	602513161	Harvard Partners LLC	contact@harvardpartners.org
IHS.FS.60880389	ACTIVE	09/05/2018	12/16/2018	12/15/2020	Haven Home Health Care		750 Swift Blvd Ste 1		Richland	WA	99352-3521	Benton	kevin@havenhhc.com			885 Penniman Ave Unit 6426		Plymouth	MI	48170-7722	Wayne		604232251	Atlantic Home Health Care LLC	kevin@havenhhc.com
IHS.FS.60153626	ACTIVE	05/20/2010	05/21/2019	05/20/2021	Haven in Allyn Home Care		180 E Wheelright St		Allyn	WA	98524-8716	Mason	haveninallyn@yahoo.com			PO Box 928		Allyn	WA	98524-0928	Mason	haveninallyn@yahoo.com	602892747	Haven in Allyn Home Care LLC	haveninallyn@yahoo.com

Public Disclosure Request - Organizations

Lists the Credential #, Credential Status, First Issuance Date, Effective Date, Expiration Date, Facility Name, Site and Mailing Addresses, Counties, and Emails, Site Phone # and Secretary of State #. 07/21/17

IHS.FS.00000308	ACTIVE		09/01/2019	08/31/2021	Havenwood Caregiver Services		303 E Wellesley Ave		Spokane	WA	99207-1578	Spokane	bpierce@havenwoodhomecare.com	(509) 535-1546		303 E Wellesley Ave		Spokane	WA	99207-1578	Spokane	bpierce@havenwoodhomecare.com	602513639	Okeeffe Enterprises LLC	jokeeffe@havenwoodhomecare.com
IHS.FS.00000309	ACTIVE		10/01/2020	09/30/2022	Health People		1600 124th Ave NE Ste B		Bellevue	WA	98005-2132	King	ekehm@healthpeople.com	(425) 454-1947		1600 124th Ave NE Ste B		Bellevue	WA	98005-2132	King	ekehm@healthpeople.com	601790637	Health People Inc	ekehm@healthpeople.com
IHS.FS.60814521	ACTIVE	07/30/2018	07/31/2019	07/30/2021	Healthy Living at Home - Vancouver LLC		1499 SE Tech Center Pl Ste 140		Vancouver	WA	98683-9575	Clark	gschackmann@healthylivinq-vancouver.com	(800) 746-1051		1499 SE Tech Center Pl Ste 140		Vancouver	WA	98683-9575	Clark	gschackmann@healthylivinq-vancouver.com	604056062	Healthy Living at Home - Vancouver LLC	Gschackmann@healthylivinq-portland.com
IHS.FS.61048459	ACTIVE	07/08/2020	07/08/2020	07/08/2021	Heart 2 Heart Homecare LLC		16300 Ordway Dr SE		Yelm	WA	98597-9462	Thurston	heart2hearthomecare2020@gmail.com	(360) 960-1997		16300 Ordway Dr SE		Yelm	WA	98597-9462	Thurston	heart2hearthomecare2020@gmail.com	604574356	Heart 2 Heart Homecare LLC	heart2hearthomecare2020@gmail.com
IHS.FS.60741443	ACTIVE	04/10/2017	01/01/2019	12/31/2020	Heart of Hospice		407 Portway Ave Ste 201		Hood River	OR	97031-1182	Hood River	steveymorris77@gmail.com	(541) 386-1942		407 Portway Ave Ste 201		Hood River	OR	97031-1182	Hood River	steveymorris77@gmail.com	604096082	Inspiring Hospice Partners of Oregon LLC	steve.morris@inspiringhospice.com
IHS.FS.00000369	ACTIVE		08/01/2019	07/31/2021	Heartlinks Hospice and Palliative Care		3920 Outlook Rd		Sunnyside	WA	98944-9202	Yakima		(509) 837-1673		3920 Outlook Rd		Sunnyside	WA	98944-9202	Yakima		601135790	Heartlinks	shelby@heartlinkshospice.org
IHS.FS.60951070	ACTIVE	05/10/2019	05/11/2020	05/10/2022	Here to Help HomeCare, LLC		16815 N Mayfair Dr		Colbert	WA	99005-9227	Spokane	here2helphomecare@gmail.com	(509) 710-6034		16815 N Mayfair Dr		Colbert	WA	99005-9227	Spokane	here2helphomecare@gmail.com	604388160	Here to Help HomeCare, LLC	here2helphomecare@gmail.com
IHS.FS.60651003	ACTIVE	04/15/2016	12/01/2018	11/30/2020	Home and About		15125 Highway 99 Ste A		Lynnwood	WA	98087-2319	Snohomish		(425) 775-2676		15125 Highway 99 Ste A		Lynnwood	WA	98087-2319	Snohomish		603600043	Home and About Senior Care Inc.	randi@homeandabout.com
IHS.FS.00000032	ACTIVE	01/01/2003	02/27/2019	02/26/2021	Home Angels		18623 36th Ave W Apt K203		Lynnwood	WA	98037-7679	Snohomish	siyayo2@aol.com	(206) 322-1801		18623 36th Ave W Apt K203		Lynnwood	WA	98037-7679	Snohomish	siyayo2@aol.com	602647350	Miguel Racelis Corporation	siyayo2@aol.com
IHS.FS.00000319	ACTIVE		05/01/2020	04/30/2022	Home Attendant Care		1151 Ellis St Ste 204		Bellingham	WA	98225-5203	Whatcom	debbie@homeattendantcare.com	(360) 734-3849		1151 Ellis St Ste 204		Bellingham	WA	98225-5203	Whatcom	debbie@homeattendantcare.com	600563516	Home Attendant Care Inc	debbie@homeattendantcare.com
IHS.FS.60618287	ACTIVE	11/30/2015	12/01/2018	11/30/2020	Home Attendant Nursing		1151 Ellis St Ste 204		Bellingham	WA	98225-5203	Whatcom	debbie@homeattendantcare.com	(360) 734-3849		1151 Ellis St Ste 204		Bellingham	WA	98225-5203	Whatcom	debbie@homeattendantcare.com	603553226	Home Attendant Nursing LLC	debbie@homeattendantcare.com
IHS.FS.60304119	ACTIVE	12/20/2012	12/21/2019	12/20/2021	Home Care Assistance		1025 108th Ave NE		Bellevue	WA	98004-4324	King	lhenrichs@homecareassistance.com	(425) 679-5770		1025 108th Ave NE		Bellevue	WA	98004-4324	King	lhenrichs@homecareassistance.com	603215512	Home Care Assistance of Washington, LLC	chen@homecareassistance.com
IHS.FS.00000028	ACTIVE	01/01/2003	07/01/2020	06/30/2022	Home Care by Wesley		815 S 216th St		Des Moines	WA	98198-6332	King	mmoove@wesleyhomes.org	(206) 870-1127		815 S 216th St		Des Moines	WA	98198-6332	King	mmoove@wesleyhomes.org	602286322	Wesley Homes Community Health Services	tbrown@WesleyHomes.org
IHS.FS.00000465	ACTIVE		03/01/2019	02/28/2021	Home Care Companions, Inc.		1401 S Union Ave		Tacoma	WA	98405-1901	Pierce	kelly@tacomaangels.com	(253) 537-3700		1401 S Union Ave		Tacoma	WA	98405-1901	Pierce	kelly@tacomaangels.com	602382511	Home Care Companions Inc	kelly@tacomaangels.com
IHS.FS.60617039	ACTIVE	11/23/2015	11/04/2019	11/03/2021	Home Care Solutions		7401 W Hood Pl Ste 204		Kennewick	WA	99336-3400	Benton	heather@yourhomecaresolutions.com	(509) 627-8575		7401 W Hood Pl Ste 204		Kennewick	WA	99336-3400	Benton	heather@yourhomecaresolutions.com	603151060	HHC Solutions Inc.	heather@yourhomecaresolutions.com
IHS.FS.60668056	ACTIVE	01/27/2017	01/28/2020	01/27/2022	Home Helpers and Direct Link		20270 Front St NE Ste 203		Poulsbo	WA	98370-7356	Kitsap	shawnas@homehelpershomecare.com	(360) 362-5735		20270 Front St NE Ste 203		Poulsbo	WA	98370-7356	Kitsap	shawnas@homehelpershomecare.com	603611124	Grey Jedi Alliance LLC	58862@homehelpershomecare.com
IHS.FS.60596369	ACTIVE	10/26/2015	10/27/2020	10/26/2022	Home Instead Senior Care		1616 W Wellesley Ave Ste A		Spokane	WA	99205-1413	Spokane		(509) 835-5898		1616 W Wellesley Ave Ste A		Spokane	WA	99205-1413	Spokane		603518638	LCA Enterprises Inc.	christie.amans@homeinstead.com
IHS.FS.61032089	ACTIVE	01/03/2020	01/03/2020	08/31/2021	Home Instead Senior Care		2821 Northup Way Ste 225		Bellevue	WA	98004-1497	King	mainng@gmail.com	(425) 454-9744		2821 Northup Way Ste 225		Bellevue	WA	98004-1497	King	mainng@gmail.com	604531837	MHE Investements, LLC	mainng@gmail.com
IHS.FS.60997115	ACTIVE	08/23/2019	08/23/2019	12/31/2020	Home Instead Senior Care		1217 Cooper Point Rd SW Ste 8		Olympia	WA	98502-7206	Thurston	kari.smith@homeinstead.com	(360) 570-0049		1217 Cooper Point Rd SW Ste 8		Olympia	WA	98502-7206	Thurston	kari.smith@homeinstead.com	604482106	Smith Family Senior Care, LLC	kari.smith@homeinstead.com
IHS.FS.60976482	ACTIVE	09/25/2019	09/26/2020	09/25/2022	Home Instead Senior Care		32700 Pacific Hwy S Ste 10		Federal Way	WA	98003-6446	King	caleb.andonian@homeinstead.com	(253) 517-3550		32700 Pacific Hwy S Ste 10		Federal Way	WA	98003-6446	King	caleb.andonian@homeinstead.com	604465985	Andonian Homecare LLC	caleb.andonian@homeinstead.com
IHS.FS.61082864	ACTIVE	07/14/2020	07/14/2020	07/31/2021	Home Instead Senior Care		203 S 4th Ave		Sequim	WA	98382-3719	Clallam	kathleen.schmidt@homeinstead.com			1130 W Spruce Ct		Sequim	WA	98382-3225	Clallam		604600170	PNW Kupuna Care, LLC	kathleen.schmidt@homeinstead.com
IHS.FS.00000031	ACTIVE	01/01/2003	08/01/2020	07/31/2022	Home Instead Senior Care		9120 NE Vancouver Mall Loop Ste 240		Vancouver	WA	98662-6355	Clark	julie.williams@homeinstead.com	(360) 253-6028		9120 NE Vancouver Mall Loop Ste 240		Vancouver	WA	98662-6355	Clark	julie.williams@homeinstead.com	602625771	J Williams Enterprises LLC	julie.williams@homeinstead.com
IHS.FS.00000324	ACTIVE		09/01/2019	08/31/2021	Home Instead Senior Care		2821 Northup Way Ste 225		Bellevue	WA	98004-1497	King	homeinstead130@gmail.com	(425) 454-9744		2821 Northup Way Ste 225		Bellevue	WA	98004-1497	King	homeinstead130@gmail.com	601130777	R K Megargel Inc	homeinstead130@gmail.com
IHS.FS.00000326	ACTIVE		03/01/2019	02/28/2021	Home Instead Senior Care		3221 Eastlake Ave E Ste 120		Seattle	WA	98102-7125	King	kristi.larson-low@homeinstead.com	(206) 622-4611		3221 Eastlake Ave E Ste 120		Seattle	WA	98102-7125	King	kristi.larson-low@homeinstead.com	602378362	RKL Group Inc	kristi.larson@homeinstead.com
IHS.FS.00000328	ACTIVE		07/01/2019	06/30/2021	Home Instead Senior Care		101 E 26th St Ste 100		Tacoma	WA	98421-1105	Pierce	loisetienne@hotmail.com	(253) 943-1603		101 E 26th St Ste 100		Tacoma	WA	98421-1105	Pierce	loisetienne@hotmail.com	601710245	ET Enterprises INC	loisetienne@hotmail.com
IHS.FS.60442686	ACTIVE	04/08/2014	04/09/2019	04/08/2021	Home Instead Senior Care		3221 Eastlake Ave E # 20		Seattle	WA	98102-7125	King	kristi.larson-low@seattlehomeinstead.com	(206) 622-4611		3221 Eastlake Ave E # 20		Seattle	WA	98102-7125	King	kristi.larson-low@seattlehomeinstead.com	603357705	KL Solutions Inc	kristi.larson@homeinstead.com
IHS.FS.60516153	ACTIVE	11/10/2014	11/01/2018	10/31/2020	Home Instead Senior Care		840 Callahan Dr Ste C		Bremerton	WA	98310-3378	Kitsap		(360) 782-4663		840 Callahan Dr Ste C		Bremerton	WA	98310-3378	Kitsap		603436325	Oneill Home Care Inc.	toneill77@gmail.com
IHS.FS.60466264	ACTIVE	04/24/2014	04/25/2019	04/24/2021	Home Instead Senior Care		8113 W Quinault Ave Ste 100		Kennewick	WA	99336-8212	Benton	roy.wu@homeinstead.com	(509) 591-0019		8113 W Quinault Ave Ste 100		Kennewick	WA	99336-8212	Benton	roy.wu@homeinstead.com	603370209	Advent Care LLC	roy.wu@homeinstead.com
IHS.FS.60112523	ACTIVE	10/01/2009	10/02/2020	10/01/2022	Home Instead Senior Care		1501 Parker Way Ste 106		Mount Vernon	WA	98273-2599	Skagit	amy.benson@homeinstead.com	(360) 982-2461		1501 Parker Way Ste 106		Mount Vernon	WA	98273-2599	Skagit	amy.benson@homeinstead.com	602925089	Benson Enterprises LLC	amy.benson@homeinstead.com
IHS.FS.60849454	ACTIVE	06/08/2018	06/09/2019	06/08/2021	Home Instead Senior Care Services 828		909 SE Everett Mall Way Ste B210		Everett	WA	98208-3753	Snohomish	laura.cen@homeinstead.com	(425) 549-3100		909 SE Everett Mall Way Ste B210		Everett	WA	98208-3753	Snohomish	laura.cen@homeinstead.com	604227737	Care In Home LLC	laura_l_cen@yahoo.com
IHS.FS.00000088	ACTIVE	01/01/2004	06/01/2019	05/31/2021	Home Watch Caregivers of Western Washington		6912 220th St SW Ste 107		Mountlake Terrace	WA	98043-2174	Snohomish				6912 220th St SW Ste 107		Mountlake Terrace	WA	98043-2174	Snohomish		602371818	Ann Judith In Home Caregivers of Western Wa LLC	dale@homewatchcaregivers.com
IHS.FS.60476938	ACTIVE	06/10/2014	02/15/2020	02/14/2022	Homecare Solutions		221 SW 119th St		Seattle	WA	98146-2929	King	ana.puloka@yahoo.com	(206) 248-6846		221 SW 119th St		Seattle	WA	98146-2929	King	ana.puloka@yahoo.com	602019754	Puloka Ana Hualani	ana.puloka@yahoo.com
IHS.FS.60724302	ACTIVE	03/17/2017	03/18/2020	03/17/2022	Homewatch CareGivers of Tacoma		2621 70th Ave W Ste C		Tacoma	WA	98466-5458	Pierce	hillyermt@comcast.net	(253) 444-8543		2621 70th Ave W Ste C		Tacoma	WA	98466-5458	Pierce	hillyermt@comcast.net	604053761	JMS Professional Services Group Inc	hillyermt@comcast.net
IHS.FS.00000092	ACTIVE	01/01/2004	08/01/2019	07/31/2021	Homewell of South King County		33309 1st Way S Ste A212		Federal Way	WA	98003-4557	King	jreyes@homewellseniorcare.com			PO Box 3501		Federal Way	WA	98063-3501	King		602394873	Homewell of South King County INC	janstafford@homewellseniorcare.com
IHS.FS.60221119	ACTIVE	04/28/2011	04/29/2020	04/28/2022	Homewell Senior Care		14419 Greenwood Ave N Ste E		Seattle	WA	98133-6865	King	kerry@homewellseniorcare.com	(206) 440-5500		14419 Greenwood Ave N Ste E		Seattle	WA	98133-6865	King	kerry@homewellseniorcare.com	603092140	LaDigitale Enterprises LLC	kerry@homewellseniorcare.com
IHS.FS.60850107	ACTIVE	06/27/2018	06/28/2019	06/27/2021	Honest and Reliable Care LLC		1302 E 41st St		Tacoma	WA	98404-3730	Pierce	terralw@hotmail.com			2602 S 38th St Unit 199		Tacoma	WA	98409-6665	Pierce		604231935	Honest and Reliable Care LLC	terralw@gmail.com
IHS.FS.60647896	ACTIVE	05/11/2016	05/12/2019	05/11/2021	HopeBridge Home Health		2117-A West Lincoln Ave		Yakima	WA	98902-2414	Yakima				2117-A West Lincoln Ave		Yakima	WA	98902-2414	Yakima		603151963	Focused Nursing Services LLC	jonathane@focusednursing.com
IHS.FS.00000332	ACTIVE		03/01/2019	02/28/2021	Horizon Hospice and Palliative Care		608 E Holland Ave		Spokane	WA	99218-1255	Spokane	lguske@horizonhospice.com	(509) 489-4581		608 E Holland Ave		Spokane	WA	99218-1255	Spokane	lguske@horizonhospice.com	601701491	Horizon Health LLC	lguske@horizonhospice.com
IHS.FS.00000337	ACTIVE		10/01/2019	09/30/2021	Hospice of Spokane		121 S Arthur St		Spokane	WA	99202-2253	Spokane	gdrummond@hospiceofspokane.org			PO Box 2215		Spokane	WA	99210-2215	Spokane		601139100	Hospice of Spokane	info@hospiceofspokane.org
IHS.FS.00000437	ACTIVE		08/01/2019	07/31/2021	Hospice of the Northwest		227 Freeway Dr Ste A		Mount Vernon	WA	98273-2805	Skagit				PO Box 1376		Mount Vernon	WA	98273-1376	Skagit		602332748	Skagit Hospice Services LLC	hospice_info@hospicenw.org
IHS.FS.60554898	ACTIVE	07/13/2015	07/14/2020	07/13/2022	Hospitality Home Care		4800 S 188th St Ste 210		Seatac	WA	98188-4632	King		(206) 966-9000		4800 S 188th St Ste 210		Seatac	WA	98188-4632	King		603475469	Hospitality Home Care LLC	info@hospitalityhomecare.com
IHS.FS.60941190	ACTIVE	03/21/2019	03/22/2020	03/21/2022	Hubaal Home Care Agency		12601 68th Ave S Apt 15B		Seattle	WA	98178-4166	King	hubaalcare@gmail.com	(206) 474-8102		12601 68th Ave S Apt 15B		Seattle	WA	98178-4166	King	hubaalcare@gmail.com	603221446	Abdi, Jamila Ali	hubaalcare@gmail.com
IHS.FS.60082962	ACTIVE	04/01/2009	04/01/2020	03/31/2022	Husky Senior Care		11339 8th Ave NE		Seattle	WA	98125-6110	King	matt@huskyseniorcare.com	(206) 599-9990		11339 8th Ave NE		Seattle	WA	98125-6110	King	matt@huskyseniorcare.com	602891895	Husky Senior Care LLC	matt@huskyseniorcare.com
IHS.FS.60653199	ACTIVE	04/29/2016	07/01/2020	06/30/2022	Hyatt Care Services		27205 Pacific Hwy S		Federal Way	WA	98003-2407	King	hyatthomecare@outlook.com			31500 1st Ave S Apt 27-102		Federal Way	WA	98003-4686	King		603598981	Hyatt Care Services	hyatthomecare@outlook.com
IHS.FS.60715617	ACTIVE	06/06/2017	06/07/2020	06/06/2022	Hyatt in Homecare Agency		85 S Tobin St Ste 103		Renton	WA	98057-5311	King	hyatt@hyatthomecareagency.com	(425) 282-4776		85 S Tobin St Ste 103		Renton	WA	98057-5311	King	hyatt@hyatthomecareagency.com	603292370	Hyatt Adult Day Home Care	hyatt@hyatthomecareagency.com
IHS.FS.60904213	ACTIVE	12/11/2018	12/12/2019	12/11/2021	ICHS PACE at Legacy House		803 S Lane St		Seattle	WA	98104-3044	King	jacquis@ichs.com			PO Box 3007		Seattle	WA	98114-3007	King		600436519	International Community Health Services	jacquis@ichs.com
IHS.FS.60899640	ACTIVE	10/23/2018	10/24/2019	10/23/2021	Immediate Home Care Agency		14818 Tukwila International Blvd Ste 102		Tukwila	WA	98168-4384	King				3730 S 148th St Apt 56		Tukwila	WA	98168-4364	King		604287624	Immediate Home Care Agency LLC	immediatehomecare19@gmail.com
IHS.FS.00000340	ACTIVE		11/01/2019	10/31/2021	In Home Care of Central Washington		130 N Main St Ste 2		Omak	WA	98841	Okanogan	cwood@ncidata.com			PO Box 3699		Omak	WA	98841-3699	Okanogan		602012949	In Home Care of Central Washington	cwood@ncidata.com
IHS.FS.60816213	ACTIVE	03/05/2018	03/06/2019	03/05/2021	In-Home Care, Northern Suburbs, LLC		6405 218th St SW Ste 308		Mountlake Terrace	WA	98043-2180	Snohomish	kranders62@yahoo.com			22832 104th Ave SE		Woodinville	WA	98077-8028	Snohomish		604184972	In-Home Care, Northern Suburbs, LLC	kranders62@yahoo.com
IHS.FS.00000342	ACTIVE		12/01/2018	11/30/2020	Infant Home Phototherapy		4908 33rd Ave W		Everett	WA	98203-1338	Snohomish	donnaghayward@hotmail.com	(425) 355-0957		4908 33rd Ave W		Everett	WA	98203-1338	Snohomish	donnaghayward@hotmail.com	601965196	Infant Home Phototherapy Inc	homephototherapy@comcast.net
IHS.FS.60955703	ACTIVE	07/10/2019	07/11/2020	07/10/2022	Infinity Homehealth Solutions Inc.		33530 1st Way S Ste 102		Federal Way	WA	98003-7332	King	dhscarellc@gmail.com	(253) 332-8815		33530 1st Way S Ste 102		Federal Way	WA	98003-7332	King	dhscarellc@gmail.com	604367269	Infinity Home Health Solutions Inc.	dhscarellc@gmail.com
IHS.FS.60164493	ACTIVE	07/26/2010	07/27/2019	07/26/2021	Infusion Solutions		134 Prince Ave Ste B		Bellingham	WA	98226-6703	Whatcom	rowena@infusionsolutionsinc.com	(360) 933-4892		134 Prince Ave Ste B		Bellingham	WA	98226-6703	Whatcom	rowena@infusionsolutionsinc.com	602939292	Infusion Solutions Inc	rowena@infusionsolutionsinc.com
IHS.FS.61014907	ACTIVE	02/28/2020	02/28/2020	02/28/2021	Integrity Care and Staffing		510 Grass Lake St NW		Olympia	WA	98502-8625	Thurston	potatoescountry@gmail.com	(206) 458-5871		510 Grass Lake St NW		Olympia	WA	98502-8625	Thurston	potatoescountry@gmail.com	604519056	Integrity Care and Staffing Inc.	potatoescountry@gmail.com
IHS.FS.60889708	ACTIVE	09/20/2018	09/21/2019	09/20/2021	Interim Healthcare of Bellevue		14040 NE 8th St Ste 302		Bellevue	WA	98007-4122	King	dexterborbe@yahoo.com	(832) 547-1216		14040 NE 8th St Ste 302		Bellevue	WA	98007-4122	King	dexterborbe@yahoo.com	604282674	Bellevue Home Health and Care, LLC	dexterborbe@yahoo.com
IHS.FS.00000345	ACTIVE		01/01/2020	12/31/2021	Interim Healthcare of Spokane, Inc		1625 W 4th Ave		Spokane	WA	99201-5620	Spokane	rickmorris@ncshosting.com	(509) 456-5665		1625 W 4th Ave		Spokane	WA	99201-5620	Spokane	rickmorris@ncshosting.com	601288070	Interim Healthcare of Spokane Inc	rickmorris@ncshosting.com
IHS.FS.00000346	ACTIVE		08/01/2019	07/31/2021	Intrepid USA Healthcare Services		9715 N Nevada St		Spokane	WA	99218-3412	Spokane	kathryn.bevilacqua@intrepidusa.com	509-466-0954		3220 Keller Springs Rd Ste 108		Carrollton	TX	75006-5911	Dallas		601972425	Intrepid of Washington Inc	kathryn.bevilacqua@intrepidusa.com
IHS.FS.60542117	ACTIVE	06/09/2015	06/10/2020	06/09/2022	JandJ Integrity Home Health Care LLC		5005 200th St SW Ste 101A		Lynnwood	WA	98036-6679	Snohomish	jojseattle@yahoo.com	(425) 361-2373		5005 200th St SW Ste 101A		Lynnwood	WA	98036-6679	Snohomish	jojseattle@yahoo.com	603434109	JandJ Integrity Home Health Care LLC	jojseattle@yahoo.com
IHS.FS.00000349	ACTIVE		10/01/2019	09/30/2021	Jefferson Healthcare Home Health and Hospice		2500 W Sims Way		Port Townsend	WA	98368-2234	Jefferson		(360) 385-0610		2500 W Sims Way		Port Townsend	WA	98368-2234	Jefferson		600154888	Hospital Dist #2 Jefferson County	dfountain@jgh.org
IHS.FS.00000350	ACTIVE		10/01/2019	09/30/2021	Jewish Family Service		1601 16th Ave		Seattle	WA	98122-4011	King	rkwong@jfsseattle.org	(206) 726-3611		1601 16th Ave		Seattle	WA	98122-4011	King	rkwong@jfsseattle.org	601141461	Jewish Family Service of Seattle	ddagrosa@jfsseattle.org
IHS.FS.60923101	ACTIVE	02/07/2019	02/08/2020	02/07/2022	Josephine at Home		9901 272nd Pl NW		Stanwood	WA	98292-7449	Snohomish	office@josephinenet.com	(360) 629-2126		9901 272nd Pl NW		Stanwood	WA	98292-7449	Snohomish	office@josephinenet.com	600089377	Josephine Caring Community	office@josephinenet.com
IHS.FS.60291296	ACTIVE	09/13/2012	09/14/2019	09/13/2021	Judson Park		23600 Marine View Dr S		Des Moines	WA	98198-7352	King	njay@abhow.com	(206) 824-4000		23600 Marine View Dr S		Des Moines	WA	98198-7352	King	njay@abhow.com	601572527	HumanGood Washington	beckey.hjaltalin@humangood.org

Public Disclosure Request - Organizations

Lists the Credential #, Credential Status, First Issuance Date, Effective Date, Expiration Date, Facility Name, Site and Mailing Addresses, Counties, and Emails, Site Phone # and Secretary of State #. 07/21/17

IHS.FS.00000353	ACTIVE		09/01/2019	08/31/2021	Kaiser Permanente Continuing Care Services		2701 NW Vaughn St Ste 140		Portland	OR	97210-5344	Multnomah	john.s.siemsen@kp.org	(503)499-5200		2701 NW Vaughn St Ste 140		Portland	OR	97210-5344	Multnomah	john.s.siemsen@kp.org	409011310	Kaiser Foundation Health Plan of the NW	john.s.siemsen@kp.org
IHS.FS.00000305	ACTIVE		09/01/2019	08/31/2021	Kaiser Permanente Home Health and Hospice		201 16th Ave E Cmb C-140		Seattle	WA	98112-5226	King	wilson.c@ghc.org	(206) 326-4826		201 16th Ave E Cmb C-140		Seattle	WA	98112-5226	King	wilson.c@ghc.org	578011461	Kaiser Foundation Health Plan of Washington	
IHS.FS.60260912	ACTIVE	01/24/2012	01/25/2019	01/24/2021	Kan Doo Unlimited		4905 234th St SW		Mountlake Terrace	WA	98043-4824	Snohomish	kandooun@aol.com	(425) 697-3578		4905 234th St SW		Mountlake Terrace	WA	98043-4824	Snohomish	kandooun@aol.com	603020106	Kan Doo Unlimited LLC	kandooun@aol.com
IHS.FS.61052647	ACTIVE	05/12/2020	05/12/2020	05/12/2021	Kayin's In-home Care Services, LLC		2060 NW Rustling Fir Ln		Silverdale	WA	98383-7866	Kitsap				PO Box 584		Silverdale	WA	98383-0584	Kitsap		604528172	Kayin's In-home Care Services, LLC	kayinsinhomecareservices@outlook.com
IHS.FS.60210875	ACTIVE	03/23/2011	03/24/2020	03/23/2022	Kays Home Health Services		6805 Quincy Ave SE		Auburn	WA	98092-3897	Pierce	oguakwaifesi@yahoo.com	(206) 285-2988		6805 Quincy Ave SE		Auburn	WA	98092-3897	Pierce	oguakwaifesi@yahoo.com	603082673	Kays Home Health Services LLC	oguakwaifesi@yahoo.com
IHS.FS.60356820	ACTIVE	07/26/2013	07/27/2020	07/26/2022	Kelly's Loving Care, Inc		8264 W Grandridge Blvd Fl 3		Kennewick	WA	99336-7812	Benton				604 Punkie Ln		Richland	WA	99352-9218	Benton		603144997	Kelly's Loving Care, Inc	kellyslovingcare@gmail.com
IHS.FS.61006746	ACTIVE	10/02/2019	10/02/2019	10/31/2021	Kin on Health Care Center		815 S Weller St Ste 212		Seattle	WA	98104-3050	King	clam@kinon.org	(206) 652-2330		815 S Weller St Ste 212		Seattle	WA	98104-3050	King	clam@kinon.org	601508556	Kin on Health Care Center	clam@kinon.org
IHS.FS.61022909	ACTIVE	03/12/2020	03/12/2020	03/12/2021	Kind and Compassionate Home Care LLC		20518 61st Pl W		Lynnwood	WA	98036-7547	Snohomish	care@kindcompassionate.com	(425) 412-3789		20518 61st Pl W		Lynnwood	WA	98036-7547	Snohomish	care@kindcompassionate.com	604495668	Kind and Compassionate Home Care LLC	care@kindcompassionate.com
IHS.FS.60158990	ACTIVE	08/02/2010	08/03/2019	08/02/2021	Kinderhafen LLC		609 S 45th Ave		Yakima	WA	98908-3336	Yakima		(509) 823-4200		420 S 32nd Ave		Yakima	WA	98902-3635	Yakima	kinderhafen@charter.net	602888990	Kinderhafen LLC	kinderhafen@charter.net
IHS.FS.60848556	ACTIVE	07/23/2018	07/24/2019	07/23/2021	Kindhearted In Home Care		6514 127th Street Ct E		Puyallup	WA	98373-5105	Pierce	akee-g@yahoo.com			17701 108th Ave SE # 125		Renton	WA	98055-6448	King		604106791	Kindhearted In Home Care Agency LLC	akee_g@yahoo.com
IHS.FS.60308064	ACTIVE	12/20/2012	12/21/2019	12/20/2021	Kindred at Home		22820 E Appleway Ave		Liberty Lake	WA	99019-9514	Spokane	katelyn.radloff@gentiva.com	509-473-4900		12900 Foster Ste 400		Overland Park	KS	66213	Johnson		601758647	Gentiva Certified Healthcare Corp	jonathan.reid@gentiva.com
IHS.FS.00000291	ACTIVE		01/01/2019	12/31/2020	Kindred at Home		4660 Kitsap Way Ste 101		Bremerton	WA	98312-2357	Kitsap			Attn: Licensing and Certification Department	6330 Sprint Pkwy Ste 300		Overland Park	KS	66211-1171	Johnson		601758647	Gentiva Certified Healthcare Corp	jonathan.reid@gentiva.com
IHS.FS.00000296	ACTIVE		01/01/2020	12/31/2021	Kindred at Home		8502 N Nevada St Ste 2		Spokane	WA	99208-7395	Spokane			Attn: Licensing and Certification Dept	12900 Foster St Ste 400		Overland Park	KS	66213-2696	Johnson		601758647	Gentiva Certified Healthcare Corp	jonathan.reid@gentiva.com
IHS.FS.00000298	ACTIVE		04/01/2020	03/31/2022	Kindred at Home		4020 S 56th St Ste 101		Tacoma	WA	98409-2626	Pierce		(425) 745-4345	Attn: Licensing and Certification Dept	12900 Foster St Ste 400		Overland Park	KS	66213-2696	Johnson	donna.vanderdoes@gentiva.com	601758647	Gentiva Certified Healthcare Corp	jonathan.reid@gentiva.com
IHS.FS.00000293	ACTIVE		04/01/2020	03/31/2022	Kindred at Home		20829 72nd Ave S Ste 125		Kent	WA	98032-1404	King	katelyn.radloff@gentiva.com		Attn: Licensing and Certification Dept	12900 Foster St Ste 400		Overland Park	KS	66213-2696	Johnson		601758647	Gentiva Certified Healthcare Corp	jonathan.reid@gentiva.com
IHS.FS.00000295	ACTIVE		10/01/2019	09/30/2021	Kindred at Home		728 134th St SW Ste 203		Everett	WA	98204-5322	Snohomish	katelyn.radloff@gentiva.com	(425) 745-4345	Attn: Licensing and Certification Dept	12900 Foster St Ste 400		Overland Park	KS	66213-2696	Johnson	donna.vanderdoes@gentiva.com	601758647	Gentiva Certified Healthcare Corp	jonathan.reid@gentiva.com
IHS.FS.00000300	ACTIVE		11/01/2019	10/31/2021	Kindred at Home		204 SE Stonemill Dr Ste 260		Vancouver	WA	98684-3507	Clark	donna.vanderdoes@gentiva.com	(360) 253-7746	Attn: Licensing and Certification Dept	12900 Foster St Ste 400		Overland Park	KS	66213-2696	Johnson	donna.vanderdoes@gentiva.com	601758647	Gentiva Certified Healthcare Corp	jonathan.reid@gentiva.com
IHS.FS.60330209	ACTIVE	07/02/2013	07/03/2020	07/02/2022	Kindred Hospice		115 NE 100th St Bldg A Ste 210		Seattle	WA	98125	King	katelyn.radloff@gentiva.com		Attn: Licensing and Certification Dept.	12900 Foster St Ste 400		Overland Park	KS	66213-2696	Johnson		602306941	Odyssey HealthCare Operating B, LP	jonathan.reid@gentiva.com
IHS.FS.60308060	ACTIVE	12/20/2012	12/21/2019	12/20/2021	Kindred Hospice		22820 E Appleway Ave		Liberty Lake	WA	99019-5214	Spokane	jonathan.reid@gentiva.com		Attn: Regulatory	PO Box 4060		Mooresville	NC	28117-4060	Iredell		602306941	Odyssey HealthCare Operating B, LP	jonathan.reid@gentiva.com
IHS.FS.00000359	ACTIVE		09/01/2020	08/31/2022	Kitsap Home Care Services		2540 Cascades Pass Blvd Ste 100		Bremerton	WA	98312-2139	Kitsap	mclosser@ktssinc.com			PO Box 5209		Bremerton	WA	98312-0493	Kitsap	jlfrey@ktssinc.com	600393152	Kitsap Tenent Support Services Inc	mclosser@ktssinc.com
IHS.FS.00000320	ACTIVE		06/01/2020	05/31/2022	Kittitas Valley Home Health and Hospice		1506 E Radio Rd		Ellensburg	WA	98926-9589	Kittitas	rholden@kvhealthcare.org	(509) 962-7438		1506 E Radio Rd		Ellensburg	WA	98926-9589	Kittitas	rholden@kvhealthcare.org	192003232	Kittitas Co Public Hospital Dist No 1	rholden@kvhealthcare.org
IHS.FS.00000360	ACTIVE		02/01/2020	01/31/2022	Klickitat County Senior Services		115 W Court St MS CH21		Goldendale	WA	98620-8905	Klickitat	sharonc@co.klickitat.wa.us	(509) 773-3757		115 W Court St MS CH21		Goldendale	WA	98620-8905	Klickitat	sharonc@co.klickitat.wa.us	202000770	Klickitat County	SHARONC@CO.KLICKITAT.WA.US
IHS.FS.00000361	ACTIVE		01/01/2020	12/31/2021	Klickitat Valley Health Home Health & Hospice		711 E Collins St		Goldendale	WA	98620-9237	Klickitat	homehealth@kvhealth.net			310 S Roosevelt St		Goldendale	WA	98620-9201	Klickitat		202000768	Public Hospital District 1 of Klickitat Co	
IHS.FS.60103742	ACTIVE	09/17/2009	09/18/2020	09/17/2022	Kline Galland Community Based Services		5950 6th Ave S Ste 100		Seattle	WA	98108-3317	King	minA@klinegalland.org	(206) 805-1930		5950 6th Ave S Ste 100		Seattle	WA	98108-3317	King	minA@klinegalland.org	601139551	The Caroline Kline Galland Home	klinegalland@klinegalland.org
IHS.FS.00000362	ACTIVE		02/29/2020	02/28/2022	Korean Women's Association		123 E 96th St		Tacoma	WA	98445-2001	Pierce	lmerrell@kwacares.org		Attention: IHC Director, Penny Rae Bradon	123 E 96th St		Tacoma	WA	98445-2001	Pierce		601057073	Korean Women's Association	lhall@kwacares.org
IHS.FS.60952471	ACTIVE	08/05/2019	08/05/2019	08/05/2020	Lakeview Homecare Agency, Inc.		915 Deschutes Pkwy SW		Olympia	WA	98502-5817	Thurston	apple-health.care@comcast.net			PO Box 294		Olympia	WA	98507-0294	Thurston		604413335	Lakeview Homecare Agency, Inc.	lakeview915@comcast.net
IHS.FS.00000041	ACTIVE	01/01/2003	01/01/2019	12/31/2020	Lincare		722 W 2nd St		Aberdeen	WA	98520-4803	Grays Harbor	ghowdesh@lincare.com	(727) 431-8283	Attn: Licensing Department	PO Box 9004		Clearwater	FL	33758-9004	Pinellas	jjones28@lincare.com	601056369	Lincare Inc.	licensing@lincare.com
IHS.FS.00000045	ACTIVE	01/01/2003	01/01/2019	12/31/2020	Lincare		1616 S Gold St Ste 10		Centralia	WA	98531-8930	Lewis	ghowdesh@lincare.com	(360) 748-4534		PO Box 9004		Clearwater	FL	33758-9004	Out of State		601056369	Lincare Inc.	licensing@lincare.com
IHS.FS.00000043	ACTIVE	01/01/2003	01/01/2019	12/31/2020	Lincare		4073 Hannegan Rd Stes I&J		Bellingham	WA	98226-7663	Whatcom	licensing@lincare.com	(727) 431-8283	Attn: Licensing Department	PO Box 9004		Clearwater	FL	33758-9004	Pinellas	jjones28@lincare.com	601056369	Lincare Inc.	licensing@lincare.com
IHS.FS.00000050	ACTIVE	01/01/2003	01/01/2019	12/31/2020	Lincare		1030 Columbia Blvd		Longview	WA	98632-1036	Cowlitz	ghowdesh@lincare.com	(727) 431-8283	Attn: Licensing Department	PO Box 9004		Clearwater	FL	33758-9004	Pinellas	jjones28@lincare.com	601056369	Lincare Inc.	licensing@lincare.com
IHS.FS.00000046	ACTIVE	01/01/2003	01/01/2019	12/31/2020	Lincare		615 Elm St		Clarkston	WA	99403-2047	Asotin	ghowdesh@lincare.com	(727) 431-8283	Attn: Licensing Department	PO Box 9004		Clearwater	FL	33758-9004	Pinellas	jjones28@lincare.com	601056369	Lincare Inc.	licensing@lincare.com
IHS.FS.00000059	ACTIVE	01/01/2003	01/01/2019	12/31/2020	Lincare		6818 W Kennewick Ave Ste C		Kennewick	WA	99336-1754	Benton	ghowdesh@lincare.com	(727) 431-8283	Attn: Licensing Department	PO Box 9004		Clearwater	FL	33758-9004	Pinellas	jjones28@lincare.com	601056369	Lincare Inc.	licensing@lincare.com
IHS.FS.00000047	ACTIVE	01/01/2003	01/01/2019	12/31/2020	Lincare		135 S Oak St		Colville	WA	99114-2845	Stevens	ghowdesh@lincare.com	(727) 431-8283	Attn: Licensing Department	PO Box 9004		Clearwater	FL	33758-9004	Pinellas	jjones28@lincare.com	601056369	Lincare Inc.	licensing@lincare.com
IHS.FS.00000055	ACTIVE	01/01/2003	01/01/2019	12/31/2020	Lincare		307 S Main St Ste A		Omak	WA	98841-9718	Okanogan	jjones28@lincare.com	(727) 431-8283	Attn: Licensing Department	PO Box 9004		Clearwater	FL	33758-9004	Pinellas	jjones28@lincare.com	601056369	Lincare Inc.	licensing@lincare.com
IHS.FS.00000061	ACTIVE	01/01/2003	01/01/2019	12/31/2020	Lincare		15310 E Marietta Ste 7 and 8		Spokane Valley	WA	99216	Spokane	licensing@lincare.com	(727) 431-8283	Attn: Licensing Department	PO Box 9004		Clearwater	FL	33758-9004	Pinellas	jjones28@lincare.com	601056369	Lincare Inc.	licensing@lincare.com
IHS.FS.00000056	ACTIVE	01/01/2003	01/01/2019	12/31/2020	Lincare		1905 E Front St		Port Angeles	WA	98362-9029	Clallam	ghowdesh@lincare.com	(727) 431-8283	Attn: Licensing Department	PO Box 9004		Clearwater	FL	33758-9004	Pinellas	jjones28@lincare.com	601056369	Lincare Inc.	licensing@lincare.com
IHS.FS.60072385	ACTIVE	03/01/2009	11/21/2019	11/20/2021	Lincare		7301 SW Kable Ln Ste 900		Portland	OR	97224-7970		ghowdesh@lincare.com	(503) 624-8884		PO Box 9004		Clearwater	FL	33758-9004	Pinellas		601056369	Lincare Inc.	licensing@lincare.com
IHS.FS.60472113	ACTIVE	07/24/2014	07/25/2019	07/24/2021	Lincare Inc.		525 Cedar St		Sandpoint	ID	83864-1535	Bonner	ghowdesh@lincare.com	(727) 431-8283	Attn: Licensing Department	PO Box 9004		Clearwater	FL	33758-9004	Pinellas	jjones28@lincare.com	601056369	Lincare Inc.	licensing@lincare.com
IHS.FS.00000065	ACTIVE	01/01/2004	01/01/2019	12/31/2020	Lincare Inc.		101 N 5th Ave		Yakima	WA	98902-2641	Yakima			Attn: Licensing Dept.	PO Box 9004		Clearwater	FL	33758-9004	Pinellas		601056369	Lincare Inc.	licensing@lincare.com
IHS.FS.00000051	ACTIVE	01/01/2003	01/01/2019	12/31/2020	Lincare Inc.		2609 W Broadway Ave Ste B		Moses Lake	WA	98837-2903	Grant	ghowdesh@lincare.com	(727) 431-8283	Attn: Licensing Department	PO Box 9004		Clearwater	FL	33758-9004	Pinellas	jjones28@lincare.com	601056369	Lincare Inc.	licensing@lincare.com
IHS.FS.00000172	ACTIVE	01/01/2007	08/31/2020	08/30/2022	Lincare Inc.		485 NE Skipanon Dr		Warrenton	OR	97146-9611	Clatsop	ghowdesh@lincare.com	(727) 431-8283	Attn: Licensing Department	PO Box 9004		Clearwater	FL	33758-9004	Pinellas	jjones28@lincare.com	601056369	Lincare Inc.	licensing@lincare.com
IHS.FS.00000042	ACTIVE	01/01/2003	01/01/2019	12/31/2020	Lincare Inc.		21414 68th Ave S Ste 105		Kent	WA	98032-2412	King	dklemenc@lincare.com	(727) 431-8283	Attn: Licensing Department	PO Box 9004		Clearwater	FL	33758-9004	Pinellas	jjones28@lincare.com	601056369	Lincare Inc.	licensing@lincare.com
IHS.FS.00000054	ACTIVE	01/01/2003	01/01/2019	12/31/2020	Lincare Inc.		426 Carpenter Rd SE Ste 101		Lacey	WA	98503-7908	Thurston	jjones28@lincare.com	(727) 431-8283	Attn: Licensing Department	PO Box 9004		Clearwater	FL	33758-9004	Pinellas	jjones28@lincare.com	601056369	Lincare Inc.	licensing@lincare.com
IHS.FS.00000048	ACTIVE	01/01/2003	01/01/2019	12/31/2020	Lincare Inc.		18824 Smokey Point Blvd Stes 107A and 107B		Arlington	WA	98223	Snohomish	cwaller1@lincare.com	(727) 431-8283	Attn: Licensing Department	PO Box 9004		Clearwater	FL	33758-9004	Pinellas	jjones28@lincare.com	601056369	Lincare Inc.	licensing@lincare.com
IHS.FS.60323022	ACTIVE	01/08/2013	01/09/2020	01/08/2022	Love at Home Senior Care		1520 W Garland Ave Ste E		Spokane	WA	99205-2613	Spokane		(509) 474-0663		1520 W Garland Ave Ste E		Spokane	WA	99205-2613	Spokane		603241632	Andy's Home Care Inc	andy@loveathomeseniorcare.net
IHS.FS.60990027	ACTIVE	06/25/2020	06/25/2020	06/25/2021	Loving Neighbor Home Care LLC		424 S Lakeside Rd		Liberty Lake	WA	99019-9574	Spokane	lovingneighborhomecare@gmail.com	(509) 304-8051		424 S Lakeside Rd		Liberty Lake	WA	99019-9574	Spokane	lovingneighborhomecare@gmail.com	604475552	Loving Neighbor Home Care LLC	lovingneighborhomecare@gmail.com
IHS.FS.00000370	ACTIVE		07/01/2019	06/30/2021	Lummi Home Care Agency		2592 Kwina Rd		Bellingham	WA	98226-9278	Whatcom	ronald@lummi-nsn.gov	(360) 312-2111		2592 Kwina Rd		Bellingham	WA	98226-9278	Whatcom	ronald@lummi-nsn.gov	603535071	Lummi Indian Business Council	justini@lummi-nsn.gov
IHS.FS.00000371	ACTIVE		04/01/2020	03/31/2022	Lutheran Community Services Northwest		223 N Yakima Ave		Tacoma	WA	98403-2230	Pierce	rnestaas@lcsnw.org	(253)272-8433		223 N Yakima Ave		Tacoma	WA	98403-2230	Pierce	rnestaas@lcsnw.org	602128998	Lutheran Community Services Northwest	rnestaas@lcsnw.org
IHS.FS.60386991	ACTIVE	07/01/2014	07/02/2019	07/01/2021	Madonna Senior Care Services LLC		2020 Grant Ave S Apt G202		Renton	WA	98055-3625	King		(206) 478-7430		2020 Grant Ave S Apt G202		Renton	WA	98055-3625	King		603190984	Madonna Senior Care Services LLC	madonnasc@comcast.net
IHS.FS.60123737	ACTIVE	11/13/2009	11/01/2018	10/31/2020	Martha and Mary At Home		19160 Front St NE		Poulsbo	WA	98370	Kitsap	dwasson@mmhc.org			PO Box 127		Poulsbo	WA	98370-0127	Kitsap		601791953	Martha and Mary Home and Community Services	mbehal@marthaandmary.org
IHS.FS.00000372	ACTIVE		04/01/2020	03/31/2022	Mary Bridge Infusion and Specialty Services		315 Martin Luther King Jr Way	MS 315-C2-HIN	Tacoma	WA	98405-4234	Pierce		(253) 403-1833		315 Martin Luther King Jr Way	MS 315-C2-HIN	Tacoma	WA	98405-4234	Pierce		601100682	Multicare Health System	jeffrey.planich@multicare.org
IHS.FS.60329553	ACTIVE	11/20/2013	11/21/2018	11/20/2020	Mattys Home Care		1129 Lawson Ln		Walla Walla	WA	99362-7250	Walla Walla	arilopez1988@msn.com	(509) 629-1453		1129 Lawson Ln		Walla Walla	WA	99362-7250	Walla Walla	arilopez1988@msn.com	603249310	Munoz Matilde	mattyshomecare67@gmail.com
IHS.FS.60282684	ACTIVE	07/24/2012	07/25/2019	07/24/2021	Maxim Healthcare Services		10220 SW Greenburg Rd Ste 400		Portland	OR	97223-5531	Washington	soreisig@maxhealth.com		Attn: Sonja Reisig	7227 Lee Deforest Dr		Columbia	MD	21046-3236	Howard		601407644	Maxim Healthcare Services Inc	chachandl@maxhealth.com
IHS.FS.00000374	ACTIVE		05/01/2019	04/30/2021	Maxim Healthcare Services		1500 W 4th Ave Ste 200		Spokane	WA	99201-7239	Spokane	chachandl@maxhealth.com	(253)671-9909	Licensure Department Chanel Chandler	7227 Lee Deforest Dr		Columbia	MD	21046-3236	Howard	chachandl@maxhealth.com	601407644	Maxim Healthcare Services Inc	chachandl@maxhealth.com
IHS.FS.00000375	ACTIVE	06/26/2003	03/01/2019	02/28/2021	Maxim Healthcare Services		4301 S Pine St Fl 5		Tacoma	WA	98409-7264	Pierce	chachandl@maxhealth.com	(253)671-9909	Licensure Department Chanel Chandler	7227 Lee Deforest Dr		Columbia	MD	21046-3236	Howard	chachandl@maxhealth.com	601407644	Maxim Healthcare Services Inc	chachandl@maxhealth.com
IHS.FS.00000373	ACTIVE		11/01/2019	10/31/2021	Maxim Healthcare Services Inc		6021 244th St SW Ste 400		Mountlake Terrace	WA	98043-5400	Snohomish	kevance@maxhealth.com	(813) 514-9550	Attn: Chanel Chandler	7227 Lee Deforest Dr		Columbia	MD	21046-3236	Howard	chachandl@maxhealth.com	601407644	Maxim Healthcare Services Inc	chachandl@maxhealth.com
IHS.FS.00000376	ACTIVE		09/01/2020	08/31/2022	Memorial Home Care Services		302 S 10th Ave		Yakima	WA	98902-3521	Yakima	laureloswalt@yvmh.org	(509) 574-3600		302 S 10th Ave		Yakima	WA	98902-3521	Yakima	laureloswalt@yvmh.org	397011023	Yakima Valley Memorial Hospital Association	RussMyers@yvmh.org
IHS.FS.60664985	ACTIVE	07/11/2016	07/12/2019	07/11/2021	Mercy Home Care		19550 International Blvd S Ste 303		Seatac	WA	98188	King	mahamed11@yahoo.com	(206) 504-1560		19550 International Blvd S Ste 303		Seatac	WA	98188	King	mahamed11@yahoo.com	602717115	Sunshine Transportation LLC	mahamed11@yahoo.com
IHS.FS.00000377	ACTIVE		02/01/2019	01/31/2021	Millennia Healthcare		21400 International Blvd Ste 205		Seatac	WA	98198-6086	King	millenniahealthcare@comcast.net	(206)878-0909		21400 International Blvd Ste 205		Seatac	WA	98198-6086	King	millenniahealthcare@comcast.net	601986687	Millennia Healthcare Inc	millenniahealthcare@comcast.net
IHS.FS.60472395	ACTIVE	08/05/2014	08/06/2019	08/05/2021	Mirabella In-Home Care		116 Fairview Ave N		Seattle	WA	98109-5322	King	koaks@retirement.org	(206) 254-1459		116 Fairview Ave N		Seattle	WA	98109-5322	King	koaks@retirement.org	602460428	Mirabella	ddaraitus@retirement.org
IHS.FS.00000090	ACTIVE	01/01/2004	08/01/2019	07/31/2021	Mountainview Home Health		409 N 2nd St		Yakima	WA	98901-2336	Yakima		(509)576-0800		409 N 2nd St		Yakima	WA	98901-2336	Yakima		602422906	Mountainview Home Health LLC	epesek@mountainviewhh.org

Public Disclosure Request - Organizations

Lists the Credential #, Credential Status, First Issuance Date, Effective Date, Expiration Date, Facility Name, Site and Mailing Addresses, Counties, and Emails, Site Phone # and Secretary of State #. 07/21/17

IHS.FS.60819258	ACTIVE	05/16/2018	05/17/2020	05/16/2022	Muckleshoot Elders In Home Support Serves		17500 SE 392nd St		Auburn	WA	98092-9705	King	Karen.Kennedy@muckleshoot.nsn.us	(253) 876-3050		17500 SE 392nd St		Auburn	WA	98092-9705	King	Karen.Kennedy@muckleshoot.nsn.us	600371424	Muckleshoot Indian Tribe	Karen.Kennedy@muckleshoot.nsn.us
IHS.FS.60639376	ACTIVE	02/29/2016	02/01/2020	01/31/2022	MultiCare Home Health, Hospice and Palliative Care		3901 S Fife St		Tacoma	WA	98409-7309	Pierce	bill.robertson@multicare.org			PO Box 5200		Tacoma	WA	98415-0200	Pierce		601100682	Multicare Health System	jeffrey.planich@multicare.org
IHS.FS.60081744	ACTIVE	02/27/2008	02/29/2020	02/28/2022	MultiCare Home Health, Hospice and Palliative Care		3901 S Fife St		Tacoma	WA	98409-7309	Pierce	bill.robertson@multicare.org			PO Box 5200		Tacoma	WA	98415-0200	Pierce		601100682	Multicare Health System	jeffrey.planich@multicare.org
IHS.FS.00000384	ACTIVE		04/01/2020	03/31/2022	NCW Respiratory Care		712 N Chelan Ave		Wenatchee	WA	98801-2069	Chelan	susan.martinez@rotech.com			3600 Vineland Rd Ste 114		Orlando	FL	32811-6460	Orange		600647397	North Central Washington Respiratory Care Services, Inc	
IHS.FS.00000142	ACTIVE	01/01/2006	07/01/2019	06/30/2021	New Care Concepts		2208 NW Market St Ste 520		Seattle	WA	98107-4098	King		(206)789-9054		2208 NW Market St Ste 520		Seattle	WA	98107-4098	King		602533389	New Care Concepts Inc.	newcare@newcareinc.com
IHS.FS.60503577	ACTIVE	11/26/2014	03/29/2020	03/28/2022	Nogah Home Care		1914 N 34th St Ste 200A		Seattle	WA	98103-9089	King	admin@nogahc.com	(206) 618-4944		1914 N 34th St Ste 200A		Seattle	WA	98103-9089	King	admin@nogahc.com	603423930	Nogah Home Care LLC	amanuel@nogahc.com
IHS.FS.60762534	ACTIVE	06/20/2017	06/21/2020	06/20/2022	Northwest Healthcare		4317 NE Thurston Way Ste 220		Vancouver	WA	98662-6660	Clark	margo@northwesthealthcare.com	(360) 574-5293		4317 NE Thurston Way Ste 220		Vancouver	WA	98662-6660	Clark	margo@northwesthealthcare.com	601998837	Northwest Healthcare Inc	bob@northwesthealthcare.com
IHS.FS.60242111	ACTIVE	10/24/2011	10/28/2019	10/27/2021	Northwest Senior Care		27538 340th Ave SE		Ravensdale	WA	98051-8404	King	jerid@northwestseniorcare.com			PO Box 562		Ravensdale	WA	98051-0562	King		603090473	Northwest Senior Care Services LLC	hope@northwestseniorcare.com
IHS.FS.60670421	ACTIVE	10/04/2016	10/05/2019	10/04/2021	Nuclear Care Partners LLC		640 Jadwin Ave Ste K		Richland	WA	99352-4244	Benton	etttenger@bowrivercapital.com			631 24 1/2 Rd Unit C		Grand Junction	CO	81505-1371	Mesa		603592347	Nuclear Care Partners LLC	lolkowski@nuclearcarepartners.com
IHS.FS.00000392	ACTIVE		12/01/2019	11/30/2021	Olympic Community Action Programs (OlyCAP)		823 Commerce Loop		Port Townsend	WA	98368-2904	Jefferson	action@olycap.org	(360) 385-2571		823 Commerce Loop		Port Townsend	WA	98368-2904	Jefferson	action@olycap.org	600443619	Olympic Community Action Programs	action@olycap.org
IHS.FS.00000393	ACTIVE		06/01/2020	05/31/2022	Olympic Medical Home Health		801 E Front St		Port Angeles	WA	98362-3636	Clallam	jmwarren@olympicmedical.org	(360)417-7315		939 Caroline St		Port Angeles	WA	98362-3909	Clallam	webmaster@olympicmedical.org	054003327	Clallam County Public Hospital Dist No 2	smcdonaldsch@olympicmedical.org
IHS.FS.60513257	ACTIVE	04/13/2016	04/14/2019	04/13/2021	One Choice One Voice Home Care Solution		7173 Bridle Vale Blvd NW		Bremerton	WA	98311-8911	Kitsap	stindahiatucker@hotmail.com	(360) 516-9673		7173 Bridle Vale Blvd NW		Bremerton	WA	98311-8911	Kitsap	stindahiatucker@hotmail.com	603439355	Stindahia Rita Mananeke	stindahiatucker@hotmail.com
IHS.FS.60709359	ACTIVE	02/28/2017	02/29/2020	02/28/2022	Open Arms Home Care		1556 Highland Ave		Clarkston	WA	99403-1150	Asotin				1556 Highland Ave		Clarkston	WA	99403-1150	Asotin		604016384	Open Arms Home Care LLC	openarmshc@outlook.com
IHS.FS.60999986	ACTIVE	07/01/2020	07/01/2020	07/01/2021	Optimal Homecare Services		15820 104th Ave NE		Bothell	WA	98011-4000	King	service@optimalhomecareservices.com			PO Box 612		Bellevue	WA	98009-0612	King		604045350	Premera Medical Staffing Agency LLC	careplusafh@yahoo.com
IHS.FS.60241176	ACTIVE	09/30/2011	10/01/2020	09/30/2022	Option Care		3310 N Pines Rd		Spokane Valley	WA	99206-4612	Spokane	michelle.mazzenga@walgreens.com			3000 Lakeside Dr Ste 300N		Bannockburn	IL	60015-5405	Lake		601778100	Option Care Enterprises Inc	michelle.mazzenga@walgreens.com
IHS.FS.00000397	ACTIVE		02/29/2020	02/28/2022	Option Care		7325 W Deschutes Ave Ste C		Kennewick	WA	99336-6705	Benton	michelle.mazzenga@walgreens.com			3000 Lakeside Dr Ste 300N		Bannockburn	IL	60015-5405	Lake		601778100	Option Care Enterprises Inc	
IHS.FS.00000396	ACTIVE		06/01/2020	05/31/2022	Option Care		728 134th St SW Bldg A Ste 128		Everett	WA	98204-5322		oc-providerenrollandlicense@optioncare.com			3000 Lakeside Dr Ste 300N		Bannockburn	IL	60015-5405	Lake		601778100	Option Care Enterprises Inc	michelle.mazzenga@walgreens.com
IHS.FS.00000398	ACTIVE		10/01/2019	09/30/2021	Option Care		13035 Gateway Dr S Ste 131		Tukwila	WA	98168-3395	King	michelle.mazzenga@walgreens.com			3000 Lakeside Dr Ste 300N		Bannockburn	IL	60015-5405	Lake		601778100	Option Care Enterprises Inc	michelle.mazzenga@walgreens.com
IHS.FS.00000468	ACTIVE		02/29/2020	02/28/2022	Option Care at Legacy Health		16195 SW 72nd Ave		Portland	OR	97224-7766	Washington				3000 Lakeside Dr Ste 300N		Bannockburn	IL	60015-5405	Lake		602815023	Option Care at Legacy Health LLC	michelle.mazzsenga@walgreens.com
IHS.FS.60073462	ACTIVE	02/01/2009	02/01/2020	01/31/2022	Optum Women's and Children's Health LLC		1111 3rd Ave Ste 1100		Seattle	WA	98101-3207	King	fern.matthews@optum.com		Attn: Fern Matthews	2100 Riveredge Pkwy Ste 500		Atlanta	GA	30328-4676	Fulton		601696425	Optum Women's and Children's Health LLC	fern.matthews@optum.com
IHS.FS.60331226	ACTIVE	02/06/2013	02/07/2020	02/06/2022	PeaceHealth Hospice and PeaceHealth Homecare		5400 MacArthur Blvd		Vancouver	WA	98661-7049	Clark	scurry@peachhealth.org	(360) 696-5100		PO Box 2369		Vancouver	WA	98668-2369	Clark		600250191	PeaceHealth Southwest Medical Center	scurry@peacehealth.org
IHS.FS.60625346	ACTIVE	02/02/2016	02/03/2019	02/02/2021	Peninsula Homecare Cooperative		1017B Water St		Port Townsend	WA	98368-6705	Jefferson	thrive@peninsulahomecare.coop			PO Box 468		Port Townsend	WA	98368-0468	Jefferson		603541426	Peninsula Homecare Cooperative	thrive@peninsulahomecare.coop
IHS.FS.60224383	ACTIVE	09/28/2011	09/29/2020	09/28/2022	Personalized Living at Park Place		601 S Park Rd		Spokane Valley	WA	99212-0593	Spokane	agalati@brookdale.com	(509) 922-7224		601 S Park Rd		Spokane Valley	WA	99212-0593	Spokane	agalati@brookdale.com	602769662	BKD Personal Assistance Services LLC	agalati@brookdale.com
IHS.FS.60083889	ACTIVE	06/01/2009	06/01/2020	05/31/2022	Popes Kids Place		230 Washington Way		Centralia	WA	98531-9325	Lewis	fmillwood@popeskidsplace.org	(360) 736-9178		230 Washington Way		Centralia	WA	98531-9325	Lewis	fmillwood@popeskidsplace.org	601629633	Popes Kids Place	fmillwood@popeskidsplace.org
IHS.FS.60917192	ACTIVE	01/04/2019	01/05/2020	01/04/2022	Priority Home Health		935 S Huntington St		Kennewick	WA	99336-4781	Benton	grace@priorityhomehealth.care	(509) 588-7017		98216 E Sidibe PR SE		Kennewick	WA	99338-0009	Benton	grace@nadxieliihealth.com	604340070	Priority Home Health LLC	grace@priorityhomehealth.care
IHS.FS.60474800	ACTIVE	07/21/2014	07/22/2019	07/21/2021	Professional Case Management of Washington LLC		303 Bradley Blvd Ste 110		Richland	WA	99352-4497	Benton	greg.austin@procasemanagement.com			500 E 8th Ave		Denver	CO	80203-3716	Denver		602828653	Act for Health Inc.	greg.austin@procasemanagement.com
IHS.FS.60259664	ACTIVE	01/06/2012	01/07/2019	01/06/2021	Providence DominiCare		110 S 3rd Ave E		Chewelah	WA	99109	Stevens	joan.sisco@providence.org	(509) 935-4925		PO Box 1070		Chewelah	WA	99109-1070	Stevens		313007977	Providence Health and Services - Washington	dovie.britton@providence.org
IHS.FS.00000415	ACTIVE		01/01/2020	12/31/2021	Providence Elder Place		4515 Martin Luther King Jr Way S Ste 100		Seattle	WA	98108-2183	King		(206) 320-5325		4515 Martin Luther King Jr Way S Ste 100		Seattle	WA	98108-2183	King		313007977	Providence Health and Services - Washington	dovie.britton@providence.org
IHS.FS.60108399	ACTIVE		08/01/2019	07/31/2021	Providence Home Health		6410 NE Halsey St Ste 200		Portland	OR	97213-4742	Multnomah	orregohomeservices@providence.org	(503) 215-4646		6410 NE Halsey St Ste 200		Portland	OR	97213-4742	Multnomah	orregohomeservices@providence.org	601097557	Providence Health & Services Oregon	
IHS.FS.60236808	ACTIVE	11/03/2011	11/04/2018	11/03/2020	Providence Home Medical Equipment		6410 NE Halsey St Ste 500		Portland	OR	97213-4759	Multnomah		(360) 816-7373		6410 NE Halsey St Ste 500		Portland	OR	97213-4759	Multnomah		601097557	Providence Health & Services Oregon	
IHS.FS.00000419	ACTIVE		06/01/2020	05/31/2022	Providence Home Services		2811 S 102nd St Ste 220		Tukwila	WA	98168-1870	King	marc.berg@providence.org	(425)525-6800		2811 S 102nd St Ste 220		Tukwila	WA	98168-1870	King	marc.berg@providence.org	313007977	Providence Health and Services - Washington	dovie.britton@providence.org
IHS.FS.60201476	ACTIVE	12/16/2010	12/17/2019	12/16/2021	Providence Hospice		6410 NE Halsey St Ste 300		Portland	OR	97213-4759	Multnomah		(503) 215-2273		6410 NE Halsey St Ste 300		Portland	OR	97213-4759	Multnomah		601097557	Providence Health & Services Oregon	
IHS.FS.00000418	ACTIVE		05/01/2020	04/30/2022	Providence Hospice and Home Care of Snohomish County		2731 Wetmore Ave Ste 500		Everett	WA	98201-3585	Snohomish	jennifer.navarro@providence.org	(425) 261-4800		2731 Wetmore Ave Ste 500		Everett	WA	98201-3585	Snohomish	jennifer.navarro@providence.org	313007977	Providence Health and Services - Washington	dovie.britton@providence.org
IHS.FS.00000336	ACTIVE		10/01/2019	09/30/2021	Providence Hospice of Seattle		2811 S 102nd St Ste 220		Tukwila	WA	98168-1870	King	hospiceinfo@providence.org	(206) 320-4000		2811 S 102nd St Ste 220		Tukwila	WA	98168-1870	King	hospiceinfo@providence.org	313007977	Providence Health and Services - Washington	dovie.britton@providence.org
IHS.FS.00000417	ACTIVE		05/01/2020	04/30/2022	Providence Infusion and Pharmacy Services		3333 S 120th Pl Ste 100		Tukwila	WA	98168-5134	King		(425) 687-4400		3333 S 120th Pl Ste 100		Tukwila	WA	98168-5134	King		313007977	Providence Health and Services - Washington	dovie.britton@providence.org
IHS.FS.60344780	ACTIVE	03/29/2013	03/30/2020	03/29/2022	Providence Infusion and Pharmacy Services		10807 E Montgomery Dr Ste 8		Spokane Valley	WA	99206-4777	Spokane				10807 E Montgomery Dr Ste 8		Spokane Valley	WA	99206-4777	Spokane		313007977	Providence Health and Services - Washington	dovie.britton@providence.org
IHS.FS.00000420	ACTIVE		05/01/2020	04/30/2022	Providence Sound HomeCare and Hospice		4200 6th Ave SE Ste 201		Lacey	WA	98503-1042	Thurston		(360) 459-8311		4200 6th Ave SE Ste 201		Lacey	WA	98503-1042	Thurston		313007977	Providence Health and Services - Washington	dovie.britton@providence.org
IHS.FS.00000446	ACTIVE		02/01/2020	01/31/2022	Providence St Mary Home Health		209 W Poplar St		Walla Walla	WA	99362-2828	Walla Walla		(509) 522-5710		PO Box 1477		Walla Walla	WA	99362-0312	Walla Walla	jennifer.navarro@providence.org	313007977	Providence Health and Services - Washington	dovie.britton@providence.org
IHS.FS.00000467	ACTIVE		07/01/2020	06/30/2022	Providence VNA Home Health		1000 N Argonne Rd		Spokane Valley	WA	99212-2600	Spokane	debra.rappuchi@providence.org	(509) 534-4300		1000 N Argonne Rd		Spokane Valley	WA	99212-2600	Spokane	debra.rappuchi@providence.org	313007977	Providence Health and Services - Washington	dovie.britton@providence.org
IHS.FS.60332035	ACTIVE	05/20/2013	05/21/2020	05/20/2022	Puget Sound Home Health		4002 Tacoma Mall Blvd Ste 204		Tacoma	WA	98409-7702	Pierce		(253) 581-9410		4002 Tacoma Mall Blvd Ste 204		Tacoma	WA	98409-7702	Pierce		603257823	Symbol Healthcare Inc	pseagle@pugetsoundhh.com
IHS.FS.60751653	ACTIVE	05/26/2017	06/01/2020	05/31/2022	Puget Sound Home Health of King County		4002 Tacoma Mall Blvd Ste 204A		Tacoma	WA	98409-7702	Pierce	pseagle@pugetsoundhh.com	(253) 735-4282		4002 Tacoma Mall Blvd Ste 204A		Tacoma	WA	98409-7702	Pierce	pseagle@pugetsoundhh.com	604111051	Emerald Healthcare Inc	pseagle@pugetsoundhh.com
IHS.FS.61032138	ACTIVE	04/22/2020	04/22/2020	04/22/2021	Puget Sound Hospice		4002 Tacoma Mall Blvd Ste 201		Tacoma	WA	98409-7702	Pierce	admin@pugetsoundhh.com	(253) 581-9410		4002 Tacoma Mall Blvd Ste 201		Tacoma	WA	98409-7702	Pierce	admin@pugetsoundhh.com	603257823	Symbol Healthcare Inc	pseagle@pugetsoundhh.com
IHS.FS.00000428	ACTIVE		01/01/2020	12/31/2021	Rainshadow Home Services, Inc		1001 E Washington St Ste 7		Sequim	WA	98382-3576	Clallam	autonurs@hotmail.com	(360) 681-6206		1001 E Washington St Ste 7		Sequim	WA	98382-3576	Clallam	autonurs@hotmail.com	602087882	Rainshadow Home Services Inc	rainshadowhomeservices@live.com
IHS.FS.61015659	ACTIVE	03/12/2020	03/12/2020	03/12/2021	Refreshing Angels Home Care and Staffing LLC		1435 S Sunset Dr		Tacoma	WA	98465-1234	Pierce	josiemburugu87@gmail.com	(253) 279-3161		1435 S Sunset Dr		Tacoma	WA	98465-1234	Pierce	josiemburugu87@gmail.com	604502561	Refreshing Angels Home Care and Staffing LLC	josiemburugu87@gmail.com
IHS.FS.60263077	ACTIVE	01/10/2012	01/11/2019	01/10/2021	Rehab Without Walls		20818 44th Ave W Ste 270		Lynnwood	WA	98036-7709	Snohomish		(425) 672-9219		20818 44th Ave W Ste 270		Lynnwood	WA	98036-7709	Snohomish		603150095	Rehab Without Walls Inc	paul.campbell@rescare.com
IHS.FS.60851874	ACTIVE	05/16/2018	05/17/2019	05/16/2021	Reliable Healthcare		719 Jadwin Ave Ste 11		Richland	WA	99352-4217	Benton	kellen@reliablehealthcareorthwest.com	(509) 743-7000		719 Jadwin Ave Ste 11		Richland	WA	99352-4217	Benton	kellen@reliablehealthcareorthwest.com	604171611	Reliable Healthcare LLC	kellen@reliablehealthcareorthwest.com
IHS.FS.60378260	ACTIVE	08/23/2013	08/24/2020	08/23/2022	Renton Divine Homecare LLC		17623 1st Ave S Apt G1		Normandy Park	WA	98148-2793	King	rentondivinehomeeaze@gmail.com	(425) 264-5924		17801 111th Ave SE		Renton	WA	98055-6540	King		603292672	Renton Divine Homecare LLC	rentondivinehomecare@gmail.com
IHS.FS.61090653	ACTIVE	08/31/2020	08/31/2020	08/31/2021	Restoration Health Services		33710 9th Ave S Ste 16		Federal Way	WA	98003-6734	King	info@rhscare.com	(253) 235-5535		33710 9th Ave S Ste 16		Federal Way	WA	98003-6734	King	info@rhscare.com	603098061	Restoration Home Health Services LLC	info@rhscare.com
IHS.FS.60998720	ACTIVE	01/09/2020	01/09/2020	01/09/2021	Ridgeline Homecare Cooperative		316 W 5th St		Port Angeles	WA	98362-2210	Clallam	jane@ridgeline.coop			PO Box 2623		Port Angeles	WA	98362-0330	Clallam		604371254	Ridgeline Homecare Cooperative	jane@ridgeline.coop
IHS.FS.60212874	ACTIVE	05/04/2011	05/05/2020	05/04/2022	Right At Home		8805 N Harborview Dr Ste 202		Gig Harbor	WA	98332-2146	Pierce	info@rahpeninsula.com	(253) 509-0728		8805 N Harborview Dr Ste 202		Gig Harbor	WA	98332-2146	Pierce	info@rahpeninsula.com	603082463	Right Care Inc	info@rahpeninsula.com
IHS.FS.00000096	ACTIVE	01/01/2004	10/01/2019	09/30/2021	Right At Home		11222 Roosevelt Way NE		Seattle	WA	98125-6241	King	ben@rahseattle.com	(206) 774-1100		11222 Roosevelt Way NE		Seattle	WA	98125-6241	King	ben@rahseattle.com	602410546	Northwest Homecare and Staffing Services LLC	ben@rahseattle.com
IHS.FS.60298689	ACTIVE	09/07/2012	09/08/2019	09/07/2021	Right At Home Northwest		114 W Magnolia St Ste 107		Bellingham	WA	98225-4354	Whatcom	sharon@rahnorthwest.com	(360) 392-3934		114 W Magnolia St Ste 107		Bellingham	WA	98225-4354	Whatcom	sharon@rahnorthwest.com	603197528	SSM Evergreen Enterprises Inc	steve@rahnorthwest.com
IHS.FS.60976474	ACTIVE	04/29/2020	04/29/2020	04/29/2021	Right at Home Spokane		5430 W Rail Canyon Rd		Deer Park	WA	99006-9430	Stevens	won.song@spokanecare.com			5919 Highway 291 Ste 1 PMB 136		Nine Mile Falls	WA	99026	Spokane		604491130	AHHPC, Inc.	won.song@spokanecare.com
IHS.FS.60142704	ACTIVE	05/11/2010	05/12/2019	05/11/2021	Right At Home- Snohomish County		909 SE Everett Mall Way Ste C319		Everett	WA	98208-3753	Snohomish	mark@rahsnoco.com	(425) 290-1714		909 SE Everett Mall Way Ste C319		Everett	WA	98208-3753	Snohomish	mark@rahsnoco.com	602976773	M and VJ Enterprise 1 Inc	mark@rahsnoco.com
IHS.FS.60610351	ACTIVE	01/21/2016	01/22/2019	01/21/2021	Ro Health		1900 W Nickerson St Ste 200		Seattle	WA	98119-1639	King	homehealth@rohealth.com			1900 W Nickerson St Ste 200		Seattle	WA	98119-1639	King	homehealth@rohealth.com	603320122	Ro Health Inc.	cyuen@rohealth.com
IHS.FS.00000386	ACTIVE		08/01/2019	07/31/2021	Rotech		15320 E Marietta Ave Ste 4		Spokane Valley	WA	99216-1870	Spokane	susan.martinez@rotech.com			3600 Vineland Rd Ste 114		Orlando	FL	32811-6460	Orange		601044154	Northwest Home Medical INC	susan.martinez@rotech.com
IHS.FS.00000427	ACTIVE		05/01/2020	04/30/2022	Rotech		1000 SW 7th St Ste F		Renton	WA	98057-5216	King	bree.feil@rotech.com			3600 Vineland Rd Ste 114		Orlando	FL	32811-6460	Orange		601840039	Centennial Medical Equipment Inc	susan.martinez@rotech.com
IHS.FS.00000431	ACTIVE		09/01/2019	08/31/2021	S and S Health Care		11319 E Carlisle Ave Ste 104		Spokane Valley	WA	99206-7651	Spokane	mbrinkley@sandshealthcare.com	(509) 533-0005		11319 E Carlisle Ave Ste 104		Spokane Valley	WA	99206-7651	Spokane	mbrinkley@sandshealthcare.com	601555893	S and S Health Care Inc	contact@sandshealthcare.com
IHS.FS.60768966	ACTIVE	07/25/2017	07/26/2020	07/25/2022	Safeguard Homecare		306 Main St # 5		Edmonds	WA	98020-3136	Snohomish	vladimir@safeguardhomecare.com			4957 Lakemont Blvd SE # C-4-271		Bellevue	WA	98006-7801	King		604120169	Attentive Care Holding LLC	vladimir@safeguardhomecare.com

Public Disclosure Request - Organizations

Lists the Credential #, Credential Status, First Issuance Date, Effective Date, Expiration Date, Facility Name, Site and Mailing Addresses, Counties, and Emails, Site Phone # and Secretary of State #. 07/21/17

IHS.FS.00000074	ACTIVE	01/01/2004	04/01/2019	03/31/2021	SAILS Washington		4121 McKinley Ave		Carnation	WA	98014	King	projectssupport@sailsgroup.com	(425) 333-4114		PO Box 1026		Carnation	WA	98014-1026	King		602416490	SAILS Washington, Inc.	projectsupport@sailsgroup.com
IHS.FS.00000433	ACTIVE		02/29/2020	02/28/2022	Sea Mar Home Health		1040 S Henderson St		Seattle	WA	98108-4720	King	deborahned@seamarchc.orq	(206) 764-4717		1040 S Henderson St		Seattle	WA	98108-4720	King	deborahned@seamarchc.orq	600537278	Sea Mar Community Health Center	carmennazario@seamarchc.orq
IHS.FS.60915444	ACTIVE	04/19/2019	04/20/2020	04/19/2022	Seacare In-Home Care Services		2265 116th Ave NE Ste 110 Office 210-3		Bellevue	WA	98004	King	brianna@seacarehomecare.com	(425) 559-4339		2265 116th Ave NE Ste 110 Office 210-3		Bellevue	WA	98004	King	brianna@seacarehomecare.com	604305497	Seacare In-Home Care Services L.L.C.	brianna@seacarehomecare.com
IHS.FS.60974854	ACTIVE	08/14/2019	08/14/2019	08/14/2020	Seameds Home Care Staffing Agency		10220 Renton Ave S		Seattle	WA	98178-2347	King	seamedsstaffing@gmail.com	(425) 524-3647		10220 Renton Ave S		Seattle	WA	98178-2347	King	seamedsstaffing@gmail.com	604459732	Seameds Home Care Staffing Agency LLC	seamedsstaffing@gmail.com
IHS.FS.00000097	ACTIVE	01/01/2004	10/01/2019	09/30/2021	Seattle Childrens Hospital Home Care Services		2525 220th St SE Ste 101		Bothell	WA	98021-4440	Snohomish	homecare.info@seattlechildrens.org	(425) 482-4000		2525 220th St SE Ste 101		Bothell	WA	98021-4440	Snohomish	homecare.info@seattlechildrens.org	178019356	Seattle Childrens Hospital	
IHS.FS.60450019	ACTIVE	02/10/2014	08/01/2019	07/31/2021	Senior Helpers		511 S Pine St Ste D		Spokane	WA	99202-1347	Spokane	markdmurphy66@gmail.com	(509) 922-4333		511 S Pine St Ste D		Spokane	WA	99202-1347	Spokane	markdmurphy66@gmail.com	603364126	SH Care Inc.	kduncan@seniorhelpers.com
IHS.FS.60306801	ACTIVE	07/18/2013	07/19/2020	07/18/2022	Senior Helpers		1101 Harvey Rd NE		Auburn	WA	98002-4219	King	cphillips@seniorhelpers.com	(425) 656-8811		1101 Harvey Rd NE		Auburn	WA	98002-4219	King	cphillips@seniorhelpers.com	603171347	RTP3 INC	cphillips@seniorhelpers.com
IHS.FS.60828754	ACTIVE	03/30/2018	03/31/2019	03/30/2021	Senior Helpers		2600 Martin Way E Ste B		Olympia	WA	98506-4974	Thurston	aketter@seniorhelpers.com	(360) 742-5300		2600 Martin Way E Ste B		Olympia	WA	98506-4974	Thurston	aketter@seniorhelpers.com	604204366	Olympia Senior Care LLC	aketter@seniorhelpers.com
IHS.FS.60269071	ACTIVE	04/27/2012	04/28/2019	04/27/2021	Senior Helpers of Vancouver		108 SE 124th Ave Ste 9		Vancouver	WA	98684-6015	Clark	nharris@seniorHelpers.com	(360) 836-0499		10415 SE Stark St Ste F		Portland	OR	97216-2764	Multnomah		603160336	December Roses LLC	nharris@seniorhelpers.com
IHS.FS.00000434	ACTIVE		07/01/2020	06/30/2022	Senior Life Resources Northwest		1824 Fowler St		Richland	WA	99352-4810	Benton	admin@seniorliferesources.org	(509) 735-1911		1824 Fowler St		Richland	WA	99352-4810	Benton	admin@seniorliferesources.org	600464998	Senior Life Resources Northwest	admin@seniorliferesources.org
IHS.FS.60660148	ACTIVE	06/17/2016	06/18/2019	06/17/2021	Serengeti Care		607 SW Grady Way Ste 110		Renton	WA	98057-2977	King	wamunanga@rocketmail.com	(425) 207-7688		607 SW Grady Way Ste 110		Renton	WA	98057-2977	King	wamunanga@rocketmail.com	603506273	Serengeti Care Partners LLC	albert@serengeticare.com
IHS.FS.60667215	ACTIVE	07/11/2016	07/12/2019	07/11/2021	Serenity Home Care LLC		400 Union Ave SE Ste 200		Olympia	WA	98501-2060	Thurston	vc.serenityhc@gmail.com	360-764-8933		1801 W Bay Dr NW Ste 203B		Olympia	WA	98502-4311	Thurston	vc.serenityhc@gmail.com	603585604	Serenity Home Care LLC	vc.serenityhc@gmail.com
IHS.FS.00000100	ACTIVE	01/01/2004	11/01/2019	10/31/2021	Service Alternatives Inc		1614 Broadway		Everett	WA	98201-1724	Snohomish	kbriscow@servalt-asl.com	(425) 252-5239		1614 Broadway		Everett	WA	98201-1724	Snohomish	kbriscow@servalt-asl.com	600515957	Service Alternatives Inc	kbriscoe@servalt-asl.com
IHS.FS.00000436	ACTIVE		12/01/2019	11/30/2021	Seuberts Quality Home Care		1702 16th Ave		Lewiston	ID	83501-4023	Nez Perce	SQHCAdmin@cableone.net	(208)743-1818		1702 16th Ave		Lewiston	ID	83501-4023	Nez Perce	SQHCAdmin@cableone.net	601393077	Seuberts Inc	SQHCAdmin@cableone.net
IHS.FS.60981959	ACTIVE	07/09/2019	07/09/2019	02/02/2021	Seventh Generation Eldercare		1101 Broadway St Ste 201		Vancouver	WA	98660-3268	Clark	info@seventh-gen.org	(360) 843-5116		1101 Broadway St Ste 201		Vancouver	WA	98660-3268	Clark	info@seventh-gen.org	604448390	Seventh Generation Eldercare LLC	info@seventh-gen.org
IHS.FS.60664993	ACTIVE	06/02/2016	01/09/2019	01/08/2021	Signature Care		8130 216th Pl SE		Woodinville	WA	98072-8005	Snohomish	signaturehomehealth12@gmail.com			914 164th St SE Ste B12		Mill Creek	WA	98012-6339	Snohomish		603590520	Prevail Healthcare LLC	signaturehomehealth12@gmail.com
IHS.FS.00000089	ACTIVE	01/01/2004	08/01/2019	07/31/2021	Signature Healthcare at Home - Bellingham		459 Stuart Rd		Bellingham	WA	98226-1204	Whatcom	jwright@4signatureservice.com			25117 SW Parkway Ave Ste F		Wilsonville	OR	97070-9697	Washington		602438155	Avamere Home Health Care LLC	
IHS.FS.00000220	ACTIVE		02/29/2020	02/28/2022	Signature Home Health		1510 140th Ave NE Ste 100		Bellevue	WA	98005-4572	King		(877) 670-3850		1510 140th Ave NE Ste 100		Bellevue	WA	98005-4572	King		601937523	A-One Home Health Services Inc	bbiddulph@4signatureservice.com
IHS.FS.00000382	ACTIVE		02/17/2019	02/16/2021	Signature Home Health		909 S 336th St Ste 100		Federal Way	WA	98003-7394	King		(253)661-5166		909 S 336th St Ste 100		Federal Way	WA	98003-7394	King		600565683	Prime Home Health, Inc	bbiddulph@4signatureservice.com
IHS.FS.60463188	ACTIVE	05/27/2014	05/28/2019	05/27/2021	Sisi Care		800 137th Ave NE Apt 204		Bellevue	WA	98005-3404	King		(206) 334-3505		800 137th Ave NE Apt 204		Bellevue	WA	98005-3404	King		603361517	Jamtsai Tsevelsuren and Bazar Balgan	j_tsevlee@hotmail.com
IHS.FS.60950400	ACTIVE	04/16/2019	04/17/2020	04/16/2022	Sofavi Home Health LLC		3801 NE 70th St		Seattle	WA	98115-6019	King	sofavihomehealth@gmail.com	(206) 402-6628		3801 NE 70th St		Seattle	WA	98115-6019	King	sofavihomehealth@gmail.com	604417575	Sofavi Home Health LLC	sofavihomehealth@gmail.com
IHS.FS.60863143	ACTIVE	06/01/2018	04/01/2020	03/31/2022	Sound Options		3518 6th Ave Ste 300		Tacoma	WA	98406-5419	Pierce	william@villageplan.com	(253) 756-5007		3518 6th Ave Ste 300		Tacoma	WA	98406-5419	Pierce	william@villageplan.com	604248455	VillagePlan Care Options LLC	william@villageplan.com
IHS.FS.60883149	ACTIVE	09/05/2018	09/06/2019	09/05/2021	Specialty Service Solutions, LLC		2471 Road 10.4 NE		Moses Lake	WA	98837-8267	Grant				2471 Road 10.4 NE		Moses Lake	WA	98837-8267	Grant		604069784	Specialty Service Solutions, LLC	specialty.service@outlook.com
IHS.FS.60408625	ACTIVE	12/12/2013	12/13/2018	12/12/2020	Spokane Tribe Personal Care		6403 Sherwood Loop Rd		Wellpinit	WA	99040	Stevens	angiec@spokanetribe.com			PO Box 100		Wellpinit	WA	99040-0100	Stevens		600293561	Spokane Tribe of Indians	angiec@spokanetribe.com
IHS.FS.60614915	ACTIVE	03/31/2016	04/01/2019	03/31/2021	St. Peter's In Home Care		10828 Gravelly Lake Dr SW Ste 109		Lakewood	WA	98499-1300	Pierce	stpeters.ihc@outlook.com	(253) 433-3908		10828 Gravelly Lake Dr SW Ste 109		Lakewood	WA	98499-1300	Pierce	stpeters.ihc@outlook.com	603542420	St. Peter's In Home Care LLC	stpeters.ihc@outlook.com
IHS.FS.60145393	ACTIVE	04/30/2010	05/01/2019	04/30/2021	Stepping Stones Pediatric Therapy		319 S Cedar St		Spokane	WA	99201-7029	Spokane	hello@ssptherapy.com	(509) 209-7429		319 S Cedar St		Spokane	WA	99201-7029	Spokane	hello@ssptherapy.com	602985256	Stepping Stones Pediatric Therapy PLLC	
IHS.FS.00000447	ACTIVE	01/01/2004	07/01/2020	06/30/2022	Sunrise Home Care		7003 Evergreen Way		Everett	WA	98203-5153	Snohomish				PO Box 2569		Everett	WA	98213-0569	Snohomish		600231010	Sunrise Services Inc	suec@sunriseemail.com
IHS.FS.60118992	ACTIVE	11/13/2009	11/14/2018	11/13/2020	Sunshine Home Health Care LLC		10410 E 9th Ave Bldg B		Spokane Valley	WA	99206-3510	Spokane	nathan@shfi.ocm	(509) 321-9050		10410 E 9th Ave Bldg B		Spokane Valley	WA	99206-3510	Spokane	nathan@shfi.ocm	602919416	Sunshine Home Health Care LLC	gretchena@shfi.com
IHS.FS.60388762	ACTIVE	08/02/2013	08/03/2020	08/02/2022	Synergy Home Care		402 S 333rd St # 109		Federal Way	WA	98003-6309	King		(253) 517-3130		402 S 333rd St # 109		Federal Way	WA	98003-6309	King		603304322	Pilgrim Care Inc	wa08@synergyhomecare.com
IHS.FS.60384083	ACTIVE	08/08/2013	08/09/2020	08/08/2022	Synergy Home Care		2920 Harrison Ave NW Ste A		Olympia	WA	98502-2609	Thurston	bradrossman@synergyhomecare.com	(360) 338-0837		2920 Harrison Ave NW Ste A		Olympia	WA	98502-2609	Thurston	bradrossman@synergyhomecare.com	603291270	IntegraCare Inc	bradrossman@synergyhomecare.com
IHS.FS.60151137	ACTIVE	06/14/2010	06/15/2019	06/14/2021	Synergy Home Care Seattle		9131 California Ave SW Ste 2		Seattle	WA	98136-2551	King	rayfitzgibbon@synergyhomecare.com	(206) 420-4394		9131 California Ave SW Ste 2		Seattle	WA	98136-2551	King	rayfitzgibbon@synergyhomecare.com	602996993	Paige Susan LLC	rayfitzgibbon@synergyhomecare.com
IHS.FS.60105273	ACTIVE	08/25/2009	08/27/2020	08/26/2022	Synergy HomeCare		1505 NW Gilman Blvd Ste 1B		Issaquah	WA	98027-5398	King	tppowers@shceastking.com	(425) 988-3759		1505 NW Gilman Blvd Ste 1B		Issaquah	WA	98027-5398	King	tppowers@shceastking.com	602933704	Powers Enrichment Group Inc	tpowers@shceastking.com
IHS.FS.60428051	ACTIVE	03/14/2014	03/15/2019	03/14/2021	Synergy HomeCare		4317 NE Thurston Way Ste 230		Vancouver	WA	98662-6660	Clark	wemerriman@synergybellevue.com	(360) 891-1506		4317 NE Thurston Way Ste 230		Vancouver	WA	98662-6660	Clark	wemerriman@synergybellevue.com	602790078	Moser Services Inc	darlene@synergycolumbia.com
IHS.FS.00000139	ACTIVE	01/01/2006	06/01/2019	05/31/2021	Synergy HomeCare of Bellevue		1603 116th Ave NE Ste 116		Bellevue	WA	98004-3009	King	wemerriman@synergyhomecare.com	(425) 462-5300		1603 116th Ave NE Ste 116		Bellevue	WA	98004-3009	King	wemerriman@synergyhomecare.com	602518612	Brown-Meiling and Hall Inc	wemerriman@synergybellevue.com
IHS.FS.60236801	ACTIVE	11/03/2011	11/04/2018	11/03/2020	Tacoma Lutheran Retirement Community		1301 N Highlands Pkwy		Tacoma	WA	98406-2116	Pierce	greatday@tacomalutheran.org	(253) 752-7112		1301 N Highlands Pkwy		Tacoma	WA	98406-2116	Pierce	greatday@tacomalutheran.org	601140483	Tacoma Lutheran Retirement Community	greatday@tacomalutheran.org
IHS.FS.60252612	ACTIVE	11/15/2011	11/16/2018	11/15/2020	Take My Hand at Home Care		9108 Bender Rd		Lynden	WA	98264-9506	Whatcom		(360) 543-5777		9108 Bender Rd		Lynden	WA	98264-9506	Whatcom		603139353	Take My Hand at Home Care LLC	sue@takemyhandathome.com
IHS.FS.61076104	ACTIVE	06/16/2020	06/16/2020	06/16/2021	Tender Angels Homecare LLC		11900 NE 1st St Bldg G Ste 300		Bellevue	WA	98005	King	info@tenderangelshomecare.com			1202 N 10th Pl Apt 1206		Renton	WA	98057-5633	King		604582744	Tender Angels Homecare LLC	tenderangels.hc@gmail.com
IHS.FS.60850096	ACTIVE	06/26/2018	06/27/2019	06/26/2021	The Arc of Spokane		320 E 2nd Ave		Spokane	WA	99202-1402	Spokane	lrichardson@arc-spokane.org	(509) 328-6326		320 E 2nd Ave		Spokane	WA	99202-1402	Spokane	lrichardson@arc-spokane.org	600397826	The Arc of Spokane	lrichardson@arc-spokane.org
IHS.FS.60877485	ACTIVE	09/27/2018	09/28/2019	09/27/2021	The Home Care Company		10400 NE 4th St Ste 500		Bellevue	WA	98004-5175	King	info@thehomecarecompany.org			18628 19th Dr SE		Bothell	WA	98012-8714	Snohomish		604280680	The Home Care Company LLC	info@thehomecarecompany.org
IHS.FS.00000174	ACTIVE	01/01/2007	10/01/2018	09/30/2020	The Personal Touch		3014 Huntington St		Port Orchard	WA	98366-4008	Kitsap	lisa@thepersonaltouch4u.com			PO Box 1996		Port Orchard	WA	98366-0717	Kitsap		602716372	The Personal Touch LLC	lisa@thepersonaltouch4u.com
IHS.FS.00000452	ACTIVE		09/01/2020	08/31/2022	Total Care		307 S 12th Ave Ste 18		Yakima	WA	98902-3147	Yakima	tchomecare@aol.com	(509) 248-7846		307 S 12th Ave Ste 18		Yakima	WA	98902-3147	Yakima	tchomecare@aol.com	601470535	Total Care Inc	tchomecare@aol.com
IHS.FS.00000454	ACTIVE		05/01/2020	04/30/2022	Touchmark at Fairway Village, LLC HH and HC		2927 SE Village Loop Ste 100		Vancouver	WA	98683-8119	Clark	bep@touchmark.com	(360) 253-3855		2927 SE Village Loop Ste 100		Vancouver	WA	98683-8119	Clark	bep@touchmark.com	601635972	Waterford at Fairway Village LLC	amc@touchmark.com
IHS.FS.00000453	ACTIVE		05/01/2020	04/30/2022	Touchmark Home Health and Home Care		2929 S Waterford Dr		Spokane	WA	99203-4400	Spokane	dave.cox@touchmark.com	(509) 536-2929		2929 S Waterford Dr		Spokane	WA	99203-4400	Spokane	dave.cox@touchmark.com	601155999	Waterford on South Hill a Limited Partnership	kar@touchmark.com
IHS.FS.00000071	ACTIVE	01/01/2004	03/01/2019	02/28/2021	Touchmark Home Health and Home Care		2929 S Waterford Dr		Spokane	WA	99203-4400	Spokane	jwc@touchmark.com	(509) 536-2929		2929 S Waterford Dr		Spokane	WA	99203-4400	Spokane	jwc@touchmark.com	601155999	Waterford on South Hill a Limited Partnership	kar@touchmark.com
IHS.FS.61057211	ACTIVE	05/29/2020	05/29/2020	05/29/2021	Transitions Care Management, LLC		9813 S 231st St		Kent	WA	98031-3144	King	stephanie@transitionscm.com	(206) 293-3078		9813 S 231st St		Kent	WA	98031-3144	King	stephanie@transitionscm.com	603571782	Transitions Care Management, LLC	stephanie@transitionscm.com
IHS.FS.00000352	ACTIVE	05/01/2003	09/01/2019	08/31/2021	Tri Cities Home Health		8819 W Victoria Ave Ste 110		Kennewick	WA	99336-7193	Benton		(509) 783-1851		8819 W Victoria Ave Ste 110		Kennewick	WA	99336-7193	Benton		602285278	Tri Cities Home Health LLC	0801@amedisys.com
IHS.FS.60904220	ACTIVE	11/09/2018	11/10/2019	11/09/2021	Trinity Care Partners, LLC		22007 Meridian Ave E Ste E		Graham	WA	98338-8412	Pierce	carolyn.goldade@ffhca.com	(253) 271-7725		22007 Meridian Ave E Ste E		Graham	WA	98338-8412	Pierce	carolyn.goldade@ffhca.com	604305692	Family First Homecare LLC	carolyn@trincp.com
IHS.FS.61043336	ACTIVE	08/24/2020	08/24/2020	08/24/2021	Tulamore, Inc.		10012 4th Ave W Apt 4		Everett	WA	98204-2735	Snohomish	thulab01@yahoo.com	(206) 854-6268		10012 4th Ave W Apt 4		Everett	WA	98204-2735	Snohomish	thulab01@yahoo.com	604503544	Tulamore Inc. Company	thulab01@yahoo.com
IHS.FS.60830680	ACTIVE	05/16/2018	05/17/2019	05/16/2021	Twilight Health		1030 N Center Pkwy Ste 119		Kennewick	WA	99336-7160	Benton	brianc@rahhc.com	(800) 718-5658		330 Research Dr Ste 110		Athens	GA	30605-2759	Clarke		604206228	Remain at Home Senior Care, LLC	brianc@rahhc.com
IHS.FS.60447793	ACTIVE	05/08/2014	05/09/2019	05/08/2021	Unicare LLC		10116 36th Avenue Ct SW Ste 5		Lakewood	WA	98499-4797	Pierce	sgathiru@yahoo.com	(253) 238-8682		10116 36th Avenue Ct SW Ste 5		Lakewood	WA	98499-4797	Pierce	sgathiru@yahoo.com	602876793	Unicare LLC	sgathiru@yahoo.com
IHS.FS.60593988	ACTIVE	11/20/2015	06/19/2019	11/20/2020	United Energy Workers Healthcare, Corp		303 Bradley Blvd Ste 102		Richland	WA	99352-4497	Benton	chris.russell@uewhealth.com			614 E Main St Ste C		Riverton	WY	82501-4460	Fremont		603525436	Black Mountain Holdings, Corp	licensing@uewhealth.com
IHS.FS.60631342	ACTIVE	09/16/2016	09/17/2019	09/16/2021	Universal Home Care LLC		7101 Martin Luther King Jr Way S Ste 202		Seattle	WA	98118-3547	King	universalhomecarellc@gmail.com			PO Box 28082		Seattle	WA	98118-1082	King		603566765	Universal Home Care LLC	universalhomecarellc@gmail.com
IHS.FS.60405684	ACTIVE	12/12/2013	12/13/2018	12/12/2020	Utopia In Home Care Solution		14100 Linden Ave N Apt 418		Seattle	WA	98133-7165	King	quan76gr@gmail.com	(206) 549-9648		14100 Linden Ave N Apt 418		Seattle	WA	98133-7165	King	quan76gr@gmail.com	603286662	Lulu Dereje G	quan76er@gmail.com
IHS.FS.60450910	ACTIVE	04/15/2014	04/16/2020	04/15/2022	Vancouver Comfort Keepers		406 SE 131st Ave Ste 205		Vancouver	WA	98683-4013	Clark	clarkdmd@comcast.net	(360) 687-0025		406 SE 131st Ave Ste 205		Vancouver	WA	98683-4013	Clark	clarkdmd@comcast.net	603365497	Vancouver Comfort Keepers LLC	vancouverwa@comfortkeepers.com
IHS.FS.60660459	ACTIVE	02/14/2017	02/15/2020	02/14/2022	Vancouver Home Healthcare Agency LLC		201 NE Park Plaza Dr Ste 284		Vancouver	WA	98684-5881	Clark	info@vhhca.com			PO Box 2988		Vancouver	WA	98668-2988	Clark		603578517	Vancouver Home Healthcare Agency LLC	info@vhhca.com
IHS.FS.60915449	ACTIVE	12/03/2018	12/04/2019	12/03/2021	Vibrant Health Homecare		5401 S Tacoma Way		Tacoma	WA	98409-4312	Pierce	annet@vibranthealthcarestaffing.com	(253) 355-3087		5003 59th Avenue Ct W		University Place	WA	98467-4134	Pierce	annet@vibranthealthcarestaffing.com	604271079	Vibrant Healthcare Staffing Agency LLC	annet@vibranthealthhomecare.com
IHS.FS.60897928	ACTIVE	11/29/2018	11/29/2019	09/28/2020	Vida At Home		1005 N Pines Rd Ste 40		Spokane Valley	WA	99206-4958	Spokane	josh@vidainhomecare.com	(509) 473-9549		1005 N Pines Rd Ste 40		Spokane Valley	WA	99206-4958	Spokane	josh@vidainhomecare.com	604286452	Vida At Home, LLC	josh@vidainhomecare.com
IHS.FS.60302537	ACTIVE	08/24/2012	08/25/2019	08/24/2021	VIP Private Home Care Services		914 164th St SE Ste B12		Mill Creek	WA	98012-6339	Snohomish	tdrigailo@gmail.com	(425) 647-8273		914 164th St SE Ste B12		Mill Creek	WA	98012-6339	Snohomish	tdrigailo@gmail.com	603176204	Private Home Care Services	tdrigailo@viphomecarewa.com
IHS.FS.00000134	ACTIVE	01/01/2006	05/01/2019	04/30/2021	Visions Home Health Care		6818 124th Ave NE		Kirkland	WA	98033-8521	King	cheryl.jordan@hhftd.org	(425) 827-6908		15111 8th Ave SW Ste 303		Burien	WA	98166-2258	King	cheryl.jordan@hhftd.org	600399606	Helping Hands for the Disabled	c.jordan@dahlialiving.org
IHS.FS.00000022	ACTIVE		06/01/2020	05/31/2022	Visiting Angels		12020 113th Ave NE Bldg C Ste 180		Kirkland	WA	98034-6938	King	makaylaa@eastsideangels.com	(425) 828-4500		12020 113th Ave NE Bldg C Ste 180		Kirkland	WA	98034-6938	King	makaylaa@eastsideangels.com	602377771	Namaste of WA Inc	makaylaa@eastsideangels.com
IHS.FS.00000462	ACTIVE		12/01/2019	11/30/2021	Visiting Angels		4213 Rural Ave		Bellingham	WA	98226-9231	Whatcom	fred@visitingangelswa.com	(360)671-8388		4213 Rural Ave		Bellingham	WA	98226-9231	Whatcom	fred@visitingangelswa.com	602054118	Fred and Debbie Inc	fred@visitingangelswa.com
IHS.FS.60191349	ACTIVE	01/05/2011	01/06/2020	01/05/2022	Visiting Angels		700 Prospect St Ste 204		Port Orchard	WA	98366-5399	Kitsap	roswald@visitingangels.com			26410 Wax Orchard Rd SW		Vashon	WA	98070-7812	King		603038007	WestSound Home Care Inc	roswald@visitingangels.com
IHS.FS.00000135	ACTIVE	01/01/2006	05/01/2019	04/30/2021	Visiting Angels		603 Officers Row		Vancouver	WA	98661-3837	Clark	rloudenback@yahoo.com			PO Box 61407		Vancouver	WA	98666-1407	Clark		602586334	The Loudenback Corporation	rloudenback@yahoo.com
IHS.FS.60653263	ACTIVE	12/27/2016	12/28/2019	12/27/2021	Visiting Angels		33410 SE Redmond-Fall City Rd		Fall City	WA	98024	King	dandrew@visitingangels.com	(425) 441-8133		PO Box 1324		Fall City	WA	98024-1324	King		603586939	Drew Senior Support Services Inc.	dandrew@visitingangels.com

Public Disclosure Request - Organizations

Lists the Credential #, Credential Status, First Issuance Date, Effective Date, Expiration Date, Facility Name, Site and Mailing Addresses, Counties, and Emails, Site Phone # and Secretary of State #. 07/21/17

IHS.FS.60686247	ACTIVE	08/05/2016	07/01/2020	06/30/2022	Visiting Angels		708 N Argonne Rd Ste 8A		Spokane Valley	WA	99212-2700	Spokane	denisej1210@gmail.com	(509) 922-1141		708 N Argonne Rd Ste 8A		Spokane Valley	WA	99212-2700	Spokane	denisej1210@gmail.com	604001326	A Lot of Extra TLC LLC	d.johnson@visitingangels.com
IHS.FS.60563884	ACTIVE	05/29/2015	05/30/2019	05/29/2021	Visiting Angels		15 N Cascade St		Kennewick	WA	99336-3853	Benton		(509) 582-7800		15 N Cascade St		Kennewick	WA	99336-3853	Benton		603478104	R V Home Care Inc.	christine@tricitiesvisitingangels.com
IHS.FS.60130349	ACTIVE	03/04/2010	03/05/2019	03/04/2021	Visiting Angels - Best Friends Senior Services		12511 Meridian E Ste 102		Puyallup	WA	98373-3425	Pierce	raptorrick1@gmail.com	(253) 841-8841		12511 Meridian E Ste 102		Puyallup	WA	98373-3425	Pierce	raptorrick1@gmail.com	602969988	Best Friends Senior Services LLC	rabel@visitingangels.com
IHS.FS.60936701	ACTIVE	03/29/2019	03/30/2020	03/29/2022	Visiting Angels of Chelan		131 S Apple Blossom Dr Unit 121		Chelan	WA	98816-8810	Chelan	mharlich@visitingangels.com	(509) 888-4781		131 S Apple Blossom Dr Unit 121		Chelan	WA	98816-8810	Chelan	mharlich@visitingangels.com	604331041	Helping Hand Home Care LLC	mharlich@visitingangels.com
IHS.FS.60024816	ACTIVE	02/06/2007	02/29/2020	02/28/2022	Visiting Angels of Renton		1035 Andover Park W Ste 110		Tukwila	WA	98188-7627	King	smoikobu@visitingangels.com	(425) 282-5505		1035 Andover Park W Ste 110		Tukwila	WA	98188-7627	King	smoikobu@visitingangels.com	602676296	Angel Network Inc	smoikobu@visitingangels.com
IHS.FS.00000466	ACTIVE		12/01/2019	11/30/2021	Visiting Health Services		1730 E 12th St		The Dalles	OR	97058-3137	Wasco		(541) 296-7280		1730 E 12th St		The Dalles	OR	97058-3137	Wasco		601088286	Mid Columbia Medical Center	donar@mcmc.net
IHS.FS.60480441	ACTIVE	06/19/2014	07/01/2020	06/30/2022	Walla Walla Community Hospice		1067 E Isaacs Ave		Walla Walla	WA	99362-2040	Walla Walla	info@wwhospice.org	(509)525-5561		1067 E Isaacs Ave		Walla Walla	WA	99362-2040	Walla Walla	info@wwhospice.org	601586678	WALLA WALLA COMMUNITY HOSPICE	info@wwhospice.org
IHS.FS.60486343	ACTIVE	08/01/2014	08/02/2019	08/01/2021	Walla Walla Valley In Home Care		5 W Alder St Ste 202		Walla Walla	WA	99362-2863	Walla Walla	wallawallavalleyinhomecare@yahoo.com	(509) 876-1152		5 W Alder St Ste 202		Walla Walla	WA	99362-2863	Walla Walla	wallawallavalleyinhomecare@yahoo.com	603072108	Santana LLC	j.santana06@yahoo.com
IHS.FS.61055973	ACTIVE	03/26/2020	08/28/2020	08/27/2022	Wellspring Home Health, LLC		8815 S Tacoma Way Ste 120		Lakewood	WA	98499-7011	Pierce	info@wellspringhomehealth.com			PO Box 33064		Tacoma	WA	98433-0064	Pierce		604416353	Wellspring Home Health, LLC	info@wellspringhomehealth.com
IHS.FS.60276500	ACTIVE	03/14/2012	01/01/2020	12/31/2021	Wesley Health and Homecare		815 S 216th St		Des Moines	WA	98198-6332	King	mmoore@wesleyhomes.org	(206) 870-1127		815 S 216th St		Des Moines	WA	98198-6332	King	mmoore@wesleyhomes.org	602702244	Wesley Homes at Home LLC	mmoore@wesleyhomes.org
IHS.FS.60522405	ACTIVE	03/20/2015	03/21/2020	03/20/2022	Westfield Home Health and Homecare Inc.		5031 168th St SW Ste 150		Lynnwood	WA	98037-5717	Snohomish		(425) 678-6919		5031 168th St SW Ste 150		Lynnwood	WA	98037-5717	Snohomish		603227916	Westfield Home Health and Homecare Inc.	sasambou@yahoo.com
IHS.FS.00000471	ACTIVE		07/01/2020	06/30/2022	Whatcom Hospice		2800 Douglas Ave		Bellingham	WA	98225-6930	Whatcom	dzender@peacehealth.org	(360) 715-6529		2800 Douglas Ave		Bellingham	WA	98225-6930	Whatcom	dzender@peacehealth.org	371009327	St Josephs Hospital	dzender@peacehealth.org
IHS.FS.00000323	ACTIVE		01/01/2020	12/31/2021	WhidbeyHealth Home Health and Hospice		202 N Main St		Coupeville	WA	98239-3420	Island	myhospital@whidbeyhealth.org	(360) 678-7605		101 N Main St		Coupeville	WA	98239-3413	Island	hanigh@whidbeygen.org	151000445	Whidbey Island Public Hospital District	
IHS.FS.60055610	ACTIVE	04/01/2009	04/01/2020	03/31/2022	Wilderness Shores Nursing		25614 Lake Wilderness Ln SE		Maple Valley	WA	98038-6019	King	wilderness.shores@yahoo.com	(206) 931-5284		25614 Lake Wilderness Ln SE		Maple Valley	WA	98038-6019	King	wilderness.shores@yahoo.com	602853459	Wilderness Shores Nursing LLC	wilderness.shores@yahoo.com
IHS.FS.60288105	ACTIVE	06/20/2012	06/21/2019	06/20/2021	Wiser Home Care		3303 18th Street Pl SW		Puyallup	WA	98373-3992	Pierce	swiser890@gmail.com	(253) 363-0746		4227 S Meridian # 251		Puyallup	WA	98373-3603	Pierce	swiser789@gmail.com	603179945	Wiser Home Care LLC	swiser789@gmail.com
IHS.FS.00000473	ACTIVE		09/01/2019	08/31/2021	With A Little Help		2021 Minor Ave E Ste A		Seattle	WA	98102-3588	King	marcia@withalittlehelp.com	(206) 352-7399		2021 Minor Ave E Ste A		Seattle	WA	98102-3588	King	marcia@withalittlehelp.com	602196804	With A Little Help Inc	paul@withalittlehelp.com

HOME HEALTH MARKET ANALYSIS

Josephine Caring Community
One Heart. Many Hands.

Prepared By:
Simione Healthcare Consultants, LLC

July 23, 2020

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1. OBJECTIVE

The objective of this engagement is to provide consulting and data analysis to inform the CON application process for Josephine Caring Community (Josephine at Home), as well as expose gaps and opportunities in Snohomish and Island counties, WA.

We organized this report to include the following for the home health service line:

- ✓ **What we identified using Medicare claims, cost report data, and other publicly reported data:**
  - Home health care utilization in Snohomish County, inclusive of Camano Island and Stanwood.
  - Market demographics
  - Competitive market share
  - Presumptive market need

2. HOME HEALTH CARE UTILIZATION

What We Identified

- Home health utilization in both counties is largely driven by hospitals and SNFs, although physicians have a greater contribution to utilization in Snohomish County.
- In Snohomish County and Camano Island, only one home health provider rated 5/5 stars on its patient survey rating summary – Alapha Home Health.
- EvergreenHealth Home Care in Snohomish County and Camano Island rated 4.5/5 starts on its rating for quality of patient care, while three others rated 4/5 for quality – Alapha, Assured, and Gentiva.
- At 155 years in existence, Providence Health & Services is the largest health care provider in Washington state, with more than 35 hospitals, health and living facilities, 20,000 employees, and nonprofit status for provision of home health and hospice services through its Snohomish County foundation.
- All other sources are diversified across referrals made to providers. Of note, clinics have a strong rate of referrals in Island County – meaning these patients were admitted upon the recommendation of a facility's clinic physician.

Agency Sources of Patients in 2019

Based on Medicare patients who live in Snohomish County

	Total Patients	Hospital	SNF	Another Facility	Physician	Clinic	Other
PROVIDENCE HOSPICE AND HOME CARE OF SNOHOMISH CO	1,981	0%	0%	0%	100%	0%	0%
EVERGREENHEALTH HOME CARE	1,437	30%	22%	0%	48%	0%	0%
GENTIVA HEALTH SERVICES	408	8%	5%	0%	79%	8%	0%
ASSURED HOME HEALTH	374	25%	29%	<3%	28%	12%	>3%
BROOKDALE HOME HEALTH, LLC	262	0%	0%	0%	100%	0%	0%
EDEN HOME HEALTH	243	25%	43%	0%	21%	12%	0%
ALAPHA HOME HEALTH	128	<9%	<9%	0%	91%	<9%	0%
SIGNATURE HOME HEALTH (507100)	57	30%	32%	0%	32%	<20%	0%
KINDRED AT HOME	44	<25%	<25%	0%	48%	<25%	<25%
PROVIDENCE HOME SERVICES - KING COUNTY	43	<26%	<26%	0%	51%	<26%	0%
GROUP HEALTH HOME HEALTH & HOSPICE	31	<35%	<35%	0%	<35%	45%	0%
CAREAGE HOME HEALTH	24	<50%	<50%	0%	<50%	<50%	0%
KLINE GALLAND HOME HEALTH	11						
SIGNATURE HOME HEALTH (507116)	<11						

Visual cues KEY

- Greater than 50%
- 25% to 50%

Values that start with "<..." indicate volumes that do not meet the minimum threshold of 11 patients.

Agency Sources of Patients in 2019

Based on Medicare patients who live in Island County

		Total Patients	Hospital	SNF	Another Facility	Physician	Clinic	Other
	EDEN HOME HEALTH	283	32%	30%	<4%	>4%	20%	0%
*	WHIDBEYHEALTH HOME HEALTH	250	40%	>4%	<4%	0%	43%	0%
+	PROVIDENCE HOSPICE AND HOME CARE OF SNOHOMISH CO	98	<11%	0%	0%	>11%	0%	0%
	SIGNATURE HOME HEALTH	85	59%	<13%	0%	22%	<13%	<13%
+	ASSURED HOME HEALTH	24	<50%	<50%	0%	<50%	<50%	0%
+	EVERGREENHEALTH HOME CARE	22	<50%	<50%	0%	<50%	0%	0%

Visual cues KEY

- Greater than 50%
- 25% to 50%

Values that start with "<..." indicate volumes that do not meet the minimum threshold of 11 patients.

According to Home Health Compare:

- * Only provides care on Whidbey Island
- + Only provides care on Camano Island

Provides care on both islands

FY2018 Medicare and Total Patient Revenue, as recorded in Cost Reports, for agencies that served patients in Snohomish and Island Counties in 2019 (when available)

		Medicare as a Percent of Revenue	Total Medicare Revenue	Net Patient Revenue
507065	HOSPICE & HOME CARE OF SNO. COUNTY	17%	$ 7,677,226	$ 44,660,947
507068	PROV HOME SERVICE - KING COUNTY	47%	$ 8,936,878	$ 19,010,241
507071	KINDRED AT HOME	75%	$ 3,254,563	$ 4,332,984
507099	ASSURED HOME HEALTH	79%	$ 7,486,419	$ 9,453,039
507100	SIGNATURE HOME HEALTH	38%	$ 2,704,532	$ 7,150,192
507102	CAREAGE HOME HEALTH	71%	$ 5,878,284	$ 8,269,702
507108	ALPHA NURSING AND SERVICES INC	50%	$ 667,373	$ 1,330,674
507110	SIGNATURE HOME HEALTH	62%	$ 3,420,054	$ 5,475,520
507120	HARVARD PARTNERS HOME HEALTHCARE	0%	$ -	$ -
507121	KLINE GALLAND	71%	$ 3,472,039	$ 4,914,979

All of the above data represents fiscal year 1/1/2018 - 12/31/2018

2019 Utilization Statistics for patients who live in the county as cared for by agencies serving the county

SNOHOMISH COUNTY

	Total Episodes	LUPA Rate	Average Total Visits per Episode (includes all)	Average Reimbursement per Episode (includes all)
PROVIDENCE HOSPICE AND HOME CARE OF SNOHOMISH CO	2312	11%	10.9	$ 3,368
EVERGREENHEALTH HOME CARE	1558	11%	13.1	$ 3,548
GENTIVA HEALTH SERVICES	471	7%	15.5	$ 4,281
ASSURED HOME HEALTH	402	11%	14.3	$ 3,695
BROOKDALE HOME HEALTH, LLC	302	6%	15.4	$ 3,665
EDEN HOME HEALTH	254	4%	16.9	$ 3,862
ALAPHA HOME HEALTH	151	11%	12.9	$ 3,208
SIGNATURE HOME HEALTH (507100)	60	7%	16.1	$ 4,009
PROVIDENCE HOME SERVICES - KING COUNTY	50	6%	12.2	$ 3,509
KINDRED AT HOME	47	13%	13.6	$ 3,739
GROUP HEALTH HOME HEALTH & HOSPICE	36	39%	7.4	$ 1,790
CAREAGE HOME HEALTH	25	4%	13.9	$ 4,274
KLINE GALLAND HOME HEALTH	11	18%	11.7	$ 3,006
ALPHA NURSING AND SERVICES INC	<11			
SIGNATURE HOME HEALTH (507116)	<11			

2019 Utilization Statistics for patients who live in the county as cared for by agencies serving the county

ISLAND COUNTY

		Total Episodes	LUPA Rate	Average Total Visits per Episode (includes all)	Average Reimbursement per Episode (includes all)
	EDEN HOME HEALTH	296	9%	14.9	$ 3,578
*	WHIDBEYHEALTH HOME HEALTH	294	14%	11.7	$ 2,610
+	PROVIDENCE HOSPICE AND HOME CARE OF SNOHOMISH CO	131	11%	12.5	$ 3,471
	SIGNATURE HOME HEALTH	85	5%	15.8	$ 3,452
+	ASSURED HOME HEALTH	25	16%	12.0	$ 3,499
+	EVERGREENHEALTH HOME CARE	23	4%	12.0	$ 3,426

According to Home Health Compare:

* Only provides care on Whidbey Island in Island County

\+ Only provides care on Camano Island in Island County

Provides care on both islands in the county

3. MARKET DEMOGRAPHICS

What We Identified

- Snohomish County has a population of more than 800,000 – a change of 15.3% over the past decade, higher than the state change of 13.2% for Washington. Adjacent Island County has grown at a lower rate and well below the state change, but still experienced a positive change in its population by more than 8% to 85,000 residents during the same period.
- Residents over 65 make up 14% of the population of Snohomish County; however, seniors represent one quarter of Island County's population.
- Household size is larger in Snohomish County, likely representing a younger, family-oriented population with nearly 300,000 households. Total employment represented 31% of the population in 2018. More than 20% of those households speak a language other than English in the home. Medicare enrollment in Snohomish County represents 58% of the population 65 years and over.
- Island County's Medicare enrollment represents 81% of its population 65 year and over. With a small household size of 2.3 persons and 34,000 households in the county, and with home ownership and value above the state rate, total employment represented 15% of the population in 2018, well below the state's employment rate of 37%.

Snohomish County

	Original Medicare		Medicare Advantage & Other Health Plans		Total	
Year	Count	Percent	Count	Percent	Count	Percent
2015	61,814	56%	48,170	44%	109,984	100%
2016	64,051	56%	50,593	44%	114,644	100%
2017	65,188	55%	53,818	45%	119,007	100%
2018	66,040	54%	57,176	46%	123,217	100%
2019	67,077	53%	60,392	47%	127,469	100%

Island County

	Original Medicare		Medicare Advantage & Other Health Plans		Total	
Year	Count	Percent	Count	Percent	Count	Percent
2015	14,486	72%	5,525	28%	20,011	100%
2016	15,269	73%	5,596	27%	20,865	100%
2017	16,052	74%	5,640	26%	21,692	100%
2018	16,747	74%	5,901	26%	22,648	100%
2019	17,304	74%	6,128	26%	23,432	100%

4. COMPETITIVE MARKET SHARE

What We Identified

Based on Medicare reimbursement for home health care provided to patients who live in Snohomish County

- Two agencies provided 66% of the care to Snohomish County patients in 2019: Providence and Evergreen.
- Providence has increased their market share by 9% over the last four years, from 30% to 39%.
- Gentiva, in the third market position, lost 4% market share in 2019 after a 3% decrease in market share in 2017.
- The agencies in the fourth and fifth market positions also decreased market share in 2019.

	2016		2017		2018		2019	
	Position	Share	Position	Share	Position	Share	Position	Share
PROVIDENCE HOSPICE AND HOME CARE OF SNOHOMISH CO	1	30%	1	35%	1	35%	1	39%
EVERGREENHEALTH HOME CARE	2	28%	2	27%	2	27%	2	27%
GENTIVA HEALTH SERVICES	3	18%	3	15%	3	14%	3	10%
ASSURED HOME HEALTH	4	8%	5	8%	4	10%	4	7%
BROOKDALE HOME HEALTH, LLC	5	7%	4	8%	5	7%	5	5%
EDEN HOME HEALTH	8	1%	7	2%	7	2%	6	5%
ALAPHA HOME HEALTH	14	0%	16.5	0%	13	0%	7	2%
SIGNATURE HOME HEALTH (507100)	6	4%	6	3%	6	2%	8	1%
KINDRED AT HOME	7	2%	8	1%	8	1%	9	1%
PROVIDENCE HOME SERVICES - KING COUNTY	10	0%	9	1%	9	1%	10	1%
CAREAGE HOME HEALTH	9	0%	10	0%	10	0%	11	1%
GROUP HEALTH HOME HEALTH & HOSPICE	11	0%	13	0%	11	0%	12	0%
KLINE GALLAND HOME HEALTH	13	0%	12	0%	12	0%	13	0%
SIGNATURE HOME HEALTH (507116)	12	0%	11	0%	14	0%	14	0%

Visual cues KEY

Change in Position	Change in Share
+2 or more	+3% or more
+1	+1% to 3%
No Change	-1% to +1%
-1	-1% to -3%
-2 or more	-3% or more

What We Identified

Based on Medicare reimbursement for home health care provided to patients who live in Island County

- Two agencies provided 67% of the care to Island County patients in 2019: Eden Home Health and WhidbeyHealth.
- Eden has dramatically increased their market share over the last four years, from 9% in 2016 to 39% in 2019.
- WhidbeyHealth Home Health lost 5% market share in 2019. Note that WhidbeyHealth only provides care on Whidbey Island, not Camano, according to Home Health Compare service areas, while Eden services both islands.
- Providence Hospice and Home Care, in the third market position, increased market share 4% in 2019 each.
- Signature Home Health, in the fourth market positions decreased market share each of the last three years, from 20% in 2016 (which put it in the second market position that year) to 11% in 2019.

		2016		2017		2018		2019	
		Position	Share	Position	Share	Position	Share	Position	Share
	EDEN HOME HEALTH	4	9%	2	25%	2	32%	1	39%
*	WHIDBEYHEALTH HOME HEALTH	1	43%	1	33%	1	33%	2	28%
+	PROVIDENCE HOSPICE AND HOME CARE OF SNOHOMISH CO	3	13%	4	12%	3	13%	3	17%
	SIGNATURE HOME HEALTH	2	20%	3	19%	4	12%	4	11%
+	ASSURED HOME HEALTH	5	9%	6	5%	5	6%	5	3%
+	EVERGREENHEALTH HOME CARE	6	6%	5	5%	6	4%	6	3%

Visual cues KEY

Change in Position	Change in Share
+2 or more	+3% or more
+1	+1% to 3%
No Change	-1% to +1%
-1	-1% to -3%
-2 or more	-3% or more

According to Home Health Compare:

* Only provides care on Whidbey Island

\+ Only provides care on Camano Island

Provides care on both islands

5. PRESUMPTIVE MARKET NEED

What We Identified

Discharge Referral Patterns and Trends for Snohomish County Hospitals

- Market-wide, inclusive of hospitals in both Snohomish and Island Counties, hospitals were about equally likely to refer patients to home health (20%) and to SNF (19%) in 2019.
- Home health referrals as a percent of total discharges increased by 3% in 2019.
- This pattern is not consistent at the hospital level--the highest volume hospital refers more patients to HH compared to SNF (22% and 17%), while the next three all refer a considerably higher volume of patients to SNF (21%-30%) compared to home health (10%-16%).
- The large percentage of patients discharged to home/self-care with no post-acute care represents an opportunity for an aggressive provider to increase home health utilization and likely reduce potential for rehospitalizations of these patients.
- Based on the data below, as well as the market share findings, there appears to be opportunity for a provider aggressively entering these counties to position itself as an alternative to the existing providers and can expect growth if a strategic, consistent approach to the market is supported and properly resourced both in sales and service.

	Home/Self Care			SNF			HHA			Hospice			Total 2019 Disch.	2019 Reamit. Rate
	2017	2018	2019	2017	2018	2019	2017	2018	2019	2017	2018	2019		
PROVIDENCE REGIONAL MEDICAL CENTER EVERETT	48% ↘	46% ↘	45%	18%	18%	17%	20% ↗	21%	22%	3%	4%	5%	7,166	15%
SWEDISH EDMONDS HOSPITAL	52%	52% ↓	44%	20% ↘	19% ↑	23%	11% ↗	12% ↑	16%	5%	5%	5%	2,914	15%
WHIDBEYHEALTH MEDICAL CENTER	56% ↗	57% ↓	49%	25% ↓	21%	21%	5% ↗	7% ↗	10%	3%	2% ↗	4%	630	13%
CASCADE VALLEY HOSPITAL	53%	53% ↓	49%	18% ↑	22% ↑	26%	8% ↑	11% ↗	13%	3%	3% ↘	1%	349	14%
EVERGREENHEALTH MONROE	57%	57% ↓	46%	19%	20% ↑	30%	10%	10% ↗	12%	3% ↘	2% ↗	3%	288	10%
SMOKEY POINT BEHAVIORAL HOSPITAL	79% ↑	88% ↓	83%	4% ↓	0%	0%	0%	0%	0%	0%	0%	0%	242	15%
Two-County Rates	**50%**	**50%** ↓	**46%**	**19%** ↘	**18%**	**19%**	**16%**	**16%** ↑	**19%**	**4%**	**4%**	**4%**	**11,589**	**15%**

Hospitals referring >46% of patients home with no post-acute care, >19% of patients to SNF, or <20% of patients to HH. Hospitals referring > 25% of patients to SNF. These may present a growth opportunity by working with the hospitals to increase home health utilization.

Hospitals referring >35% of patients to home health. Demonstrates an existing propensity to refer to HH. May present a growth opportunity if you can demonstrate a unique advantage of working with your agency over existing referral partners.

Change in Referral Rates

- ↑ +3% or more
- ↗ 1 <= change < 3
- -1 <= change < +1
- ↘ -3 <= change < -1
- ↓ -3% or more

Values that start with "<..." indicate volumes that do not meet the minimum threshold of 11 patients.

HHAs providing service to at least one zip code in the noted county, according to Home Health Compare *(released May 2020)*

Snohomish County

CCN	Provider Name
507007	GROUP HEALTH HOME HEALTH & HOSPICE
507028	MEMORIAL HOME CARE SERVICES
507044	ASSURED HOME HEALTH
507050	JEFFERSON HEALTHCARE HOME HEALTH
507052	SEA MAR COMMUNITY HEALTH CENTER
507055	WHIDBEYHEALTH HOME HEALTH
507065	PROVIDENCE HOSPICE AND HOME CARE OF SNOHOMISH CO
507068	PROVIDENCE HOME SERVICES KING COUNTY
507071	GENTIVA HEALTH SERVICES
507079	EVERGREENHEALTH HOME CARE
507082	KINDRED AT HOME
507084	BROOKDALE HOME HEALTH, LLC
507099	ASSURED HOME HEALTH
507100	SIGNATURE HOME HEALTH
507102	CAREAGE HOME HEALTH
507105	EDEN HOME HEALTH
507107	ALAPHA HOME HEALTH
507108	ALPHA NURSING AND SERVICES INC
507110	SIGNATURE HOME HEATLH
507116	SIGNATURE HOME HEALTH
507120	HARVARD PARTNERS LLC
507121	KLINE GALLAND HOME HEALTH
507123	BROOKDALE HOME HEALTH SEATTLE
507128	EDEN HOME HEALTH

Exhibit 9

Home Health Agencies: CMS Flexibilities to Fight COVID-19

Home Health Agencies: CMS Flexibilities to Fight COVID-19

*** Indicates items added or revised in the most recent update*

Since the beginning of the COVID-19 Public Health Emergency, the Trump Administration has issued an unprecedented array of temporary regulatory waivers and new rules to equip the American healthcare system with maximum flexibility to respond to the 2019 Novel Coronavirus (COVID-19) pandemic. These temporary changes will apply immediately across the entire U.S. healthcare system for the duration of the emergency declaration. The goals of these actions are to 1) expand the healthcare system workforce by removing barriers for physicians, nurses, and other clinicians to be readily hired from the community or from other states; 2) ensure that local hospitals and health systems have the capacity to handle a potential surge of COVID-19 patients through temporary expansion sites (also known as CMS Hospital Without Walls); 3) increase access to telehealth in Medicare to ensure patients have access to physicians and other clinicians while keeping patients safe at home; 4) expand in-place testing to allow for more testing at home or in community based settings; and 5) put Patients Over Paperwork to give temporary relief from many paperwork, reporting and audit requirements so providers, health care facilities, Medicare Advantage and Part D plans, and States can focus on providing needed care to Medicare and Medicaid beneficiaries affected by COVID-19.

Medicare Telehealth and Telecommunications Technology

- Home Health Agencies (HHAs) can provide more services to beneficiaries using telecommunications technology within the 30-day period of care, so long as it's part of the patient's plan of care and does not replace needed in-person visits as ordered on the plan of care. We acknowledge that the use of such technology may result in changes to the frequency or types of in-persons visits outlined on existing or new plans of care. Telecommunications technology can include, for example: remote patient monitoring; telephone calls (audio only and TTY); and 2-way audio-video technology that allows for real-time interaction between the clinician and patient. However, only in-person visits can be reported on the home health claim.

- The required face-to-face encounter for home health can be conducted via telehealth (i.e., 2-way audio-video telecommunications technology that allows for real-time interaction between the physician/allowed practitioner and the patient).

Patients Over Paperwork

- *Homebound Definition*: A beneficiary is considered homebound when their physician advises them not to leave the home because of a confirmed or suspected COVID-19 diagnosis or if the patient has a condition that makes them more susceptible to contract

COVID-19. As a result, if a beneficiary is homebound due to COVID-19 and needs skilled services, an HHA can provide those services under the Medicare Home Health benefit.

- *Detailed Information Sharing for Discharge Planning for Home Health Agencies***.** CMS is waiving the requirements of 42 CFR §484.58(a) to provide detailed information regarding discharge planning, to patients and their caregivers, or the patient's representative in selecting a post-acute care provider by using and sharing data that includes, but is not limited to, (another) home health agency (HHA), skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), and long-term care hospital (LTCH) quality measures and resource use measures. This temporary waiver provides facilities the ability to expedite discharge and movement of residents among care settings. CMS is maintaining all other discharge planning requirements.

- *Plans of Care and Certifying/Recertifying Patient Eligibility*: In addition to a physician, section 3708 of the CARES Act allows a Medicare-eligible home health patient to be under the care of a nurse practitioner, clinical nurse specialist, or a physician assistant who is working in accordance with State law. These physicians/practitioners can: (1) order home health services; (2) establish and periodically review a plan of care for home health services (e.g., sign the plan of care), (3) certify and re-certify that the patient is eligible for Medicare home health services. These changes, effective March 1, 2020, provide the flexibility needed for more timely initiation of services for home health patients, while allowing providers and patients to practice social distancing. Specifically, for Medicare, these changes are effective for Medicare claims with a "claim through date" on or after March 1, 2020.

- *Clinical Records*: In accordance with section 1135(b)(5) of the Act, CMS is extending the deadline for completion of the requirement at 42 CFR §484.110(e), which requires HHAs to provide a patient a copy of their medical record at no cost during the next visit or within four business days (when requested by the patient). Specifically, CMS will allow HHAs ten business days to provide a patient's clinical record, instead of four.

- *Training and Assessment of Aides***:** CMS is waiving the requirement at 42 CFR §418.76(h)(2) for Hospice and 42 CFR §484.80(h)(1)(iii) for HHAs, which require a registered nurse, or in the case of an HHA a registered nurse or other appropriate skilled professional (physical therapist/occupational therapist, speech language pathologist) to make an annual onsite supervisory visit (direct observation) for each aide that provides services on behalf of the agency. In accordance with section 1135(b)(5) of the Act, we are postponing completion of these visits. All postponed onsite assessments must be completed by these professionals no later than 60 days after the expiration of the PHE.

- *12-hour annual in-service training requirement for home health aides***:** CMS is modifying the requirement at 42 C.F.R. §484.80(d) that home health agencies must assure that each home health aide receives 12 hours of in-service training in a 12-month period. In

accordance with section 1135(b)(5) of the Act, we are postponing the deadline for completing this requirement throughout the COVID-19 PHE until the end of the first full quarter after the declaration of the PHE concludes. This will allow aides and the registered nurses (RNs) who teach in-service training to spend more time delivering direct patient care and additional time for staff to complete this requirement.

- *Quality Assurance and Performance Improvement (QAPI)*: CMS is modifying the requirement at 42 CFR §418.58 for Hospice and §484.65 for HHAs, which requires these providers to develop, implement, evaluate, and maintain an effective, ongoing, hospice/HHA-wide, data-driven QAPI program. Specifically, CMS is modifying the requirements at §418.58(a)–(d) and §484.65(a)–(d) to narrow the scope of the QAPI program to concentrate on infection control issues, while retaining the requirement that remaining activities should continue to focus on adverse events. This modification decreases burden associated with the development and maintenance of a broad-based QAPI program, allowing the providers to focus efforts on aspects of care delivery most closely associated with COVID-19 and tracking adverse events during the PHE. The requirement that HHAs and hospices maintain an effective, ongoing, agency-wide, data-driven quality assessment and performance improvement program will remain.

- *Waive Onsite Visits for HHA Aide Supervision*: CMS is waiving the requirements at 42 CFR §484.80(h), which require a nurse to conduct an onsite visit every two weeks. This would include waiving the requirements for a nurse or other professional to conduct an onsite visit every two weeks to evaluate if aides are providing care consistent with the care plan, as this may not be physically possible for a period of time. This waiver is also temporarily suspending the 2-week aide supervision by a registered nurse for home health agencies requirement at §484.80(h)(1), but virtual supervision is encouraged during the period of the waiver.

- *Reporting*: CMS is providing relief to HHAs on the timeframes related to OASIS transmission through the following 1) extending the 5-day completion requirement for the comprehensive assessment to 30 days; and 2) waiving the 30-day OASIS submission requirement. Delayed submission is permitted during the PHE. We are now allowing 30 days for the completion of the comprehensive assessment. HHAs must submit OASIS data prior to submitting their final claim in order to receive Medicare payment.

- *Home Health Quality Reporting Program*: HHAs are exempted from the Home Health Quality Reporting Program reporting requirements. The time period covered by this exemption is October 1, 2019 through June 30, 2020. HHAs that do not submit data for those quarters will not have their annual market basket percentage increase reduced by two percentage points. CMS is also delaying the compliance dates for collecting and reporting the Transfer of Health Information quality measures and certain standardized patient assessment data elements (SPADEs) adopted for the HH Quality Reporting

Program. HHAs will be required to begin collecting the Transfer of Health Information quality measures and certain SPADEs on January 1st of the year that is at least one calendar year after the end of the public health emergency.

- *Home Health Value Based Purchasing (HHVBP) Model:* CMS is implementing a policy to align HHVBP data submission requirements with any exceptions or extensions granted for purposes of the Home Health Quality Reporting Program during the PHE for the COVID-19 pandemic, as well as a policy for granting exceptions to the New Measures data reporting requirements under the HHVBP Model during the PHE for the COVID-19 pandemic.

- *Allow Occupational Therapists (OTs), Physical Therapists (PTs), and Speech Language Pathologists (SLPs) to Perform Initial and Comprehensive Assessment for all Patients:* CMS is waiving the requirements in 42 CFR § 484.55(a)(2) and § 484.55(b)(3) that rehabilitation skilled professionals may only perform the initial and comprehensive assessment when only therapy services are ordered. This temporary blanket modification allows any rehabilitation professional (OT, PT, or SLP) to perform the initial and comprehensive assessment for all patients receiving therapy services as part of the plan of care, to the extent permitted under state law, regardless of whether or not the service establishes eligibility for the patient to be receiving home care. The existing regulations at § 484.55(a) and (b)(2) would continue to apply; rehabilitation skilled professionals would not be permitted to perform assessments in nursing only cases. We would continue to expect HHAs to match the appropriate discipline that performs the assessment to the needs of the patient to the greatest extent possible. Therapists must act within their state scope of practice laws when performing initial and comprehensive assessments, and access a registered nurse or other professional to complete sections of the assessment that are beyond their scope of practice. Expanding the category of therapists who may perform initial and comprehensive assessments provides HHAs with additional flexibility that may decrease patient wait times for the initiation of home health services.

- *Requests for Anticipated Payments (RAPs):* MACs can extend the auto-cancellation date of RAPs during emergencies. RAPs are a pre-payment for home health services.

- ** *Review Choice Demonstration for Home Health Services*: CMS is offering flexibilities for home health agencies in the Review Choice Demonstration for Home Health Services. CMS is phasing in participation in the Review Choice Demonstration for Home Health Agencies (HHAs) in North Carolina and Florida, for a limited period of time, to help ease the transition during the current public health emergency. If Florida and North Carolina HHAs wish to participate, they may submit pre-claim review requests for billing periods beginning August 31, 2020. Florida and North Carolina providers who have already made a choice selection do not need to take any further action if they choose not to participate. CMS plans to reassess this phased-in approach in 60 days. In Illinois, Ohio,

and Texas, claims submitted under Choice 1 without going through the pre-claim review process will not be subject to a 25% payment reduction until further notice, but will be subject to prepayment review. Cycle 2 in Illinois and Cycle 1 in Texas will end on September 30, 2020. Cycle 2 in Ohio will begin on August 31, 2020, as previously stated.

Medicare appeals in Fee for Service, Medicare Advantage (MA) and Part D

- CMS is allowing Medicare Administrative Contractors (MACs) and Qualified Independent Contractor (QICs) in the FFS program 42 CFR 405.942 and 42 CFR 405.962 and MA and Part D plans, as well as the Part C and Part D Independent Review Entity (IREs), 42 CFR 562, 42 CFR 423.562, 42 CFR 422.582 and 42 CFR 423.582 to allow extensions to file an appeal;

- CMS is allowing MACs and QICs in the FFS program 42 CFR 405. 950 and 42 CFR 405.966 and the Part C and Part D IREs to waive requirements for timeliness for requests for additional information to adjudicate appeals; MA plans may extend the timeframe to adjudicate organization determinations and reconsiderations for medical items and services (but not Part B drugs) by up to 14 calendar days if: the enrollee requests the extension; the extension is justified and in the enrollee's interest due to the need for additional medical evidence from a noncontract provider that may change an MA organization's decision to deny an item or service; or, the extension is justified due to extraordinary, exigent, or other non-routine circumstances and is in the enrollee's interest 42 CFR § 422.568(b)(1)(i), § 422.572(b)(1) and § 422.590(f)(1);

- CMS is allowing MACs and QICs in the FFS program 42 C.F.R 405.910 and MA and Part D plans, as well as the Part C and Part D IREs to process an appeal even with incomplete Appointment of Representation forms 42 CFR § 422.561, 42 CFR § 423.560. However, any communications will only be sent to the beneficiary;

- CMS is allowing MACs and QICs in the FFS program 42 CFR 405. 950 and 42 CFR 405.966 and MA and Part D plans, as well as the Part C and Part D IREs to process requests for appeal that don't meet the required elements using information that is available 42 CFR § 422.562, 42 CFR § 423.562.

- CMS is allowing MACs and QICs in the FFS program 42 CFR 405. 950 and 42 CFR 405.966 and MA and Part D plans, as well as the Part C and Part D IREs, 42 CFR 422.562, 42 CFR 423.562 to utilize all flexibilities available in the appeal process as if good cause requirements are satisfied.

- *Accelerated/Advance Payments*: In order to provide additional cash flow to healthcare providers and suppliers impacted by COVID-19, CMS expanded and streamlined the Accelerated and Advance Payments Program, which provided conditional partial payments to providers and suppliers to address disruptions in claims submission and/or claims processing subject to applicable safeguards for fraud, waste and abuse. Under

this program, CMS made successful payment of over $100 billion to healthcare providers and suppliers. As of April 26, 2020, CMS is reevaluating all pending and new applications for the Accelerated Payment Program and has suspended the Advance Payment Program, in light of direct payments made available through the Department of Health & Human Services' (HHS) Provider Relief Fund. Distributions made through the Provider Relief Fund do not need to be repaid. For providers and suppliers who have received accelerated or advance payments related to the COVID-19 Public Health Emergency, CMS will not pursue recovery of these payments until 120 days after the date of payment issuance. Providers and suppliers with questions regarding the repayment of their accelerated or advance payment(s) should contact their appropriate Medicare Administrative Contractor (MAC).

- *Provider Enrollment*: CMS has established toll-free hotlines for all providers as well as the following flexibilities for provider enrollment:
    - Waive certain screening requirements.
    - Postpone all revalidation actions.
    - Expedite any pending or new applications from providers.

Cost Reporting

- CMS is delaying the filing deadline of certain cost report due dates due to the COVID-19 outbreak. We are currently authorizing delay for the following fiscal year end (FYE) dates. CMS will delay the filing deadline of FYE 10/31/2019 cost reports due by March 31, 2020 and FYE 11/30/2019 cost reports due by April 30, 2020. The extended cost report due dates for these October and November FYEs will be June 30, 2020. CMS will also delay the filing deadline of the FYE 12/31/2019 cost reports due by May 31, 2020. The revised extended cost report due date for FYE 12/31/2019 will be August 31, 2020. For the FYE 01/31/2020 cost report, the extended due date is August 31, 2020. For the FYE 02/29/2020 cost report, the extended due date is September 30, 2020.

COVID-19 Diagnostic Testing

- If a patient is already receiving Medicare home health services, the home health nurse, during an otherwise covered visit, could obtain the sample to send to the laboratory for COVID-19 diagnostic testing.

Workforce

- *Ordering Medicaid Home Health Services and Equipment:* Medicaid home health regulations now allow non-physician practitioners to order medical equipment, supplies and appliances, home health nursing and aide services, and physical therapy, occupational therapy or speech pathology and audiology services, in accordance with state scope of practice laws.

- *Waived onsite visits for both HHA Aide Supervision*: CMS is waiving the requirements at 42 CFR 484.80(h), which require a nurse to conduct an onsite visit every two weeks. This

would include waiving the requirements for a nurse or other professional to conduct an onsite visit every two weeks to evaluate if aides are providing care consistent with the care plan, as this may not be physically possible for a period of time. This waiver is also temporarily suspending 2-week aide supervision requirement at 42 CFR §484.80(h)(1) by a registered nurse for home health agencies, but virtual supervision is encouraged during the period of the waiver.

- *Allow Occupational Therapists (OTs) to Perform Initial and Comprehensive Assessment for all Patients:* 42 CFR 484.55(a)(2) and 484.55(b)(3). CMS is waiving the requirement that OTs may only perform the initial and comprehensive assessment if occupational therapy is the service that establishes eligibility for the patient to be receiving home health care. This temporary blanket modification allows OTs to perform the initial and comprehensive assessment for all patients receiving therapy services as part of the plan of care, to the extent permitted under state law, regardless of whether occupational therapy is the service that establishes eligibility. The existing regulations at § 484.55(a) and (b)(2) would continue to apply that OTs and other therapists would not be permitted to perform assessments in nursing only cases. We would continue to expect HHAs to match the appropriate discipline that performs the assessment to the needs of the patient to the greatest extent possible. Therapists must act within their state scope of practice laws when performing initial and comprehensive assessments, and access a registered nurse or other professional to complete sections of the assessment that are beyond their scope of practice. Expanding the category of therapists who may perform initial and comprehensive assessments to include OTs provides HHAs with additional flexibility that may decrease patient wait times for the initiation of home health services.

- *Certification for Payment of Medicare Home Health Services*: As required under section 3708 of the CARES Act, CMS is allowing nurse practitioners, clinical nurse specialists and physician assistants to certify the need for home health services as defined under 42 CFR § 424.507(b)(1) payment requirements for covered Part A or Part B home health services.

Patients Over Paperwork

- *"Stark Law" Waivers:* The physician self-referral law (also known as the "Stark Law") prohibits a physician from making referrals for certain healthcare services payable by Medicare if the physician (or an immediate family member) has a financial relationship with the entity performing the service. There are statutory and regulatory exceptions, but in short, a physician cannot refer a patient to any entity with which he or she has a financial relationship. On March 30, 2020, CMS issued blanket waivers of certain provisions of the Stark Law regulations. These blanket waivers apply to financial relationships and referrals that are related to the COVID-19 emergency. The remuneration and referrals described in the blanket waivers must be solely related to

COVID-19 Purposes, as defined in the blanket waiver document. Under the waivers, CMS will permit certain referrals and the submission of related claims that would otherwise violate the Stark Law. These flexibilities include:

- Hospitals and other health care providers can pay above or below fair market value for the personal services of a physician (or an immediate family member of a physician), and parties may pay below fair market value to rent equipment or purchase items or services. For example, a physician practice may be willing to rent or sell needed equipment to a hospital at a price that is below what the practice could charge another party. Or, a hospital may provide space on hospital grounds at no charge to a physician who is willing to treat patients who seek care at the hospital but are not appropriate for emergency department or inpatient care.

- Health care providers can support each other financially to ensure continuity of health care operations. For example, a physician owner of a hospital may make a personal loan to the hospital without charging interest at a fair market rate so that the hospital can make payroll or pay its vendors.

- Hospitals can provide benefits to their medical staffs, such as multiple daily meals, laundry service to launder soiled personal clothing, or child care services while the physicians are at the hospital and engaging in activities that benefit the hospital and its patients.

- Health care providers may offer certain items and services that are solely related to COVID-19 Purposes (as defined in the waivers), even when the provision of the items or services would exceed the annual non-monetary compensation cap. For example, a home health agency may provide continuing medical education to physicians in the community on the latest care protocols for homebound patients with COVID-19, or a hospital may provide isolation shelter or meals to the family of a physician who was exposed to the novel coronavirus while working in the hospital's emergency department.

- Physician-owned hospitals can temporarily increase the number of their licensed beds, operating rooms, and procedure rooms, even though such expansion would otherwise be prohibited under the Stark Law. For example, a physician-owned hospital may temporarily convert observation beds to inpatient beds to accommodate patient surge during the COVID-19 pandemic in the United States.

- Some of the restrictions regarding when a group practice can furnish medically necessary designated health services (DHS) in a patient's home are loosened. For example, <u>any</u> physician in the group may order medically necessary DHS that is

furnished to a patient by one of the group's technicians or nurses in the patient's home contemporaneously with a physician service that is furnished via telehealth by the physician who ordered the DHS.

- Group practices can furnish medically necessary MRIs, CT scans or clinical laboratory services from locations like mobile vans in parking lots that the group practice rents on a part-time basis.

Additional Guidance

- The Interim Final Rule and waivers can be found at: https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers .

- CMS has released guidance to describe standards of practice for infection control and prevention of COVID-19 in home health agencies at https://www.cms.gov/files/document/qso-20-18-hha.pdf.

- CMS has released guidance to providers related to relaxed reporting requirements for quality reporting programs at https://www.cms.gov/files/document/guidance-memo-exceptions-and-extensions-quality-reporting-and-value-based-purchasing-programs.pdf.

Exhibit 10

Admissions Policy Draft

Referral Policy Draft (included in Admissions Policy)

Charity Care Policy Draft

Admissions Policy

Objective

To provide guidelines for accepting clients for home health care services to be provided in the client's place of residence that are clear to the home care staff, the medical and lay community, and that abide by state/federal guidelines.

Policy

Admissions Criteria

A direct request for service shall be made to the agency. It may be generated by a client, physician, caregiver, health facility representative or community member.

1. A patient must have a physician who
    a. Is a doctor of medicine, osteopathy or podiatry legally authorized to practice medicine and surgery in the state of Washington;
    b. Is available at all times during operating hours; and
    c. Participates in the establishment and periodic review of a written plan of care
    d. Is a PECOS enrolled provider for traditional Medicare patients

Services for a client receiving Skilled Nursing, Therapy or Home Health Aide services must follow a written Plan of Care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. The written Plan of Care shall be reviewed at least every 60 days by that physician or their designee

2. Skilled services and homebound status are considered to determine appropriateness for admission to HH.
3. HH services personnel and resources are adequate and suitable to provide services ordered by the physician for the patient.
4. The patient and family are cooperative and willing to participate with HH services.
5. There must be a reasonable expectation that the patient's health will be benefited by care at home as distinguished from care in a hospital or extended care facility.
6. Equipment, supplies and pharmaceutical products are available at the time of admission to meet the patient/client needs.
7. Patient's place of residence or surrounding area does not pose a safety hazard or security risk to staff.
8. Patient resides within the defined service area for HH.

If the referral has been accepted, and then it is determined that a person did not qualify for HH Services, the person and physician will be notified promptly.

If JAH is unable to meet patient needs, a referral will be made for services as available elsewhere, upon physician approval.

Referral Sources and Response

Referrals

Referrals are accepted by phone, fax, email and software referral systems. Patient insurance will be verified with the intent to receive an authorization prior to initiation of HH Services. Ongoing authorizations may be required.

All patients who accept admission to HH shall be assessed within 48 hours of the receipt of the referral or as specified by the physician. The secondary service (any discipline beyond the admitting discipline) contact to the patient will be made within 72 hours. The physician will be informed by phone call or written communication if the initial visit for any discipline is changed.

Once it is determined that a patient meets the Admission Criteria, (should we add anything here about insurance, Charity Care or other forms of payment?) and is appropriate for HH, the admission to service will begin.

Admission Process

The referral is will be handled by the Intake Coordinator. The Admission Process ensures that HH has the following information at time of referral/admission:

1. Attending physician name, address and telephone number
2. Patient's address
3. Patient's working contact number
4. Patient's admitting diagnosis
5. History and Physical as possible
6. Current orders for HH Services
7. Insurance information

In determining the appropriate hour to make the home visit, such factors as physician's instructions, knowledge of patient needs, and geographic area will be given consideration. All admission visits will be preceded by a phone call to the patient to agree upon an appointed time.

When multidisciplinary services are ordered at the initial referral the scheduler will schedule all disciplines.

Nondiscrimination Policy

Consistent with the Josephine Caring Community's Mission and Values, it is the policy of Josephine At Home to not discriminate against, exclude or treat differently any individuals accessing any Josephine At Home Program or Activity on any basis prohibited by local, state or federal laws, including but not limited to on the basis of race, color, national origin, age, disability, handicap, gender, gender identity, sexual orientation, or as those terms are defined under federal law and rules. Where applicable, federal statutory protections for religious freedom and conscience are applied. It is also Josephine At Home's policy to provide aids and language assistance services to individuals

with a disability, handicap, or limited English proficiency who are accessing a Josephine At Home Program or Activity. Such services may include providing qualified bilingual/multilingual staff, qualified interpreters, and qualified translators.

Any individuals will be provided with a prompt and equitable resolution of complaints alleging violations of applicable federal or state laws that prohibit discrimination, including but not limited to Section 504 of the Rehabilitation Act of 1973, Section 1557 of the Affordable Care Act (42 U.S.C 18116) and Title VI of the Civil Rights Act of 1964. Josephine At Home has established an internal grievance procedure for any person who believes that someone accessing a Josephine At Home Program or Activity has been subjected to discrimination. Filing a grievance can be achieved by contacting any one of the following:

- Executive Director (360) 386-3284
- CEO: (360)-629-2126 (ext. 122)
- HR Director : (360)-629-2126 (ext. 336)

Josephine requires that all staff, physicians, and agents/vendors who believe someone may be violating the law, the Code, or any Josephine At Home policies or procedures regarding discrimination to report it immediately to the Administrator, CEO, or HR Director.

Charity Care Policy

Objective

To set forth a Josephine At Home Charity Care policy designed to promote necessary care for those without the ability to pay, and to offer a discount from the billed charges for individuals who are able to pay for only a portion of the costs of their care.

Policy

Patients may be eligible for charity care at the time of admission to Josephine At Home or during the period when they receive home health services. Application of charity care is contingent upon the patient's cooperation with the application process, including timely submission of all information that Josephine At Home deems necessary or appropriate to enable it to make a charity care determination. Screening and application to Medicaid is required prior to charity care determination.

Admitted patients can appeal charity care determinations according to the Patient Grievances policy. Patient who are eligible for charity care at the time of admission to Josephine At Home or during the period then they receive home health services, is based on household income and family size as outlined below.

Income Level of 200% or less – 100% discount level

Income Level of 201% to 300% - 75% discount level

Income Level of 301% to 400% - 50% discount level

Josephine At Home will refer to the annual National Federal Poverty Guideline to apply the above metrics

PERSONS IN FAMILY/HOUSEHOLD	POVERTY GUIDELINE
1	$12,490
2	$16,910
3	$21,330
4	$25,750
5	$30,170
6	$34,590
7	$39,010
8	$43,430
For families/households with more than 8 persons, add $4,420 for each additional person.	

Exhibit 11

Pro Forma Budget

Snohomish County				
Age Cohort	2021	2022	2023	2024
0-64	714,416	718,158	721,919	725,700
65-79	95,379	97,312	99,267	101,242
80+	35,170	35,883	36,603	37,332
65 and Over	**130,549**	**133,195**	**135,870**	**138,574**
Total	**844,965**	**851,353**	**857,789**	**864,274**

	Patients			
	2021	2022	2023	2024
	84.5%	84.4%	84.2%	84.0%
73.06%	11.3%	11.4%	11.6%	11.7%
26.94%	4.2%	4.2%	4.3%	4.3%
100.00%	15.5%	15.6%	15.8%	16.0%
	100.0%	100.0%	100.0%	100.0%

Island County				
Age Cohort	2021	2022	2023	2023
0-64	63,907	64,018	64,129	64,240
65-79	18,692	19,926	21,185	22,471
80+	5,913	6,303	6,702	7,109
65 and Over	**24,605**	**26,229**	**27,887**	**29,580**
Total	**88,512**	**90,247**	**92,016**	**93,820**

	Patients			
	2021	2022	2023	
	72.2%	70.9%	69.7%	
76.0%	21.1%	22.1%	23.0%	
24.0%	6.7%	7.0%	7.3%	
100.0%	27.8%	29.1%	30.3%	
	100.0%	100.0%	100.0%	

Snohomish County			
Patients by Cohort	2021	2022	2023
0-64	407	488	526
65-79	54	66	72
80+	20	25	27
65 and Over	**74**	**91**	**99**
Total	**481**	**579**	**625**

Island County			
Patients by Cohort	2021	2022	2023
0-64	1	20	24
65-79	1	6	8
80+	-	2	3
65 and Over	**1**	**8**	**11**
Total	**2**	**28**	**35**

Snohomish County			
Visits	2021	2022	2023
0-64	-	-	-
65-79	-	-	-
80+	-	-	-
65 and Over	**-**	**-**	**-**
Total	**-**	**-**	**-**

Island County			
Visits	2021	2022	2023
0-64	-	-	-
65-79	-	-	-
80+	5	1	2
65 and Over	**5**	**1**	**2**
Total	**5**	**1**	**2**

Q#7

	2021	2022	2023
	Visits	**Visits**	**Visits**
RN	3,504	4,057	4,272
PT	4,164	4,866	5,193
HHA	311	343	344
OT	1,716	2,003	2,141
ST	340	401	431
MSW	470	582	649
Unduplicated Patients	481	579	625
Total	10,505	12,252	13,030

Q#11

Payer Mix	2021	2022	2023
Medicare FFS	1,201,496	1,733,838	2,099,915
Medicare Managed Care	292,559	339,711	280,275
Medicaid	1,988	2,280	12,188
Medicaid Managed Care			
Commercial	87,379	93,496	83,303
Self-Pay	4,078	4,559	4,063
Other (L&I, TRICARE, VA)			
Charity	10,144	15,958	10,157
Other			
Total	1,597,644	2,189,842	2,489,901

Q#16

	2021		2022		2023	
	Direct Cost	**Charge**	**Direct Cost**	**Charge**	**Direct Cost**	**Charge**
RN	$ 98.27	-	$ 92.94	-	$ 101.37	-
PT	$ 105.84	-	$ 107.91	-	$ 105.76	-
OT	$ 80.00	-	$ 80.00	-	$ 80.00	-
ST	$ 75.00	-	$ 75.00	-	$ 75.00	-
MSW	$ 75.00	-	$ 75.00	-	$ 75.00	-
HHA	$ 25.00	-	$ 25.00	-	$ 25.00	-

OVERHEAD PERCENT			Total			CHARGE (Nearest Multiple of $50)		
2021	**2022**	**2023**	**2021**	**2022**	**2023**	**2021**	**2022**	**2023**
0.7109533	0.7887564	0.7269985	0.7269985	#DIV/0!	#DIV/0!			
69.86	73.31	73.69	$ 168.13	$ 166.25	$ 175.06	$ 200.00	$ 200.00	$ 200.00
75.25	85.12	76.88	$ 181.09	$ 193.03	$ 182.64	$ 200.00	$ 200.00	$ 200.00
56.88	63.1	58.16	$ 136.88	$ 143.10	$ 138.16	$ 150.00	$ 150.00	$ 150.00
53.32	59.16	54.52	$ 128.32	$ 134.16	$ 129.52	$ 150.00	$ 150.00	$ 150.00
53.32	59.16	54.52	$ 128.32	$ 134.16	$ 129.52	$ 150.00	$ 150.00	$ 150.00
17.77	19.72	18.17	$ 42.77	$ 44.72	$ 43.17	$ 75.00	$ 75.00	$ 75.00

Q#C1

	Current FTE		2021		2022		2023	
Staff	FTE	Contracted	FTE	Contracted	FTE	Contracted	FTE	Contracted
RN			2.01	0.86	2.01		3.01	0.88
LPN								
HH Aide				0.25		0.31		0.35
NURSING TOTAL	**-**	**-**	**2.01**	**1.12**	**2.01**	**0.31**	**3.01**	**1.24**

Admin			3.00		5.00		5.00	
Medical Director								
DNS			1.00		1.00		1.00	
Business/Clerical								
ADMIN. TOTAL	**-**	**-**	**4.00**	**-**	**6.00**	**-**	**6.00**	**-**
PT			1.51	1.16	2.01	1.31	2.01	1.56
OT				0.81		0.99		1.09
Speech Therapist				0.17		0.17		0.19
Med Social Work				0.09		0.11		0.12
Other (specify):								
ALL OTHERS TOTAL	**-**	**-**	**1.51**	**2.22**	**2.01**	**2.57**	**2.01**	**2.96**
TOTAL STAFFING	**-**	**-**	**7.52**	**3.34**	**10.02**	**2.89**	**11.02**	**4.20**

Q#C2

Type of Staff	**Staff / Visit Ratio**
Skilled Nursing (RN & LPN)	4.75
Physical Therapist	5.00
Occupational Therapist	5.00
Medical Social Worker	4.00
Speech Therapist	5.00
Home Health Aide	7.00
Other (list)	
Total	

CAPTIAL EXPENDITURES	
Desk and Chairs, Partitions, Etc.	$ 5,200

Josephine At Home
Detailed P&L
Budget Years 2021 -2023
in thousands '000s

Staffing Input by FTEs Operations	FY 2021		FY 2022		FY 2023
Operations					
Nursing	3.83		4.35		4.78
Physical Therapy	3.71		4.50		4.97
Occupational Therapy	1.54		1.88		2.08
Speech Therapy	0.32		0.32		0.36
Medical Social Worker	0.20		0.25		0.29
Home Health Aides	0.35		0.43		0.48
Administrative					
Director/Administrator	1.00		1.00		1.00
Supervisor of Clinical Services	1.00		1.00		1.00
Scheduling Coordinator	0.50		1.00		1.00
Intake Adnmission	0.50		1.00		1.00
Marketing Exec	0.50		1.00		1.00
Admin Support	1.00		1.00		1.00

Josephine At Home
Detailed P&L
Budget Years 2021 -2023
in thousands '000s

	FY 2021	FY 2022	FY 2023
Total Net Revenue	**$ 1,587,000**	**$ 2,174,000**	**$ 2,479,000**
Total Direct Expenses	**$ 1,054,000**	**$ 1,256,000**	**$ 1,416,000**
Gross Margin	**$ 533,000**	**$ 918,000**	**$ 1,063,000**
Percentage	***33.6%***	***42.2%***	***42.9%***
Total Indirect Expenses	**$ 633,000**	**$ 844,000**	**$ 874,000**
Net Profit / (Loss)	**(100,000)**	**74,000**	**189,000**
Net Profit / (Loss) %	**-6.3%**	**3.4%**	**7.6%**

Josephine At Home
Percent Payer Mix
Budget Years 2021 -2023
in thousands '000s

Percent Payer Mix (Based on Budget Proforma Gross Revenue Projection)	FY 2021		FY 2022		FY 2023
Medicare	75.2%		79.2%		84.4%
Medicare Advantage	18.3%		15.5%		11.2%
Medicaid	0.1%		0.1%		0.5%
Commercial Insurance	5.4%		4.2%		3.3%
Charity	0.6%		0.7%		0.4%
Self-Pay	0.3%		0.2%		0.2%
	100.0%		100.0%		100.0%

Josephine At Home
Detailed P&L
Budget Years 2021 -2023
in thousands '000s

	FY 2021	FY 2022	FY 2023
Revenue			
Gross Revenue			
Medicare	$ 1,201,000	$ 1,734,000	$ 2,100,000
Medicare Advantage	293,000	340,000	280,000
Medicaid	2,000	2,000	12,000
Commercial Insurance	87,000	93,000	83,000
Charity	10,000	16,000	10,000
Self-Pay	4,000	5,000	4,000
Total Gross Revenue	$ 1,597,000	$ 2,190,000	$ 2,489,000
Contractual Allowances			
Medicare Sequestration	$ -	$ -	$ -
Medicare Advantage	-	-	-
Medicaid	-	-	-
Commercial Insurance	-	-	-
Charity	10,000	16,000	10,000
Self-Pay	-	-	-
Total Contractual Allowances	$ 10,000	$ 16,000	$ 10,000
Net Revenue			
Medicare	$ 1,201,000	$ 1,734,000	$ 2,100,000
Medicare Advantage	293,000	340,000	280,000
Medicaid	2,000	2,000	12,000
Commercial Insurance	87,000	93,000	83,000
Charity	-	-	-
Self-Pay	4,000	5,000	4,000
Total Net Revenue	$ 1,587,000	$ 2,174,000	$ 2,479,000
Direct Expenses			
Full Time Salaries & Wages			
Skilled Nursing	$ 188,000	$ 192,000	$ 288,000
Physical Therapy	172,000	230,000	230,000
Occupational Therapy	-	-	-
Speech Therapy	-	-	-
Medical Social Service	-	-	-
Home Health Aide	-	-	-
Total Full Time Salaries & Wages	$ 360,000	$ 422,000	$ 518,000
Benefits			
30.0%	$ 108,000	$ 126,000	$ 155,000
Per Diem Salaries & Wages			
Skilled Nursing	$ 126,000	$ 171,000	$ 129,000
Physical Therapy	205,000	232,000	275,000
Occupational Therapy	135,000	164,000	182,000
Speech Therapy	26,000	26,000	30,000
Medical Social Service	13,000	17,000	19,000
Home Health Aide	13,000	16,000	18,000
Total Per Diem Salaries & Wages	$ 518,000	$ 626,000	$ 653,000
Other Direct Expenses			
Medical Supplies	$ 23,000	$ 28,000	$ 30,000
Mileage	45,000	54,000	60,000
Total Other Direct Expenses	$ 68,000	$ 82,000	$ 90,000

Josephine At Home
Detailed P&L
Budget Years 2021 -2023
in thousands '000s

	FY 2021	FY 2022	FY 2023
Total Direct Expenses	**$ 1,054,000**	**$ 1,256,000**	**$ 1,416,000**
Gross Margin	**$ 533,000**	**$ 918,000**	**$ 1,063,000**
Percentage	***33.6%***	***42.2%***	***42.9%***
Indirect Expenses			
Administrative Salaries & Wages			
Director/Administrator	**$ 109,000**	**$ 148,000**	**$ 148,000**
Supervisor of Clinical Services	**90,000**	**92,000**	**92,000**
Scheduling Coordinator	**19,000**	**39,000**	**39,000**
Intake Adnmission	**27,000**	**54,000**	**54,000**
Marketing Exec	**33,000**	**67,000**	**67,000**
Admin Support	**42,000**	**43,000**	**43,000**
Total Administrative Salaries & Wages	**$ 320,000**	**$ 443,000**	**$ 443,000**
Benefits			
30.0%	**$ 96,000**	**$ 133,000**	**$ 133,000**
Other Administrative Expenses			
Executive Management	**$ 13,000**	**$ 17,000**	**$ 20,000**
Finance Patient Accounts/Revenue Cycle	**6,000**	**9,000**	**10,000**
Accounting/AP/AR	**11,000**	**15,000**	**17,000**
Intake	**-**	**2,000**	**2,000**
Medical Records	**5,000**	**7,000**	**7,000**
Information Systems	**37,000**	**22,000**	**22,000**
Human Resources & Education	**13,000**	**17,000**	**20,000**
Sales & Marketing	**6,000**	**8,000**	**9,000**
Development & Fundraising	**5,000**	**7,000**	**7,000**
QAPI, Clinical Support & Supervision	**44,000**	**61,000**	**69,000**
Office Support	**11,000**	**15,000**	**17,000**
Space Occupancy	**13,000**	**17,000**	**20,000**
Liability Insurance	**5,000**	**7,000**	**7,000**
Bad Debt	**6,000**	**9,000**	**10,000**
Equipment Purchase/Lease/Repairs	**3,000**	**4,000**	**5,000**
Legal & Audit	**6,000**	**9,000**	**10,000**
Interest Expense	**-**	**-**	**-**
All Other Administrative & General	**24,000**	**33,000**	**37,000**
Depreciation & Amortization	**9,000**	**9,000**	**9,000**
Total Other Administrative Expenses	**$ 217,000**	**$ 268,000**	**$ 298,000**
Total Indirect Expenses	**$ 633,000**	**$ 844,000**	**$ 874,000**
Net Profit / (Loss)	**(100,000)**	**74,000**	**189,000**
Net Profit / (Loss) %	**-6.3%**	**3.4%**	**7.6%**

Josephine At Home
BAlANCE SHEET
Budget Years 2021 -2023
in thousands '000s

	FY 2021		FY 2022		FY 2023	
ASSETS						
Current Assets						
Cash		$ -		$ (28,000)		$ 123,000
Accounts Receivables		382,000		504,000		507,000
Total Current Assets		**382,000**		**476,000**		**630,000**
Fixed Assets						
Office Furniture and Equipment	60,000		60,000		60,000	
Less: Accumulated Depreciation	6,000		12,000		18,000	
Net Fixed Assets		**54,000**		**48,000**		**42,000**
Other Assets						
Deposits		1,000		1,000		1,000
Intangible Assets - Start Up Costs	95,000		95,000		95,000	
Less: Accumulated Amortization	-		-		6,000	
Net Intangible Assets		**95,000**		**95,000**		**89,000**
Other Assets		**96,000**		**96,000**		**90,000**
Total Assets		**532,000**		**620,000**		**762,000**
LIABILITIES AND FUND BALANCE						
Current Liabilities						
Accounts Payable		$ 100,000		$ 111,000		$ 49,000
Related Party Line of Credit		584,000		584,000		584,000
Total Current Assets		**684,000**		**695,000**		**633,000**
Fund Balance		$ (100,000)		$ (26,000)		$ 127,000
Total Assets		**584,000**		**669,000**		**760,000**

Josephine At Home
CASH FLOWS
Budget Years 2021 -2023
in thousands '000s

	FY 2021	FY 2022	FY 2023
Cash Flows from Operating Activities			
Patient Cash Receipts	1,205,000	2,043,000	2,387,000
Payroll and Payroll Related Expenses	(1,402,000)	(1,749,000)	(1,901,000)
Payments to NonPayroll Related Vendors	(232,000)	(323,000)	(376,000)
Net Cash Provided by (Used In) Operating Activities	**(429,000)**	**(29,000)**	**110,000**
Cash Flows from Investing Activities			
Purchase of Fixed Assets and Leasehold Improvements	(5,000)	-	
Investment in Startup of Home Care Program	(95,000)	-	-
Net Cash Provided by (Used In) Investment Activities	**(100,000)**	**-**	**-**
Cash Flows from Financing Activities			
Proceeds from Related Party Line of Credit	584,000	-	-
Net Cash Provided by (Used In) Financing Activities	**584,000**	**-**	**-**
CASH EQUIVALENTS AT YEAR END	55,000	(29,000)	110,000

Reconciliation of Net Income / (Loss) to Net Cash Provided by (Used In) Operating Activities			
Net Income / (Loss)	(100,000)	74,000	189,000
Adjustments to Net Income / (Loss)			
Depreciation	9,000	9,000	9,000
Increase in Accounts Receivables	(382,000)	(122,000)	(3,000)
Increase in Accounts Payables	100,000	11,000	(62,000)
Rounding	(1,000)		1,000
Net Cash Provided By (Used In) Operating Activities	***(374,000)***	***(28,000)***	***134,000***

Exhibit 12
Letter of Financial Support

Josephine
Caring Community
One Heart, Many Hands.

Fullness of *life.*

September 29, 2020

Certificate of Need Program
Department of Health
PO BOX 47852
Olympia, Washington 98504-7852

RE: Financial Letter of Commitment

To Whom It May Concern,

This letter is issued on behalf of Josephine Caring Community to inform the Washington State Department of Health that Josephine At Home, a subsidiary of Josephine Caring Community, will have all working capital necessary to finance the entire Home Health Agency project. All Home Health Agency working capital and cash-flow needs will be fully funded by Josephine Caring Community.

Thank you for your assistance. Please contact me directly with any questions at **(360) 510-2083**.

Sincerely,

Terry Robertson,
CEO
Josephine Caring Community

Exhibit 13

Moss Adams Annual Audit

Josephine
Caring Community
One Heart. Many Hands.

Fullness of *life.*

April 15, 2020

Moss Adams LLP
1301 A Street, Suite 600
Tacoma, WA 98402

We are providing this letter in connection with your audits of the financial statements of Josephine Caring Community (the "Organization"), which comprise the balance sheets, statements of activities and changes in net assets, functional expenses and cash flows as of December 31, 2019 and 2018 and for the years then ended and the related notes to the financial statements for the purpose of expressing an opinion as to whether the financial statements are presented fairly, in all material respects, in accordance with accounting principles generally accepted in the United States (U.S. GAAP). Certain representations in this letter are described as being limited to matters that are material. Items are considered material, regardless of size, if they involve an omission or misstatement of accounting information that, in the light of surrounding circumstances, makes it probable that the judgment of a reasonable person relying on the information would be changed or influenced by the omission or misstatement.

Except where otherwise stated below, immaterial matters less than $30,000 collectively are not considered to be exceptions that require disclosure for the purpose of the following representations. This amount is not necessarily indicative of amounts that would require adjustment to or disclosure in the financial statements.

We confirm that, to the best of our knowledge and belief, having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves as of April 15, 2020.

Financial Statements

1. The Organization has fulfilled our responsibilities, as set out in the terms of the audit engagement letter dated October 31, 2019, for the preparation and fair presentation of the financial statements in accordance with U.S. GAAP.
2. The Organization acknowledges our responsibility for 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.
3. The Organization acknowledges our responsibility for the design, implementation and maintenance of internal controls to prevent and detect fraud.
4. Significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable.
5. Related party relationships and transactions have been appropriately accounted for and disclosed in accordance with the requirements of U.S. GAAP.
6. All events subsequent to the date of the financial statements and for which U.S. GAAP requires adjustment or disclosure have been adjusted or disclosed.
7. The effects of all known actual or possible litigation and claims have been accounted for and disclosed in accordance with U.S. GAAP.

Information Provided

8. The Organization has provided you with:
    a. Access to all information, of which we are aware that is relevant to the preparation and fair presentation of the financial statements such as records, documentation and other matters;

b. Minutes of the meetings of stockholders, directors, and committees of directors, or summaries of actions of recent meetings for which minutes have not yet been prepared;

c. Additional information that you have requested from us for the purpose of the audit;

d. Unrestricted access to persons within the entity from whom you determined it necessary to obtain audit evidence.

9. All transactions have been properly recorded in the accounting records and are reflected in the financial statements.

10. The Organization has disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.

11. The Organization has no knowledge of any fraud or suspected fraud that affects the entity and involves—

    a. Management,

    b. Employees who have significant roles in internal control, or

    c. Others when the fraud could have a material effect on the financial statements.

12. The Organization has no knowledge of any allegations of fraud or suspected fraud, affecting the entity's financial statements communicated by employees, former employees, analysts, regulators or others.

13. The Organization has disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing financial statements.

14. The Organization is not aware of any pending or threatened litigation, claims, and assessments whose effects other than the claim disclosed that should be considered when preparing the financial statements. The estimate of any potential settlement is not material.

15. The Organization has disclosed to you the identity of the entity's related parties and all the related party relationships and transactions of which we are aware.

16. We have reviewed long-lived assets to be held and used for impairment in accordance with ASC 360-10-05, *Accounting for Impairment or Disposal of Long-Lived Assets*, whenever events or changes in circumstances have indicated that the carrying amount of assets might not be recoverable, and have appropriately recorded the adjustment. Specifically, as of December 31, 2018 and with information about the results of operations subsequent to that date through the date of this letter, we believe that no material impairment of long-lived assets, including land held for sale and land held for development, exists at December 31, 2019.

17. As part of your audit, you assisted with the preparation of the draft financial statements and related footnotes. We have designated our Controller to oversee your services and have made all management decisions. We have reviewed, approved and accepted responsibility for the financial statements, related footnotes and supplemental information.

18. Cost reports filed with third parties:

    a. All required Medicare, Medicaid, and similar reports have been properly filed or will be according to the due dates set by Medicare and Medicaid.

    b. Management is responsible for the accuracy and propriety of all cost reports filed.

    c. All costs reflected on such reports are appropriate and allowable under applicable reimbursement rules and regulations and are patient-related and properly allocated to applicable payors.

    d. The reimbursement methodologies and principles employed are in accordance with applicable rules and regulations.

    e. Adequate consideration has been given to, and appropriate provision made for, audit adjustments by intermediaries, third-party payors, or other regulatory agencies.

    f. All items required to be disclosed, including disputed costs that are being claimed to establish a basis for a subsequent appeal, have been fully disclosed in the cost report.

g. Recorded third-party settlements include differences between filed (and to be filed) cost reports and calculated settlements, which are necessary based on historical experience or new or ambiguous regulations that may be subject to differing interpretations. While management believes the entity is entitled to all amounts claimed on the cost reports, management also believes the amounts of these differences are appropriate.

19. There are no violations, or possible violations of laws and regulations, such as those related to the Medicare and Medicaid antifraud and abuse statutes, including but not limited to the Medicare and Medicaid Anti-Kickback Statute, Limitations on Certain Physician Referrals (the "Stark Law"), and the False Claims Act, in any jurisdiction, whose effects should be considered for disclosure in the financial statements or as a basis for recording a loss contingency other than those disclosed or accrued in the financial statements.

    a. Billing to third-party payors comply in all material respects with applicable coding guidelines (for example, ICD-10-CM, RUG guidelines and CPT-4) and laws and regulations (including those dealing with Medicare and Medicaid antifraud and abuse), and billings reflect only charges for goods and services that were medically necessary; properly approved by the regulatory bodies (for example, the Food and Drug Administration); if required; and properly rendered.

    b. There have been no communications (oral or written) from regulatory agencies, governmental representatives, employees, or others concerning investigations or allegations of noncompliance with laws and regulations in any jurisdiction (including those related to the Medicare and Medicaid antifraud and abuse statutes), deficiencies in financial reporting practices, or other matters that could have a material adverse effect on the financial statements, other than those previously mentioned.

20. The Organization is an exempt organization under Section 501(c)(3) of the Internal Revenue Code. Any activities of which we are aware that would jeopardize the organization's tax-exempt status, and all activities subject to tax on unrelated business income or excise or other tax, have been disclosed to you. All required filings with tax authorities are up to date.

21. The functional allocations disclosed in the financial statements are reasonable.

22. The Organization has assessed the financial instruments of the Organization in accordance with ASC 820, *Fair Value Measurements and Disclosures*, and believes the disclosures related to the fair value of the investments are appropriate.

23. The financial statement disclosures related to the endowment assets to the Community Foundation of Snohomish County are complete and accurate. We have acknowledged that the investments are a beneficial interest in the Community Foundation of Snohomish County.

24. The Organization is in compliance with the requirements of the Washington Uniform Prudent Management of Institutional Funds ("WUPMIFA") and all disclosures included in the financial statements are accurate and in compliance with WUPMIFA.

25. The Organization is in compliance with all covenant requirements of the outstanding bonds.

26. We confirm that the Organization's outstanding bonds are private placement. We believe that the original financial institutions in which the bonds are entered into have retained the obligation. Therefore, we confirm that our outstanding bond continues to be private placement.

27. The Organization has not included the volunteer hours' time in the financial statements as they would not be material to the financial statements.

28. We have evaluated Accounting Standards Update (ASU) 2014-15, Presentation of Financial Statements – Going Concern (Subtopic 205-40): Disclosure of Uncertainties About an Entity's Ability to Continue as a Going Concern, and have concluded that no substantial doubt exists as of December 31, 2019 and no events have transpired subsequent to December 31, 2019 through April 15, 2020, which would result in substantial doubt about the Company's ability to continue as a going concern for at least the next twelve months.

29. We have complied with the disclosure requirements of the standards associated with Endowments of Not-for-Profit Organizations: Net Assets Classification of Funds Subject to an Enacted Version of the Uniform Prudent Management of Institutional Funds Act (UPMIFA) and Enhanced Disclosure of All Endowment Funds to the extent deemed necessary.

REPORT OF INDEPENDENT AUDITORS
AND FINANCIAL STATEMENTS
WITH SUPPLEMENTARY INFORMATION

JOSEPHINE CARING COMMUNITY

December 31, 2019 and 2018

MOSSADAMS

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MOSSADAMS

Report of Independent Auditors

To the Board of Directors
Josephine Caring Community

Report on Financial Statements

We have audited the accompanying financial statements of Josephine Caring Community, which comprise the balance sheets as of December 31, 2019 and 2018, and the related statements of activities and changes in net assets, functional expenses, 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 audits 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 Josephine Caring Community as of December 31, 2019 and 2018, and the results of its operations and its cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Emphasis of a Matter

As discussed in Note 2 to the financial statements, as of January 1, 2019, the Josephine Caring Community adopted Financial Accounting Standards Board (FASB) Accounting Standards Update (ASU) 2014-09, *Revenue from Contracts with Customers* (Topic 606). Our opinion is not modified with respect to this matter.

Other Matters

Our audit was conducted for the purpose of forming an opinion on the basic financial statements taken as a whole. The accompanying supplementary information on page 27 presented for purposes of additional analysis and is not a required part of the basic financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the basic financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the financial statements as a whole.

Moss Adams LLP

Tacoma, Washington
April 15, 2020

Josephine Caring Community
Balance Sheets

ASSETS

	December 31, 2019	December 31, 2018
CURRENT ASSETS		
Cash and cash equivalents	$ 4,253,759	$ 2,233,767
Assets restricted for use	49,987	45,343
Accounts receivable, net	1,565,274	1,519,535
Investments	6,716,872	5,842,386
Prepaid expenses	194,376	147,409
Inventory	69,882	75,617
Total current assets	12,850,150	9,864,057
ASSETS RESTRICTED FOR LONG-TERM USE	1,025,606	767,873
LAND, BUILDINGS, AND EQUIPMENT, net	5,562,878	5,861,903
OTHER ASSETS		
Land held for future development	3,880,725	3,975,487
Estimated litigation settlement	150,000	-
Land held for sale	-	176,281
Total assets	$ 23,469,359	$ 20,645,601

LIABILITIES AND NET ASSETS

CURRENT LIABILITIES		
Accounts payable	$ 240,802	$ 271,583
Accrued payroll and vacation	713,657	674,454
Accrued payroll taxes and benefits	528,430	530,470
Other liabilities	24,359	40,939
Unearned revenue	29,763	28,167
Funds held for residents	14,296	15,407
Estimated litigation settlement	150,000	-
Current portion of bonds payable	402,000	386,000
Total current liabilities	2,103,307	1,947,020
LONG-TERM DEBT AND OTHER LIABILITIES		
Bonds payable, net of current portion	3,285,188	3,691,188
Less loan fees, net of accumulated amortization of $173,907 and $158,514 for the years ended 2019 and 2018, respectively	148,807	164,200
	3,136,381	3,526,988
Deferred compensation	435,629	260,633
Total liabilities	5,675,317	5,734,641
NET ASSETS		
Without donor restrictions	17,152,229	14,363,727
With donor restrictions	641,813	547,233
Total net assets	17,794,042	14,910,960
Total liabilities and net assets	$ 23,469,359	$ 20,645,601

See accompanying notes.

Josephine Caring Community
Statements of Activities and Changes in Net Assets
Year Ended December 31, 2019

	Without Donor Restrictions	With Donor Restrictions	Total
REVENUE, GAINS, AND OTHER SUPPORT			
Nursing home revenue	$ 16,554,005	$ -	$ 16,554,005
Boarding home revenue	2,159,236	-	2,159,236
Child care revenue	999,052	-	999,052
Child care grant revenue	315,954	-	315,954
Other program revenue	280,066	-	280,066
Other revenue	54,897	-	54,897
Gain on sale of assets	483,402	-	483,402
Contributions	63,576	6,849	70,425
Home health revenue	22,805	-	22,805
Interest and dividends	144,906	16	144,922
Net assets released from restriction	11,335	(11,335)	-
Total revenue, gains, and other support	21,089,234	(4,470)	21,084,764
EXPENSES			
Salaries and wages	11,724,468	-	11,724,468
Payroll taxes and benefits	2,074,235	-	2,074,235
Ancillary expenses	1,318,279	-	1,318,279
Supplies	1,574,008	-	1,574,008
Depreciation and amortization	711,975	-	711,975
Interest	161,718	-	161,718
Other	2,069,321	-	2,069,321
Total expenses	19,634,004	-	19,634,004
EXCESS REVENUES (DEFICIENCY) OVER EXPENSES	1,455,230	(4,470)	1,450,760
UNREALIZED GAIN ON INVESTMENTS	1,333,272	99,050	1,432,322
CHANGE IN NET ASSETS	2,788,502	94,580	2,883,082
NET ASSETS, beginning of year	14,363,727	547,233	14,910,960
NET ASSETS, end of year	$ 17,152,229	$ 641,813	$ 17,794,042

See accompanying notes.

Josephine Caring Community
Statements of Activities and Changes in Net Assets
Year Ended December 31, 2018

	Without Donor Restrictions	With Donor Restrictions	Total
REVENUE, GAINS, AND OTHER SUPPORT			
Nursing home revenue	$ 15,766,310	$ -	$ 15,766,310
Boarding home revenue	2,074,681	-	2,074,681
Child care revenue	960,371	-	960,371
Child care grant revenue	337,496	-	337,496
Other program revenue	161,349	-	161,349
Other revenue	7,028	-	7,028
Contributions	25,673	13,398	39,071
Interest and dividends	142,180	1,603	143,783
Net assets released from restriction	20,656	(20,656)	-
Total revenue, gains, and other support	19,495,744	(5,655)	19,490,089
EXPENSES			
Salaries and wages	11,443,840	-	11,443,840
Payroll taxes and benefits	2,051,804	-	2,051,804
Ancillary expenses	1,384,340	-	1,384,340
Supplies	1,519,287	-	1,519,287
Depreciation and amortization	800,823	-	800,823
Interest	171,587	-	171,587
Other	2,107,601	-	2,107,601
Total expenses	19,479,282	-	19,479,282
EXCESS REVENUES OVER EXPENSES	16,462	(5,655)	10,807
UNREALIZED LOSS ON INVESTMENTS	(401,070)	(32,787)	(433,857)
CHANGE IN NET ASSETS	(384,608)	(38,442)	(423,050)
NET ASSETS, beginning of year	14,748,335	585,675	15,334,010
NET ASSETS, end of year	$ 14,363,727	$ 547,233	$ 14,910,960

See accompanying notes.

Josephine Caring Community
Statements of Functional Expenses
Year Ended December 31, 2019

	Nursing Home Expenses	Boarding Home Expenses	Child Care Expense	Other Program	General and Administrative	Fundraising Expenses	Total 2019
Salaries and wages	$ 9,001,445	$ 910,864	$ 773,931	$ 122,749	$ 915,479	$ -	$ 11,724,468
Payroll taxes and benefits	1,554,039	191,223	157,203	16,461	155,309	-	2,074,235
Total salaries and related expenses	10,555,484	1,102,087	931,134	139,210	1,070,788	-	13,798,703
Supplies	1,111,861	209,533	107,681	5,392	137,941	1,600	1,574,008
Ancillary expenses	1,318,279	-	-	-	-	-	1,318,279
Depreciation and amortization	457,932	180,024	21,873	2,242	49,572	332	711,975
Utilities	320,898	126,053	32,785	-	12,446	-	492,182
Contract Labor	175,389	-	650	-	159,933	-	335,972
Repairs and maintenance	155,420	7,064	942	-	73,250	-	236,676
Miscellaneous expense	1,873	8,549	-	8,436	152,423	-	171,281
Advertising and publications	87,918	137	594	14,916	63,362	-	166,927
Interest expense	82,712	55,772	-	-	23,234	-	161,718
Insurance	48,617	8,388	15,279	891	80,959	-	154,134
Licenses and fees	-	7,703	1,841	9,694	99,920	-	119,158
Professional fees	-	1,222	-	-	93,430	-	94,652
Telephone	-	2,367	-	-	57,407	-	59,774
Property taxes	-	-	-	-	56,016	-	56,016
Education	26,562	2,288	3,028	2,798	12,000	-	46,676
Safety net assessment	43,523	-	-	-	-	-	43,523
Vehicle expense	18,069	2,657	4,854	1,367	-	-	26,947
Events	16,398	-	5,803	-	-	-	22,201
Program expenditures	-	-	-	16,351	-	-	16,351
Board expense	-	-	-	-	10,655	-	10,655
Postage	-	-	-	-	8,492	-	8,492
Public relations	-	-	-	-	4,246	-	4,246
Travel	-	-	999	1,209	-	-	2,208
State and local taxes	-	-	-	-	1,250	-	1,250
Total expenses	$ 14,420,935	$ 1,713,844	$ 1,127,463	$ 202,506	$ 2,167,324	$ 1,932	$ 19,634,004

See accompanying notes.

Josephine Caring Community
Statements of Functional Expenses
Year Ended December 31, 2018

	Nursing Home Expenses	Boarding Home Expenses	Child Care Expense	Other Program	General and Administrative	Fundraising Expenses	Total 2018
Salaries and wages	$ 8,792,680	$ 902,569	$ 780,834	$ -	$ 967,757	$ -	$ 11,443,840
Payroll taxes and benefits	1,537,733	181,427	163,172	-	169,472	-	2,051,804
Total salaries and related expenses	10,330,413	1,083,996	944,006	-	1,137,229	-	13,495,644
Supplies	1,092,348	199,649	92,741	5,171	128,128	1,250	1,519,287
Ancillary expenses	1,384,340	-	-	-	-	-	1,384,340
Depreciation and amortization	529,111	186,729	25,165	-	57,450	2,368	800,823
Utilities	340,622	130,496	35,105	-	13,376	-	519,599
Contract Labor	323,659	-	2,963	-	136,980	9,589	473,191
Repairs and maintenance	153,001	5,993	900	-	76,367	-	236,261
Miscellaneous expense	11,433	9,773	504	1,045	23,970	-	46,725
Advertising and publications	68,366	-	545	34	137,589	-	206,534
Interest expense	88,167	59,450	-	-	65,467	-	213,084
Insurance	46,555	8,663	15,788	-	35,730	-	106,736
Licenses and fees	-	6,890	2,089	-	87,223	-	96,202
Professional fees	-	1,944	-	-	85,798	-	87,742
Telephone	-	2,460	-	-	59,666	-	62,126
Property taxes	-	-	-	-	53,139	-	53,139
Education	24,665	2,039	2,384	546	-	-	29,634
Safety net assessment	42,167	-	-	-	7,182	-	49,349
Vehicle expense	20,281	1,456	8,596	-	-	-	30,333
Events	15,313	-	6,496	-	-	-	21,809
Program expenditures	-	-	-	16,968	-	-	16,968
Board expense	-	-	-	-	15,447	-	15,447
Postage	-	-	-	-	8,877	-	8,877
Public relations	-	-	-	-	3,377	-	3,377
Travel	-	-	750	-	1,305	-	2,055
State and local taxes	-	-	-	-	-	-	-
Total expenses	$ 14,470,441	$ 1,699,538	$ 1,138,032	$ 23,764	$ 2,134,300	$ 13,207	$ 19,479,282

See accompanying notes.

Josephine Caring Community
Statements of Cash Flows

	Years Ended December 31, 2019	2018
CASH FLOWS FROM OPERATING ACTIVITIES		
Change in net assets	$ 2,883,082	$ (423,050)
Adjustments to reconcile change in net assets to net cash from operating activities		
Depreciation and amortization	711,975	800,823
Amortization of loan fees included in interest expense	15,393	18,245
Provision for bad debt	30,641	83,537
(Gain) Loss on disposal of property and equipment	(483,402)	2,309
Unrealized (gain) loss on investments	(1,333,272)	401,070
Changes in operating assets and liabilities		
Accounts receivable	(76,380)	(189,096)
Prepaid expenses	(46,967)	(6,393)
Inventory	5,735	(3,668)
Accounts payable	(30,781)	(99,424)
Accrued payroll and vacation	39,203	86,940
Accrued payroll taxes and benefits	(2,040)	(52,552)
Other liabilities	(16,580)	(1,170)
Unearned revenue	1,596	25,941
Funds held for residents	(1,111)	(4,905)
Net cash from operating activities	1,697,092	638,607
CASH FLOWS FROM (USED IN) INVESTING ACTIVITIES		
Proceeds from sale of investments	1,424,205	1,661,917
Purchase of investments	(965,419)	(1,225,537)
Proceeds from sale of land held for sale	659,683	-
Purchase of land, buildings, and equipment	(318,188)	(285,821)
Net cash from investing activities	800,281	150,559
CASH FLOWS FROM (USED IN) FINANCING ACTIVITIES		
Gain on assets restricted for use	11,669	70,729
Sale of investments restricted for use	-	257,504
Purchase of investments restricted for use	-	(320,172)
Unrealized (gain) loss on assets restricted for use	(99,050)	32,787
Principal payments on bonds payable	(390,000)	(374,000)
Principal payments on capital lease obligation	-	(22,682)
Net cash used in financing activities	(477,381)	(355,834)
INCREASE IN CASH AND CASH EQUIVALENTS	2,019,992	433,332
CASH AND CASH EQUIVALENTS, beginning of year	2,233,767	1,800,435
CASH AND CASH EQUIVALENTS, end of year	$ 4,253,759	$ 2,233,767
Cash paid for interest	$ 143,325	$ 153,343
SUPPLEMENTAL DISCLOSURE OF NON-CASH INFORMATION		
Increase (decrease) in deferred compensation and assets limited for use	$ 174,996	$ (9,642)

See accompanying notes.

Note 1 – Description of Operations

Josephine Caring Community (the Organization) is a nonprofit, member-owned corporate affiliate of the Evangelical Lutheran Church in America. Corporate membership is composed of 18 local congregations. Members of the Organization's corporation are entitled to elect the board of directors and approve certain actions of the board of directors. The Organization operates a 160-bed skilled nursing facility, a 57-unit boarding home licensed for 65 residents, and a child care program licensed for a capacity of 111 children in Stanwood, Washington.

Note 2 – Summary of Significant Accounting Policies

Basis of accounting – The Organization maintains its financial records using the accrual basis of accounting, whereby revenues are recognized when earned and expenses are recognized when an obligation is incurred.

Basis of presentation – The Organization presents its financial statements in accordance with generally accepted accounting principles (GAAP), as codified by the Financial Accounting Standards Board (FASB). The Organization has implemented Accounting Standards Codifications (ASC) 958, *Not-for-Profit Entities*. Under ASC 958, the Organization reports information regarding its financial position and activities according to two classes of net assets: without donor restrictions and with donor restrictions.

- *Net assets without donor restrictions* – Net assets available for use in general operations and not subject to donor restrictions.

- *Net assets with donor restrictions* – Net assets subject to donor-imposed restrictions. Some donor-imposed restrictions are temporary in nature, such as those that will be met by the passage of time or other events specified by the donor. Other donor-imposed restrictions are perpetual in nature, where the donor stipulates that resources be maintained in perpetuity. Donor-imposed restrictions are released when a restriction expires; that is, when the stipulated time has elapsed, when the stipulated purpose for which the resource was restricted has been fulfilled, or both. These are reported as reclassifications between the applicable classes of net assets.

Federal income tax – The Organization is exempt from federal income tax under Section 501 (c)(3) of the Internal Revenue Code. Exemption has also been given by Snohomish County (the County) from all personal property taxes. In addition, the County has granted exemption for real property associated with the nursing home, boarding home, and child care programs. Also, the Organization qualifies for the charitable contribution deduction under Section 170(b)(l)(A) and has been classified as an organization that is not a private foundation under Section 509(a)(2).

The Organization accounts for uncertain tax positions whereby the effect of the uncertainty would be recorded if the outcome was considered probable and was reasonably estimable. As of December 31, 2019, the Organization had not identified any uncertain tax positions requiring accrual or disclosure.

Note 2 – Summary of Significant Accounting Policies (continued)

Cash and cash equivalents – Cash and cash equivalents consist of highly liquid investments with remaining maturity at the date of purchase of three months or less.

Investments – The Organization records its investments in accordance with ASC 958, Not-for-Profit Entities. Under ASC 958, investments in marketable securities with readily determinable fair values and all investments in debt securities are reported at their fair values in the balance sheets. Unrealized gains and losses are included in the statements of activities and changes in net assets (Note 10).

Inventory – Inventory consists mainly of dietary supplies, central supplies, food, and gift shop merchandise and is stated at the lower of cost (first-in, first-out method) or market.

Accounts receivable – The Organization carries its accounts receivable at standard rates less an allowance for uncollectible accounts. On a periodic basis, the Organization evaluates its accounts receivable and establishes an allowance for uncollectible accounts, based on a history of past write-offs and collections. The allowance is $41,500 and $192,636 at December 31, 2019 and 2018, respectively.

The Organization can charge interest of 12% per annum on skilled nursing and boarding home private past due accounts. Other nursing home and boarding home late fees may be assessed according to the resident financial agreements in place during the year. Approximately $2,514 and $3,692 of child care accounts receivable and $266,173 and $205,802 of skilled nursing and boarding home accounts receivable are greater than 90 days at December 31, 2019 and 2018, respectively.

Land, buildings, and equipment – Land, buildings, and equipment are stated at cost, less accumulated depreciation. The Organization capitalizes fixed assets with a cost greater than $750. Maintenance and repair costs are expensed as incurred. The cost and related accumulated depreciation of significant assets sold or retired are removed from the property accounts, and any resulting gain or loss is reported as an increase or decrease in net assets as explained in the revenue recognition section.

Depreciation is provided on the straight-line method over the assets' estimated useful lives, which, for land improvements, is 5 to 25 years, for buildings is 25 to 30 years, for building improvements is 10 to 26 years, for furniture and equipment is 3 to 20 years, and for vehicles is 4 to 10 years.

The Organization, using its best estimates based on reasonable and supportable assumptions and projections, reviews for impairment of long-lived assets when indicators of impairment are identified. The review addresses the estimated recoverability of the assets' carrying value, which is principally determined based on projected undiscounted cash flows generated by the underlying tangible assets.

When the carrying value of an asset exceeds estimated recoverability, an asset impairment is recognized. No impairment losses were present for the years ended December 31, 2019 and 2018.

Note 2 – Summary of Significant Accounting Policies (continued)

Endowments – The Organization has interpreted the Washington Uniform Prudent Management of Institutional Funds Act as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, the Organization classifies as with donor restrictions net assets (1) the original value of gifts donated to the endowment, (2) the original value of subsequent gifts to the endowment, and (3) accumulations to the endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund.

The Organization has adopted investment and spending policies for endowment assets that attempt to provide a predictable stream of funding to programs supported by its endowment while seeking to maintain the purchasing power of the endowment assets. Endowment assets include those assets of donor-restricted funds that the Organization must hold in perpetuity or for a donor-specified period, an accumulation of earnings on the fund in accordance with the endowment fund investment policy, and board-designated funds (if any). Under this policy, as approved by the board of directors, the endowment assets are invested in a manner that is intended to produce results that exceed the price and yield results while assuming a low level of investment risk. The Organization expects its endowment funds, over time, to provide a consistent rate of return. Actual returns in any given year may vary. The Organization has a policy that allows spending of annual interest earned on the corpus of the endowment fund. The amount of interest earnings to be released annually for distribution is specified by the board as soon as equitably possible after fiscal year-end. The interest funds are spent as authorized by the board on programs or capital expenditures to benefit the Organization in accordance with the endowment policy. See Note 12 for endowment investment information.

Revenue recognition – On January 1, 2019, the Organization adopted Accounting Standards Codification Topic 606, *Revenue from Contracts with Customers* (ASC 606) applying the modified retrospective method. There was no cumulative effect on the opening balance of accumulated deficit as a result of adopting the standard as of January 1, 2019. Results for reporting periods beginning after January 1, 2019, are presented under ASC 606, while comparative information has not been restated and continues to be reported under the accounting standards in effect for those periods.

Resident Care (Nursing Home and Boarding Home) Revenue – Resident care revenue is reported at the amount that reflects the consideration the Organization expects to receive in exchange for the services provided. These amounts are due from residents or third-party payors and include variable consideration for retroactive adjustments, if any, under reimbursement programs. Performance obligations are determined based on the nature of the services provided. Resident care revenue is recognized as performance obligations are satisfied. Under the Organization's senior living residency agreements, the Organization provides senior living services to residents for a stated daily or monthly fee. The Organization recognizes revenue for skilled nursing residency, assistance with activities of daily living, healthcare, and personalized health services in accordance with the provisions of ASC 606. The Organization has determined that the senior living services included under the daily or monthly fee have the same timing and pattern of transfer and are a series of distinct services that are considered one performance obligation which is satisfied over time.

Note 2 – Summary of Significant Accounting Policies (continued)

Child Care Revenue – The Organization provides child care services to individuals at standard rates. The Early Childhood Education and Assistance Program is a state-funded kindergarten preparedness program for limited income four-year-olds provided by a grant through the Snohomish County Human Services Department. During 2019, the grant was renewed and expires on June 30, 2020. The Organization has determined that the child care services included under the daily or monthly fee have the same timing and pattern of transfer and are a series of distinct services that are considered one performance obligation which is satisfied over time.

The Organization determines the transaction price based on level of care in accordance with Centers for Medicare and Medicaid Services (CMS) guidelines and criteria and provider contracts, reduced by contractual adjustments provided to third-party. The Organization determines its estimates of contractual adjustments based on contractual agreements and historical experience. Agreements with third-party payors provide for payments at amounts less than established charges. A summary of the payment arrangements with major third-party payors follows:

Medicare – Certain health care services are paid at prospectively determined rates per level of care based on clinical, diagnostic or other factors. Certain services are paid based on a cost-reimbursement methodologies subject to certain limits. Services are paid based upon established fee schedules.

Medicaid – The Organization's reimbursement methodology is determined based on prospective rates similar to the Medicare methodology. Medicaid rates are facility-specific. Rates are determined based on services provided, occupancy levels, the resource needs of individual residents, as well as a quality incentive component. Certain services are paid based on a cost-reimbursement methodologies subject to certain limits. Services are paid based upon established fee schedules.

Private – Generally, patients who are covered by third-party payors are responsible for related deductibles and coinsurance, which vary in amount. The Organization estimates the transaction price for patients with deductibles and coinsurance based on historical experience and current market conditions. The initial estimate of the transaction price is determined by reducing the standard charge by any contractual adjustments determined on a resident by resident basis. Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to health services revenue in the period of the change. Subsequent changes that are determined to be the result of an adverse change in the residents' ability to pay are recorded as bad debt expense.

Third-party payors – Payment agreements with certain commercial insurance carriers, health maintenance organizations and preferred provider organizations provide for payment using prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

Note 2 – Summary of Significant Accounting Policies (continued)

	Nursing Home Revenue	Boarding Home Revenue	Child Care Revenue	Home Health and Other Revenue
Medicaid	$ 9,603,131	$ 503,008	$ -	$ -
Medicare	4,467,666	-	-	-
Private	2,483,208	1,656,228	999,052	22,805
Miscellaneous	-	-	315,954	280,066
	$ 16,554,005	$ 2,159,236	$ 1,315,006	$ 302,871

Contributions – The Organization records contributions according to ASC 958, *Not-for-Profit Entities*. In accordance with ASC 958, contributions, including unconditional promises to give, are recorded in the period made. All contributions are available for unrestricted use unless specifically restricted by the donor. Conditional promises to give are recognized when the conditions on which they depend are substantially met. Unconditional promises to give due in the next year are recorded at their net realizable value. Unconditional promises to give due in subsequent years are reported at the present value of their net realizable value, using risk-free interest rates applicable to the years in which the promises are to be received.

During 2019, more than 80 volunteers contributed significant amounts of time and effort in assisting to carry out the programs and activities of the Organization. The time contributed by volunteers is not reflected in the financial statements.

Recognition of donor-restricted contributions – Support that is restricted by the donor is reported as an increase in net assets without donor restrictions if the restriction expires in the reporting period in which the support is recognized. All other donor-restricted support is reported as an increase in net assets with donor restrictions, depending on the nature of the restriction. When a restriction expires, the donor restrictions net assets are reclassified to without donor restrictions net assets.

Loan issuance fees – Loan issuance fees are amortized on the straight-line basis over the term of the debt. Straight-line calculation of loan fees is not significantly different than the effective interest method. Amortization included in interest expense was $15,393 and $18,245 for the years ended December 31, 2019 and 2018, respectively. Accumulated amortization was $173,907 and $158,514 as of December 31, 2019 and 2018, respectively.

Use of estimates – The preparation of financial statements in accordance 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, and disclosure of contingent assets and liabilities at the date of the financial statements and reported amounts of revenue and expense during the reporting period. Actual results could differ from those estimates.

Note 2 – Summary of Significant Accounting Policies (continued)

Performance indicator – Excess revenues over expenses as reflected in the accompanying statements of activities is a performance indicator. Excess revenues over expenses include changes in net assets without donor restrictions other than net unrealized losses (gains) on investments.

Expense allocation – Directly identifiable expenses are charged to program, fund raising, and general and administrative expenses. Expenses relating to more than one function are charged to the function based on an estimate of utilization, square footage, or revenue on each function. General and administrative expenses include those expenses that are not directly identifiable with any specific function but to provide for the overall support of the Organization.

Recent accounting pronouncements – In February 2016, the FASB issued Accounting Standards Update No. 2016-02 (ASU 2016-02), *Leases (Topic 842)*. ASU 2016-02 requires lessees to recognize a right-of-use asset and lease liability in the balance sheet for all leases, including operating leases, with terms of more than twelve months. The new guidance will be effective for nonpublic company fiscal years beginning on or after December 15, 2020, with early adoption permitted. The amendment must be applied on a modified retrospective basis.

The Organization is currently evaluating the impact of the adoption of this standard on the financial statements.

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

The Organization evaluated subsequent events through April 15, 2020, which is the date the financial statements were available to be issued, for events requiring recording or disclosure in the financial statements for the year ended December 31, 2019.

On March 11, 2020, the World Health Organization officially declared COVID-19, the disease caused by the novel coronavirus, a pandemic. Management is closely monitoring the evolution of this pandemic, including how it may affect the economy and the general population. Management has not yet determined the financial impact of these events.

Note 3 – Liquidity and Availability

The Organization regularly monitors liquidity required to meet its operating needs, liabilities, and other obligations as they become due. The Organization is substantially supported by a contract with the Department of Social and Health Services in the state of Washington for Medicaid reimbursement and the federal government for Medicare reimbursement. The majority of the financial assets recorded by the Organization are used to support the skilled nursing facility, boarding home and a child care program in Snohomish County and surrounding communities in the northern Puget Sound region.

In addition to financial assets available to meet general expenditures over the next twelve months, the Organization operates with a balanced budget and anticipates collecting sufficient revenue to cover general expenditures.

The Organization has $12,535,905 and $9,595,688 as of December 31, 2019 and 2018, respectively, of financial assets available within one year of the statement of financial position date to meet cash needs for general expenditure consisting of cash and cash equivalents and investments of $10,970,631 and $8,076,153 and accounts receivable of $1,565,274 $1,519,535 as of December 31, 2019 and 2018, respectively. None of these financial assets are subject to donor or other contractual restrictions that make them unavailable for general expenditure within one year of the statement of financial position date.

Note 4 – Assets Restricted for Use

The following assets are limited in use for specific purposes by donor designation or by trustee under trust indenture as of December 31:

	2019	2018
Josephine Endowment Fund	$ 616,451	$ 526,380
Scholarship fund	4,853	2,577
Good Samaritan Fund	26,688	22,659
Resident trust accounts	13,743	15,407
Nonqualified deferred compensation plan	413,858	246,193
	$ 1,075,593	$ 813,216

The assets restricted for use are invested in the following at December 31:

	2019	2018
Cash	$ 49,987	$ 45,343
Beneficial interest in Community Foundation of Snohomish County	611,748	521,680
Other investments	413,858	246,193
	$ 1,075,593	$ 813,216

Note 4 – Assets Restricted for Use (continued)

Josephine Endowment Fund – The Josephine Endowment Fund was established to support and further the mission and ministry of the Organization (Note 11).

Scholarship fund – The Organization maintains a scholarship fund that is used to help fund the education of employees wishing to further their education in a field that benefits the Organization.

Good Samaritan Fund – The Good Samaritan Fund was established to provide for quality of life enhancements to residents in financial need.

Resident trust accounts – The Organization maintains two resident trust bank accounts for its residents as required by the Department of Social and Health Services of Washington State (Note 8).

Nonqualified deferred compensation plan – The Organization adopted a nonqualified deferred compensation plan in 2013 for a certain highly paid employee. This deferred compensation arrangement is unfunded, unsecured, and subject to a vesting schedule that begins when the employee reaches 62 years of age. The Plan allows for both an elective deferral and an employer deferral. Benefits are reported on the employee's W-2 and subject to FICA tax as vesting occurs.

The Participant's entire accrued benefit is subject to the following vesting schedule:

Year	Age	Vesting %
2024	62	20%
2025	63	40%
2026	64	60%
2027	65	80%
2028	66	100%

Plan assets are included in assets restricted for long term use on the balance sheet. Deferred compensation liability on the balance sheet includes accrued employer taxes. The total amount accrued under the deferred compensation plan was $435,629 and $260,633 at December 31, 2019 and 2018, respectively.

Employer contributions consist of premiums paid for a life insurance contract having a face value of $800,000, with a cash surrender value of $60,646 and $48,689 at December 31, 2019 and 2018. The Organization is both owner and beneficiary of this policy, which insures the life of the plan participant. Employer contributions totaled $19,331 and $12,000 in 2019 and 2018, respectively. Premiums anticipated to be paid to keep the policy's underlying contracts in force are $12,000 annually until 2020.

Note 5 – Inventory

Inventory consists of the following at December 31:

	2019	2018
Central supplies	$ 46,249	$ 52,807
Food	18,499	19,037
Dietary supplies	3,126	1,881
Gift shop	2,008	1,892
	$ 69,882	$ 75,617

Note 6 – Assets at Fair Value

ASC 820, *Fair Value Measurements and Disclosures*, provides the framework for measuring fair value. That framework provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurement) and the lowest priority to unobservable inputs (Level 3 measurement). The three levels of the fair value hierarchy under ASC 820 are described as follows:

Basis of fair value measurement

Level 1 – Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Organization has the ability to access.

Level 2 – Quoted prices in markets that are not considered to be active or financial instruments without quoted market prices, but for which all significant inputs are observable, either directly or indirectly.

Level 3 – Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

The asset or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

Following is a description of the valuation methodologies used for assets measured at fair value. There have been no changes in the methodologies used at December 31, 2019.

Registered investment companies (mutual funds) – Valued at the net asset value (NAV) of shares held in the fund at year-end using prices quoted by the relevant pricing agent.

Note 6 – Assets at Fair Value (continued)

Pooled investment accounts – The pooled investment accounts are a beneficial interest in Community Foundation of Snohomish County (CFSC) are valued using the net asset value practical expedient (NAV practical expedient) of the common account as reported by the common account managers. The NAV practical expedient is based on the fair value of the underlying assets owned by the common account, minus its liabilities, and then divided by the number of units outstanding. These investments do not allow the Organization to submit redemption requests above the total spendable balance of $36,079 and $8,740 as of December 31, 2019 and 2018, respectively, as the investments are restricted.

Other investments – The Organization accounts for its investment in life settlement contracts in accordance with the investment method, using the contract value of the policy. Cash disbursements related to this investment are classified in the cash flow statement under operating and non-cash activity as it is used as deferred compensation. The insurance policy is classified within Level 2 of the valuation hierarchy.

Common stock – Common stock is valued at the closing price reported on the active market on which the individual securities are traded. Common stock is generally classified within Level 1 of the valuation hierarchy.

The following table discloses, by level, the fair value hierarchy of the Organization's investments and assets limited to use at fair value as of December 31, 2019 and 2018, respectively:

	Fair Value Measurement at December 31, 2019			
	Level 1	Level 2	Level 3	Total
Operating investments				
Registered investment companies	$ 3,937,291	$ -	$ -	$ 3,937,291
Common stock	2,779,581	-	-	2,779,581
Other investments	-	413,858	-	413,858
	$ 6,716,872	$ 413,858	$ -	7,130,730
Endowment investments				
Pooled investment accounts				611,748
				$ 7,742,478

Note 6 – Assets at Fair Value (continued)

	Fair Value Measurement at December 31, 2018			
	Level 1	Level 2	Level 3	Total
Operating investments				
Registered investment companies	$ 3,428,737	$ -	$ -	$ 3,428,737
Common stock	2,413,649	-	-	2,413,649
Other investments	-	246,193	-	246,193
	$ 5,842,386	$ 246,193	$ -	6,088,579
Endowment investments				
Pooled investment accounts				521,680
				$ 6,610,259

Note 7 – Land, Buildings, and Equipment

The following represents the amounts of land, buildings, equipment, vehicles, and construction in progress for the Organization at December 31:

	2019	2018
Buildings and improvements	$ 16,144,595	$ 15,984,041
Furniture and equipment	2,228,646	2,139,565
Major movable equipment	970,544	955,767
Land and improvements	778,828	677,166
Construction in progress	477,492	498,014
Vehicles	348,439	313,121
	20,948,544	20,567,674
Less accumulated depreciation	15,385,666	14,705,771
	$ 5,562,878	$ 5,861,903

Depreciation expense is $711,975 and $800,823 for the years ended December 31, 2019 and 2018, respectively.

Land held for future development – Land, and costs attributable to the development activities of the land, which are held for future development where no significant development has been undertaken are stated at cost less impairment costs, if any. As of December 31, 2019, management does not believe this land has been impaired.

Land held for sale – Land which is held for sale is stated at cost less impairment costs, if any. The land held for sale was sold in 2019.

Note 8 – Funds Held for Residents

The Organization maintains resident trust bank accounts for its residents under an agency arrangement as required by the Department of Social and Health Services of Washington State. The associated asset is recorded under assets restricted for use. The combined balance of these accounts was $14,296 and $15,407 as of December 31, 2019 and 2018, respectively. Interest is credited to individual resident accounts as earned.

Note 9 – Bonds Payable

	2019	2018
Low income housing assistance revenue bonds, 2005, payable to Housing Authority of Snohomish County, due in varying principal installments from approximately $256,000 in 2013 to $523,188 in 2027, plus interest at the floating rate established on the Index Reset Date; secured by real property and the assignment of leases. The floating rate is equal to the product of (a) the sum of (i) the Applicable Spread plus (ii) the product of (1) the LIBOR Index multiplied by (2) the Applicable Factor multiplied by (b) the Margin Rate Factor. At December 31, 2019, this rate was 3.078% per annum. This bond matures in January 2028.	$ 3,687,188	$ 4,077,188
Less current portion	402,000	386,000
	$ 3,285,188	$ 3,691,188

Interest expense totaled $143,325 and $153,434 in 2019 and 2018, respectively.

Included under the terms of the bond financing are covenants that require the maintenance of various minimum financial ratios and filing requirements for annual audited financial statements. Management represents that the organization is in compliance with these requirements.

Scheduled principal repayments of long-term debt are as follows:

2020	$ 402,000
2021	418,000
2022	434,000
2023	450,000
2024	469,000
Thereafter	1,514,188
	$ 3,687,188

Note 10 – Net Assets

As of December 31, 2019 and 2018, respectively, net assets with donor restrictions are available for the following purposes:

	2019	2018
Josephine Endowment Fund	$ 616,451	$ 526,380
Good Samaritan Fund	18,472	17,357
Scholarship fund	4,908	1,996
Construction Fund	1,555	1,280
Child Programs	427	220
	$ 641,813	$ 547,233

Included in the Josephine Endowment Fund are investments that are to be maintained by the Organization in perpetuity totaling $450,941 and $448,941 for the years ended December 31, 2019 and 2018, respectively. The income from these funds will be with donor restrictions to support the capital improvements within the property, grounds, buildings, and programs of the Organization.

Net assets were released from donor restrictions by incurring expenses satisfying the purpose or time restrictions specified by donors as follows at December 31:

	2019	2018
Josephine Endowment Fund	$ 8,982	$ 6,651
Good Samaritan Fund	2,353	5,468
Scholarship fund	-	1,000
Music Fund	-	5,000
Child programs	-	2,537
	$ 11,335	$ 20,656

Note 11 – Endowment

The Organization’s endowment consists of one individual fund, the Josephine Endowment Fund, which was established to support and further the mission of the Organization. The endowment includes donor-restricted endowment funds. As required by generally accepted accounting principles, net assets associated with endowment funds are classified and reported based on the existence or absence of donor-imposed restrictions.

Note 11 – Endowment (continued)

In prior years, the Organization transferred endowment funds in the amount of $200,000 to the Community Foundation of Snohomish County (CFSC) for their management. CFSC invests the funds in a mix of equity, fixed income, and real asset funds. At December 31, 2019 and 2018, the Organization's funds invested with CFSC were valued at $616,451 and $526,380, respectively. These funds increased in value by $99,050 in 2019 and decreased in value by $34,884 in 2018, as a result of unrealized capital gain earnings during the year.

In prior years, the Organization transferred endowment funds in the amount of $50,000 to the Thrivent Mutual Funds for their management. Thrivent invests the funds in a mix of equity and fixed income funds. These funds were transferred in to the CFSC in 2018. These funds increased in value by $2,625 in 2018.

In prior years, the Organization transferred endowment funds in the amount of $75,000 to the InFaith Community Foundation (InFaith) (formerly Lutheran Community Foundation) for their management. InFaith invests the funds in a pool with funds from other Lutheran social service organizations. These funds were transferred in to the CFSC in 2018. These funds decreased in value by $529 in 2018.

Endowment net assets at December 31:

	2019	2018
The portion of perpetual endowment funds that is required to be retained by explicit donor stipulation	$ 450,941	$ 448,941
Endowment net assets, end of year	$ 616,451	$ 526,380

Note 12 – Change in Endowment Net Assets

Changes in endowment fund net assets are as follows for the year ended December 31, 2019:

	Without Donor Restrictions	With Donor Restrictions	Total
Endowment net assets, beginning of year	$ -	$ 526,380	$ 526,380
Investment return (loss)			
Investment income	-	3	3
Unrealized (loss)	-	99,050	99,050
Total investment (loss)	-	99,053	99,053
Contributions	-	-	-
Appropriation of endowment assets for expenditure	-	(8,982)	(8,982)
Endowment net assets, end of year	$ -	$ 616,451	$ 616,451

Changes in endowment fund net assets are as follows for the year ended December 31, 2018:

	Without Donor Restrictions	With Donor Restrictions	Total
Endowment net assets, beginning of year	$ -	$ 564,177	$ 564,177
Investment return			
Investment income	-	1,591	1,591
Unrealized gain	-	(32,787)	(32,787)
Total investment return	-	(31,196)	(31,196)
Contributions	-	50	50
Appropriation of endowment assets for expenditure	-	(6,651)	(6,651)
Endowment net assets, end of year	$ -	$ 526,380	$ 526,380

Note 13 – Concentrations

Approximately 45% and 51% of revenue in 2019 and 2018, respectively, was derived from a contract with the Department of Social and Health Services in the state of Washington to provide skilled nursing and assisted living/congregate care to medical recipient residents. Approximately 18% and 19% of revenue in 2019 and 2018, respectively, was derived from private pay or other third-party payors. Approximately 20% and 24% of revenue in 2019 and 2018, respectively, was derived from the federal government. The primary geographic source of patients for skilled nursing and assisted living includes Snohomish County and surrounding communities in the northern Puget Sound region.

In addition to skilled nursing and assisted living operations, the Organization derives approximately 6% and 7% of revenues in 2019 and 2018, respectively, by providing child day care and a Montessori school to the Stanwood community.

Approximately 50% and 40% of accounts receivable in 2019 and 2018, respectively, was derived from a contract with the Department of Social and Health Services in the state of Washington to provide skilled nursing and assisted living/congregate care to medical recipient residents. Approximately 16% and 18% of accounts receivable in 2019 and 2018, was derived from private pay or other third-party payors. Approximately 33% and 41% of accounts receivable in 2019 and 2018, respectively, was derived from the federal government.

Financial instruments that potentially subject the Organization to concentrations of credit risk consist of cash and cash equivalents, certificates of deposit, investments, and accounts receivable. At times, cash deposits, including amounts held as investments, exceed the federally insured limits of the financial institution and expose the Organization to credit risk.

Note 14 – Defined Contribution Plan

The Organization sponsors a defined contribution plan, in which employees who have completed one year of service and have attained age 21 are eligible to receive safe harbor contributions using the following formula:

- 100% of each participant’s elective deferrals up to 3% of the participant’s compensation (excluding grossed up bonuses and length of service awards).

- Plus 50% of each participant’s elective deferrals in excess of 3% but not in excess of 5% of the participant’s compensation (excluding grossed up bonuses and length of service awards).

The Organization has accrued $244,186 and $251,851 of employer contributions to be made to the Plan for the years ended December 31, 2019 and 2018, respectively.

Note 15 – Cost Reports

The Organization is contractually required to prepare an annual Medicaid cost report. The 2019 report has not been filed and is due March 31, 2020, and is subject to audit and possible adjustment.

The Organization is also contractually required to prepare an annual Medicare cost report. The 2019 report is due May 31, 2020, and is subject to audit and possible adjustment.

Note 16 – Medical Malpractice Insurance

The Organization maintains medical malpractice insurance coverage through “claims made” type policies for the benefit of its clinical employees and the Organization. Should the “claims made” policies not be renewed or replaced with equivalent insurance, claims related to occurrences during their terms, but reported subsequent to their termination, may be uninsured.

Accounting principles generally accepted in the United States of America require that a health care facility disclose the estimated costs of malpractice claims in the period of the incident of malpractice, if it is reasonably possible that liabilities may be incurred and losses can be reasonably estimated. A health care facility shall also recognize an insurance receivable at the same time that it recognizes the liability. The Company has a claim outstanding as of December 31, 2019. The range of the liability as a result of this claim is not determinable although it is reasonably certain the claim will not exceed $150,000, which is fully covered by insurance. Therefore, a provision for the settlement of this matter has been included in these financial statements as of December 31, 2019, for $150,000.

Note 17 – Commitments and Contingencies

In the ordinary course of business, the Organization is a party to claims and legal actions by residents, providers, employees, and others. After consulting with legal counsel, the Organization’s management is of the opinion that any liability that may ultimately be incurred as a result of claims or legal actions will not have a material effect on the financial position or results of operations of the Organization.

Industry regulations – The health care industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditations, government health care program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Government activity continues with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by health care providers. Violations of these laws and regulations could result in expulsion from government health care programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management believes that the Organization is in compliance with fraud and abuse regulations, as well as other applicable government laws and regulations. Although no regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions known or unasserted at this time.

Note 17 – Commitments and Contingencies (continued)

Accounting for conditional asset retirement obligations – ASC 410, *Asset Retirement and Environmental Obligations*, requires management to recognize the fair value of a liability related to environmental matters. Management cannot estimate the impact of this standard on the balance sheets for the Organization.

Supplementary Information

Josephine Caring Community
Summary of Revenue, Gains, and Support

	Years Ended December 31,	
	2019	2018
Nursing home resident revenue		
Medicaid, state portion	$ 7,750,630	$ 7,524,304
Medicaid, private portion	1,852,501	1,688,887
Private	2,483,208	1,947,413
Medicare	4,467,666	4,605,706
Total nursing home resident revenue	16,554,005	15,766,310
Boarding home resident revenue		
Medicaid, state portion	205,174	194,638
Medicaid, private portion	297,834	253,911
Private	1,656,228	1,626,132
Total boarding home resident revenue	2,159,236	2,074,681
Child care revenue		
Private	999,052	1,007,147
Miscellaneous	315,954	290,720
Total child care revenue	1,315,006	1,297,867
Contributions	70,425	39,071
Other revenue		
Home Health	22,805	-
Miscellaneous	818,365	168,377
Interest income	144,922	143,783
Total other revenue	986,092	312,160
Total revenue, gains, and support	$ 21,084,764	$ 19,490,089


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REPORT OF INDEPENDENT AUDITORS
AND FINANCIAL STATEMENTS
WITH SUPPLEMENTARY INFORMATION

JOSEPHINE CARING COMMUNITY

December 31, 2018 and 2017

MOSSADAMS

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Report of Independent Auditors

To the Board of Directors
Josephine Caring Community

Report on Financial Statements

We have audited the accompanying financial statements of Josephine Caring Community, which comprise the balance sheets as of December 31, 2018 and 2017, and the related statements of activities and changes in net assets 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 audits 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 Josephine Caring Community as of December 31, 2018 and 2017, and the results of its operations and its cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Our audit was conducted for the purpose of forming an opinion on the basic financial statements taken as a whole. The accompanying supplementary information on pages 25 through 28 presented for purposes of additional analysis and is not a required part of the basic financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the basic financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the financial statements as a whole.

Emphasis of Matter

As discussed in Note 1 to the financial statements, as of December 31, 2018, Josephine Caring Community adopted Accounting Standards Update (ASU) 2016-14, Presentation of Financial Statements for Not-for-Profit Entities. The update addresses the complexity and understandability of net asset classification, information about liquidity and availability of resources, and other support information, and direction for consistency about information provided on investment return. The adoption of the standard resulted in additional footnote disclosures and changes to the disclosures related to net assets.

Moss Adams LLP

Tacoma, Washington
March 26, 2019

Josephine Caring Community
Balance Sheets

ASSETS

	December 31, 2018	December 31, 2017
CURRENT ASSETS		
Cash and cash equivalents	$ 2,233,767	$ 1,800,435
Assets restricted for use	45,343	253,325
Accounts receivable, net	1,519,535	1,413,976
Investments	5,842,386	6,679,836
Prepaid expenses	147,409	141,016
Inventory	75,617	71,949
Total current assets	9,864,057	10,360,537
ASSETS RESTRICTED FOR LONG-TERM USE	767,873	610,381
LAND, BUILDINGS, AND EQUIPMENT, net	5,861,903	6,379,214
OTHER ASSETS		
Land held for future development	3,975,487	3,975,487
Land held for sale	176,281	176,281
Total assets	$ 20,645,601	$ 21,501,900

LIABILITIES AND NET ASSETS

CURRENT LIABILITIES		
Accounts payable	$ 271,583	$ 371,007
Accrued payroll and vacation	674,454	587,514
Accrued payroll taxes and benefits	530,470	583,022
Other liabilities	40,939	42,109
Unearned revenue	28,167	2,226
Funds held for residents	15,407	20,312
Current portion of bonds payable	386,000	374,000
Current portion of capital lease	-	22,682
Total current liabilities	1,947,020	2,002,872
LONG-TERM DEBT AND OTHER LIABILITIES		
Bonds payable, net of current portion	3,691,188	4,077,188
Less loan fees, net of accumulated amortization of $158,514 and $140,269 for the years ended 2018 and 2017, respectively	164,200	182,445
	3,526,988	3,894,743
Deferred compensation	260,633	270,275
Total liabilities	5,734,641	6,167,890
NET ASSETS		
Without donor restrictions	14,363,727	14,748,335
With donor restrictions	547,233	585,675
Total net assets	14,910,960	15,334,010
Total liabilities and net assets	$ 20,645,601	$ 21,501,900

See accompanying notes.

Josephine Caring Community
Statements of Activities and Changes in Net Assets
Year Ended December 31, 2018

	Without Donor Restrictions	With Donor Restrictions	Total
REVENUE, GAINS, AND OTHER SUPPORT			
Nursing home revenue	$ 15,766,310	$ -	$ 15,766,310
Boarding home revenue	2,074,681	-	2,074,681
Child care revenue	960,371	-	960,371
Child care grant revenue	337,496	-	337,496
Other program revenue	161,349	-	161,349
Other revenue	7,028	-	7,028
Contributions	25,673	13,398	39,071
Interest and dividends	142,180	1,603	143,783
Net assets released from restriction	20,656	(20,656)	-
Total revenue, gains, and other support	19,495,744	(5,655)	19,490,089
EXPENSES			
Salaries and wages	11,443,840	-	11,443,840
Payroll taxes and benefits	2,051,804	-	2,051,804
Ancillary expenses	1,384,340	-	1,384,340
Supplies	1,519,287	-	1,519,287
Depreciation and amortization	800,823	-	800,823
Interest	171,587	-	171,587
Other	2,107,601	-	2,107,601
Total expenses	19,479,282	-	19,479,282
EXCESS REVENUES (DEFICIENCY) OVER EXPENSES	16,462	(5,655)	10,807
UNREALIZED LOSS ON INVESTMENTS	(401,070)	(32,787)	(433,857)
CHANGE IN NET ASSETS	(384,608)	(38,442)	(423,050)
NET ASSETS, beginning of year	14,748,335	585,675	15,334,010
NET ASSETS, end of year	$ 14,363,727	$ 547,233	$ 14,910,960

See accompanying notes.

Josephine Caring Community
Statements of Activities and Changes in Net Assets
Year Ended December 31, 2017

	Without Donor Restrictions	With Donor Restrictions	Total
REVENUE, GAINS, AND OTHER SUPPORT			
Nursing home revenue	$ 15,437,079	$ -	$ 15,437,079
Boarding home revenue	2,019,021	-	2,019,021
Child care revenue	960,011	-	960,011
Child care grant revenue	368,607	-	368,607
Other program revenue	127,237	-	127,237
Other revenue	56,592	-	56,592
Contributions	47,573	15,918	63,491
Interest and dividends	110,371	4,956	115,327
Net assets released from restriction	20,354	(20,354)	-
Total revenue, gains, and other support	19,146,845	520	19,147,365
EXPENSES			
Salaries and wages	10,769,178	-	10,769,178
Payroll taxes and benefits	2,156,557	-	2,156,557
Ancillary expenses	1,693,998	-	1,693,998
Supplies	1,389,142	-	1,389,142
Depreciation and amortization	803,113	-	803,113
Interest	127,735	-	127,735
Other	2,095,003	-	2,095,003
Total expenses	19,034,726	-	19,034,726
EXCESS REVENUES OVER EXPENSES	112,119	520	112,639
UNREALIZED GAIN ON INVESTMENTS	764,478	52,017	816,495
CHANGE IN NET ASSETS	876,597	52,537	929,134
NET ASSETS, beginning of year	13,871,738	533,138	14,404,876
NET ASSETS, end of year	$ 14,748,335	$ 585,675	$ 15,334,010

See accompanying notes.

Josephine Caring Community
Statements of Cash Flows

	Years Ended December 31, 2018	2017
CASH FLOWS FROM OPERATING ACTIVITIES		
Change in net assets	$ (423,050)	$ 929,134
Adjustments to reconcile change in net assets to net cash from operating activities		
Depreciation and amortization	800,823	803,113
Amortization of loan fees included in interest expense	18,245	18,244
Provision for bad debt	83,537	29,668
Loss on disposal of property and equipment	2,309	9,638
Unrealized gain (loss) on investments	401,070	(816,495)
Changes in operating assets and liabilities		
Accounts receivable	(189,096)	344,314
Prepaid expenses	(6,393)	23,446
Inventory	(3,668)	5,072
Accounts payable	(99,424)	(75,207)
Accrued payroll and vacation	86,940	65,838
Accrued payroll taxes and benefits	(52,552)	53,233
Other liabilities	(1,170)	18,517
Unearned revenue	25,941	(30,390)
Funds held for residents	(4,905)	3,309
Net cash from operating activities	638,607	1,381,434
CASH FLOWS FROM (USED IN) INVESTING ACTIVITIES		
Proceeds from sale of investments	1,661,917	840,187
Purchase of investments	(1,225,537)	(2,628,883)
Purchase of land held for future development	-	(1,501,402)
Purchase of land, buildings and equipment	(285,821)	(297,615)
Net cash from (used in) investing activities	150,559	(3,587,713)
CASH FLOWS FROM (USED IN) FINANCING ACTIVITIES		
Gain (loss) on assets restricted for use	70,729	(3,266)
Sale of investments restricted for use	257,504	-
Purchase of investments restricted for use	(320,172)	-
Unrealized gain (loss) on assets restricted for use	32,787	(52,017)
Principal payments on bonds payable	(374,000)	(361,000)
Principal payments on capital lease obligation	(22,682)	(34,701)
Net cash used in financing activities	(355,834)	(450,984)
INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	433,332	(2,657,263)
CASH AND CASH EQUIVALENTS, beginning of year	1,800,435	4,457,698
CASH AND CASH EQUIVALENTS, end of year	$ 2,233,767	$ 1,800,435
Cash paid for interest	$ 170,501	$ 124,210
SUPPLEMENTAL DISCLOSURE OF NON-CASH INFORMATION		
Increase (decrease) in deferred compensation and assets limited for use	$ (9,642)	$ 42,821

See accompanying notes.

Note 1 – Description of Operations

Josephine Caring Community (the Organization) is a nonprofit, member-owned corporate affiliate of the Evangelical Lutheran Church in America. Corporate membership is composed of 18 local congregations. Members of the Organization's corporation are entitled to elect the board of directors and approve certain actions of the board of directors. The Organization operates a 160-bed skilled nursing facility, a 57-unit boarding home licensed for 65 residents, and a child care program licensed for a capacity of 111 children in Stanwood, Washington.

Note 2 – Summary of Significant Accounting Policies

Basis of accounting – The Organization maintains its financial records using the accrual basis of accounting, whereby revenues are recognized when earned and expenses are recognized when an obligation is incurred.

Basis of presentation – The Organization presents its financial statements in accordance with generally accepted accounting principles (GAAP), as codified by the Financial Accounting Standards Board (FASB). The Organization has implemented Accounting Standards Codifications (ASC) 958, *Not-for-Profit Entities*. Under ASC 958, the Organization reports information regarding its financial position and activities according to two classes of net assets: without donor restrictions and with donor restrictions.

- *Net assets without donor restrictions* – Net assets available for use in general operations and not subject to donor restrictions.

- *Net assets with donor restrictions* – Net assets subject to donor-imposed restrictions. Some donor-imposed restrictions are temporary in nature, such as those that will be met by the passage of time or other events specified by the donor. Other donor-imposed restrictions are perpetual in nature, where the donor stipulates that resources be maintained in perpetuity. Donor-imposed restrictions are released when a restriction expires; that is, when the stipulated time has elapsed, when the stipulated purpose for which the resource was restricted has been fulfilled, or both. These are reported as reclassifications between the applicable classes of net assets.

In accordance with ASC 958, net assets at December 31, 2017, have been reclassified as follows:

	Without Donor Restrictions	With Donor Restrictions
Unrestricted	$ 14,748,335	$ -
Temporarily restricted	-	136,784
Permanently restricted	-	448,891
	$ 14,748,335	$ 585,675

Note 2 – Summary of Significant Accounting Policies (continued)

Federal income tax – The Organization is exempt from federal income tax under Section 501 (c)(3) of the Internal Revenue Code. Exemption has also been given by Snohomish County (the County) from all personal property taxes. In addition, the County has granted exemption for real property associated with the nursing home, boarding home, and child care programs. Also, the Organization qualifies for the charitable contribution deduction under Section 170(b)(I)(A) and has been classified as an organization that is not a private foundation under Section 509(a)(2).

The Organization accounts for uncertain tax positions whereby the effect of the uncertainty would be recorded if the outcome was considered probable and was reasonably estimable. As of December 31, 2018, the Organization had not identified any uncertain tax positions requiring accrual or disclosure.

Cash and cash equivalents – Cash and cash equivalents consist of highly liquid investments with remaining maturity at the date of purchase of three months or less.

Investments – The Organization records its investments in accordance with ASC 958, Not-for-Profit Entities. Under ASC 958, investments in marketable securities with readily determinable fair values and all investments in debt securities are reported at their fair values in the balance sheets. Unrealized gains and losses are included in the statements of activities and changes in net assets (Note 12).

Inventory – Inventory consists mainly of dietary supplies, central supplies, food, and gift shop merchandise and is stated at the lower of cost (first-in, first-out method) or market.

Accounts receivable – The Organization carries its accounts receivable at standard rates less an allowance for uncollectible accounts. On a periodic basis, the Organization evaluates its accounts receivable and establishes an allowance for uncollectible accounts, based on a history of past write-offs and collections. The allowance is $192,636 and $93,246 at December 31, 2018 and 2017, respectively.

The Organization can charge interest of 12% per annum on skilled nursing and boarding home private past due accounts. Other nursing home and boarding home late fees may be assessed according to the resident financial agreements in place during the year. Approximately $3,692 and $3,065 of child care accounts receivable and $205,802 and $172,407 of skilled nursing and boarding home accounts receivable are greater than 90 days at December 31, 2018 and 2017, respectively.

Land, buildings, and equipment – Land, buildings, and equipment are stated at cost, less accumulated depreciation. The Organization capitalizes fixed assets with a cost greater than $750. Maintenance and repair costs are expensed as incurred. The cost and related accumulated depreciation of significant assets sold or retired are removed from the property accounts, and any resulting gain or loss is reported as an increase or decrease in net assets as explained in the revenue recognition section.

Depreciation is provided on the straight-line method over the assets' estimated useful lives, which, for land improvements, is 5 to 25 years, for buildings is 25 to 30 years, for building improvements is 10 to 26 years, for furniture and equipment is 3 to 20 years, and for vehicles is 4 to 10 years.

Note 2 – Summary of Significant Accounting Policies (continued)

During 2013, the Organization entered into a capital lease for equipment. Total assets under capital lease were approximately $147,187 with accumulated amortization of $147,187 and $122,656 as of December 31, 2018 and 2017, respectively.

The Organization, using its best estimates based on reasonable and supportable assumptions and projections, reviews for impairment of long-lived assets when indicators of impairment are identified. The review addresses the estimated recoverability of the assets' carrying value, which is principally determined based on projected undiscounted cash flows generated by the underlying tangible assets.

When the carrying value of an asset exceeds estimated recoverability, an asset impairment is recognized. No impairment losses were present for the years ended December 31, 2018 and 2017.

Endowments – The Organization has interpreted the Washington Uniform Prudent Management of Institutional Funds Act as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, the Organization classifies as with donor restrictions net assets (1) the original value of gifts donated to the endowment, (2) the original value of subsequent gifts to the endowment, and (3) accumulations to the endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund.

The Organization has adopted investment and spending policies for endowment assets that attempt to provide a predictable stream of funding to programs supported by its endowment while seeking to maintain the purchasing power of the endowment assets. Endowment assets include those assets of donor-restricted funds that the Organization must hold in perpetuity or for a donor-specified period, an accumulation of earnings on the fund in accordance with the endowment fund investment policy, and board-designated funds (if any). Under this policy, as approved by the board of directors, the endowment assets are invested in a manner that is intended to produce results that exceed the price and yield results while assuming a low level of investment risk. The Organization expects its endowment funds, over time, to provide a consistent rate of return. Actual returns in any given year may vary. The Organization has a policy that allows spending of annual interest earned on the corpus of the endowment fund. The amount of interest earnings to be released annually for distribution is specified by the board as soon as equitably possible after fiscal year-end. The interest funds are spent as authorized by the board on programs or capital expenditures to benefit the Organization in accordance with the endowment policy. See Note 12 for endowment investment information.

Revenue recognition – Revenues are reported as increases in net assets without donor restrictions unless use of the related assets are limited by donor-imposed restrictions. Expenses are reported as decreases in net assets without donor restrictions. Gains and losses on investments and other assets or liabilities are reported as increases or decreases in net assets without donor restrictions unless their use is restricted by explicit donor stipulation or by law. Expirations of with donor restrictions net assets are reported as transfers between the applicable classes of net assets.

Note 2 – Summary of Significant Accounting Policies (continued)

The Organization is reimbursed for services provided to qualifying residents of the nursing and boarding homes under contracts and is reimbursed at rates that may be different from its standard charge. Unearned revenue at year-end consists of prepaid room and board fee payments from individuals for the month following year-end.

The Organization provides child care services to individuals at standard rates. The Early Childhood Education and Assistance Program is a state-funded kindergarten preparedness program for limited-income four-year-olds provided by a grant through the Snohomish County Human Services Department. During 2018, the grant was renewed and expires on June 30, 2019.

Contributions – The Organization records contributions according to ASC 958, *Not-for-Profit Entities*. In accordance with ASC 958, contributions, including unconditional promises to give, are recorded in the period made. All contributions are available for unrestricted use unless specifically restricted by the donor. Conditional promises to give are recognized when the conditions on which they depend are substantially met. Unconditional promises to give due in the next year are recorded at their net realizable value. Unconditional promises to give due in subsequent years are reported at the present value of their net realizable value, using risk-free interest rates applicable to the years in which the promises are to be received.

During 2018, more than 80 volunteers contributed significant amounts of time and effort in assisting to carry out the programs and activities of the Organization. The time contributed by volunteers is not reflected in the financial statements.

Recognition of donor-restricted contributions – Support that is restricted by the donor is reported as an increase in net assets without donor restrictions if the restriction expires in the reporting period in which the support is recognized. All other donor-restricted support is reported as an increase in net assets with donor restrictions, depending on the nature of the restriction. When a restriction expires, with donor restrictions net assets are reclassified to without donor restrictions net assets.

Land held for future development – Land, and costs attributable to the development activities of the land, which are held for future development where no significant development has been undertaken are stated at cost less impairment costs, if any. As of December 31, 2018, Management does not believe this land has been impaired.

Land held for sale – Land which is held for sale is stated at cost less impairment costs, if any. As of December 31, 2018, Management does not believe this land has been impaired.

Loan issuance fees – Loan issuance fees are amortized on the straight-line basis over the term of the debt. Straight-line calculation of loan fees is not significantly different than the effective interest method. Amortization included in interest expense was $18,245 for the years ended December 31, 2018 and 2017, respectively. Accumulated amortization was $158,514 and $140,269 as of December 31, 2018 and 2017, respectively.

Note 2 – Summary of Significant Accounting Policies (continued)

Use of estimates – The preparation of financial statements in accordance 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, and disclosure of contingent assets and liabilities at the date of the financial statements and reported amounts of revenue and expense during the reporting period. Actual results could differ from those estimates.

Performance indicator – Changes in excess revenues over expenses as reflected in the accompanying statements of activities is a performance indicator. Changes in excess revenues over expenses include changes in net assets without donor restrictions other than net realized and unrealized losses (gains) on investments.

Expense allocation – Directly identifiable expenses are charged to program, fund raising, and general and administrative expenses (Note 16). Expenses relating to more than one function are charged to the function based on an estimate of utilization, square footage, or revenue on each function. General and administrative expenses include those expenses that are not directly identifiable with any specific function but to provide for the overall support of the Organization.

Change in accounting principle – In August 2016, the Financial Accounting Standards Board (FASB) issued Accounting Standard Update (ASU) 2016-14, *Not-for-Profit Entities (Topic 958): Presentation of Financial Statements of Not-for-Profit Entities*, which provided guidance related to the presentation and disclosure requirements for not-for profit entities. The guidance is intended to provide more relevant information about an entity's resources (and the changes in those resources) to donors, grantors, creditors, and other users. Changes in qualitative and quantitative requirements as a result of the standards update are included in the following areas: net asset classes, investment return, expenses, liquidity and availability of resources, and presentation of operating cash flows. The requirements of this standard are to be applied retrospectively, with the exception of the analysis of expenses by both natural classification and functional classification, and disclosures about liquidity and availability of resources. The Organization has implemented this standard for the year ended December 31, 2018.

Recent accounting pronouncements – In February 2016, the FASB issued Accounting Standards Update No. 2016-02 (ASU 2016-02), *Leases (Topic 842)*. ASU 2016-02 requires lessees to recognize a right-of-use asset and lease liability in the balance sheet for all leases, including operating leases, with terms of more than twelve months. The new guidance will be effective for nonpublic company fiscal years beginning on or after December 15, 2019 with early adoption permitted. The amendment must be applied on a modified retrospective basis.

In May 2014, the FASB issued authoritative guidance for revenue from contracts with customers, which provides a single comprehensive revenue recognition model to apply in determining how and when to recognize revenue. The core principle of the guidance is that an entity should recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. When applying the new revenue model to contracts with customers, the guidance requires five steps to be applied, which include: 1) identify the contract(s) with a customer, 2) identify the performance obligations in the contract, 3) determine the transaction price, 4) allocate the transaction price to the performance obligations in the contract, and 5) recognize revenue when (or as) the entity satisfies a performance obligation.

Note 2 – Summary of Significant Accounting Policies (continued)

The guidance also requires both quantitative and qualitative disclosures, which are more comprehensive than existing revenue standards. The disclosures are intended to enable financial statement users to understand the nature, timing and uncertainty of revenue and the related cash flow. For nonpublic entities the new guidance will be effective for fiscal years beginning on or after December 15, 2018, with early adoption permitted. The amendment must be applied on a modified retrospective basis.

The Organization is currently evaluating the impact of the adoption of these standards on the financial statements.

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

The Organization did not have any subsequent events through March 26, 2019, which is the date the financial statements were available to be issued, for events requiring recording or disclosure in the financial statements for the year ended December 31, 2018.

Reclassification – Certain reclassifications have been made to the prior financial statements to conform to the current presentation. Such reclassifications have no effect on previously reported net income.

Note 3 – Liquidity and Availability

The Organization regularly monitors liquidity required to meet its operating needs, liabilities, and other obligations as they become due. The Organization is substantially supported by a contract with the Department of Social and Health Services in the state of Washington for Medicaid reimbursement and the federal government for Medicare reimbursement. The majority of the financial assets recorded by the Organization are used to support the skilled nursing facility, boarding home and a child care program in Snohomish County and surrounding communities in the northern Puget Sound region.

In addition to financial assets available to meet general expenditures over the next twelve months, the Organization operates with a balanced budget and anticipates collecting sufficient revenue to cover general expenditures.

The Organization has $9,595,688 of financial assets available within one year of the statement of financial position date to meet cash needs for general expenditure consisting of cash and cash equivalents and investments of $8,076,153 and accounts receivable of $1,519,535. None of these financial assets are subject to donor or other contractual restrictions that make them unavailable for general expenditure within one year of the statement of financial position date.

Note 4 – Assets Restricted for Use

The following assets are limited in use for specific purposes by donor designation or by trustee under trust indenture as of December 31:

	2018	2017
Josephine Endowment Fund	$ 526,380	$ 564,177
Scholarship fund	2,577	1,191
Good Samaritan Fund	22,659	22,462
Resident trust accounts	15,407	20,041
Nonqualified deferred compensation plan	246,193	255,835
	$ 813,216	$ 863,706

The assets restricted for use are invested in the following at December 31:

	2018	2017
Cash	$ 45,343	$ 174,003
Mutual funds	-	79,322
Beneficial interest in Community Foundation of Snohomish County	521,680	242,285
Other investments	246,193	368,096
	$ 813,216	$ 863,706

Josephine Endowment Fund – The Josephine Endowment Fund was established to support and further the mission and ministry of the Organization (Note 12).

Scholarship fund – The Organization maintains a scholarship fund that is used to help fund the education of employees wishing to further their education in a field that benefits the Organization.

Good Samaritan Fund – The Good Samaritan Fund was established to provide for quality of life enhancements to residents in financial need.

Resident trust accounts – The Organization maintains two resident trust bank accounts for its residents as required by the Department of Social and Health Services of Washington State (Note 8).

Nonqualified deferred compensation plan – The Organization adopted a nonqualified deferred compensation plan in 2013 for a certain highly paid employee. This deferred compensation arrangement is unfunded, unsecured, and subject to a vesting schedule that begins when the employee reaches 62 years of age. The Plan allows for both an elective deferral and an employer deferral. Benefits are reported on the employee's W-2 and subject to FICA tax as vesting occurs.

Note 4 – Assets Restricted for Use (continued)

The Participant's entire accrued benefit is subject to the following vesting schedule:

Year	Age	Vesting %
2024	62	20%
2025	63	40%
2026	64	60%
2027	65	80%
2028	66	100%

Plan assets are included in assets restricted for long term use on the balance sheet. Deferred compensation liability on the balance sheet includes accrued employer taxes. The total amount accrued under the deferred compensation plan was $260,633 and $270,275 at December 31, 2018 and 2017, respectively.

Employer contributions consist of premiums paid for a life insurance contract having a face value of $800,000, with a cash surrender value of $48,689 and $37,080 at December 31, 2018 and 2017. The Organization is both owner and beneficiary of this policy, which insures the life of the plan participant. Employer contributions totaled $12,000 in both 2018 and 2017. Premiums anticipated to be paid to keep the policy's underlying contracts in force are $12,000 annually until 2020.

Note 5 – Inventory

Inventory consists of the following at December 31:

	2018	2017
Central supplies	$ 52,807	$ 47,485
Food	19,037	17,779
Dietary supplies	1,881	4,497
Gift shop	1,892	2,188
	$ 75,617	$ 71,949

Note 6 – Assets at Fair Value

ASC 820, *Fair Value Measurements and Disclosures*, provides the framework for measuring fair value. That framework provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurement) and the lowest priority to unobservable inputs (Level 3 measurement). The three levels of the fair value hierarchy under ASC 820 are described as follows:

Basis of fair value measurement

Level 1 – Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Organization has the ability to access.

Level 2 – Quoted prices in markets that are not considered to be active or financial instruments without quoted market prices, but for which all significant inputs are observable, either directly or indirectly.

Level 3 – Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

The asset or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

Following is a description of the valuation methodologies used for assets measured at fair value. There have been no changes in the methodologies used at December 31, 2018.

Registered investment companies (mutual funds) – Valued at the net asset value (NAV) of shares held in the fund at year-end using prices quoted by the relevant pricing agent.

Pooled investment accounts – The pooled investment accounts are a beneficial interest in Community Foundation of Snohomish County (CFSC) are valued using the net asset value practical expedient (NAV practical expedient) of the common account as reported by the common account managers. The NAV practical expedient is based on the fair value of the underlying assets owned by the common account, minus its liabilities, and then divided by the number of units outstanding. These investments do not allow the Organization to submit redemption requests.

Other investments – The Organization accounts for its investment in life settlement contracts in accordance with the investment method, using the contract value of the policy. Cash disbursements related to this investment are classified in the cash flow statement under operating and non-cash activity as it is used as deferred compensation. The insurance policy is classified within Level 2 of the valuation hierarchy.

Note 6 – Assets at Fair Value (continued)

Common stock – Common stock is valued at the closing price reported on the active market on which the individual securities are traded. Common stock is generally classified within Level 1 of the valuation hierarchy.

The following table discloses, by level, the fair value hierarchy of the Organization's investments and assets limited to use at fair value as of December 31, 2018 and 2017, respectively:

	Fair Value Measurement at December 31, 2018			
	Level 1	Level 2	Level 3	Total
Operating investments				
Registered investment companies	$ 3,428,737	$ -	$ -	$ 3,428,737
Common stock	2,413,649	-	-	2,413,649
Other investments	-	246,193	-	246,193
	$ 5,842,386	$ 246,193	$ -	6,088,579
Endowment investments				
Pooled common accounts				521,680
				$ 6,610,259

	Fair Value Measurement at December 31, 2017			
	Level 1	Level 2	Level 3	Total
Operating investments				
Registered investment companies	$ 3,793,692	$ -	$ -	$ 3,793,692
Common stock	2,886,144	-	-	2,886,144
Other investments	-	112,261	-	112,261
	$ 6,679,836	$ 112,261	$ -	6,792,097
Endowment investments				
Pooled common accounts				498,120
				$ 7,290,217

Note 7 – Land, Buildings, and Equipment

The following represents the amounts of land, buildings, equipment, vehicles, and construction in progress for the Organization at December 31:

	2018	2017
Buildings and improvements	$ 15,984,041	$ 15,883,622
Furniture and equipment	2,139,565	2,028,711
Major movable equipment	955,767	932,281
Land and improvements	677,166	675,804
Construction in progress	498,014	461,147
Vehicles	313,121	313,121
	20,567,674	20,294,686
Less accumulated depreciation	14,705,771	14,021,472
	$ 5,861,903	$ 6,273,214

Depreciation expense is $800,823 and $803,113 for the years ended December 31, 2018 and 2017, respectively.

Note 8 – Funds Held for Residents

The Organization maintains resident trust bank accounts for its residents under an agency arrangement as required by the Department of Social and Health Services of Washington State. The associated asset is recorded under assets restricted for use. The combined balance of these accounts was $15,407 and $20,312 as of December 31, 2018 and 2017, respectively. Interest is credited to individual resident accounts as earned.

Note 9 – Bonds Payable

	2018	2017
Low income housing assistance revenue bonds, 2005, payable to Housing Authority of Snohomish County, due in varying principal installments from approximately $256,000 in 2013 to $523,188 in 2027, plus interest at the floating rate established on the Index Reset Date; secured by real property and the assignment of leases. The floating rate is equal to the product of (a) the sum of (i) the Applicable Spread plus (ii) the product of (1) the LIBOR Index multiplied by (2) the Applicable Factor multiplied by (b) the Margin Rate Factor. At December 31, 2018, this rate was 3.80% per annum. This bond matures in January 2028.	$ 4,077,188	$ 4,451,188
Less current portion	386,000	374,000
	$ 3,691,188	$ 4,077,188

Interest expense totaled $170,582 and $124,210 in 2018 and 2017, respectively.

Included under the terms of the bond financing are covenants that require the maintenance of various minimum financial ratios and filing requirements for annual audited financial statements. Management represents that the organization is in compliance with these requirements.

Scheduled principal repayments of long-term debt are as follows:

2019	$ 386,000
2020	402,000
2021	418,000
2022	434,000
2023	450,000
Thereafter	1,987,188
	$ 4,077,188

Note 10 – Capital Lease

The Company's capital lease terminated in September 2018 and had no future minimum lease payments as of December 31, 2018.

Interest expense totaled $1,005 and $3,525 in 2018 and 2017, respectively.

Note 11 – Net Assets

As of December 31, 2018 and 2017, respectively, net assets with donor restrictions are available for the following purposes:

	2018	2017
Josephine Endowment Fund	$ 526,380	$ 564,177
Good Samaritan Fund	17,357	17,709
Scholarship fund	1,996	1,191
Construction Fund	1,280	720
Child Programs	220	1,878
	$ 547,233	$ 585,675

Included in the Josephine Endowment Fund are investments that are to be maintained by the Organization in perpetuity totaling $448,941 for the years ended December 31, 2018 and 2017. The income from these funds will be with donor restrictions to support the capital improvements within the property, grounds, buildings, and programs of the Organization:

Net assets were released from donor restrictions by incurring expenses satisfying the purpose or time restrictions specified by donors as follows at December 31:

	2018	2017
Josephine Endowment Fund	$ 6,651	$ 4,969
Good Samaritan Fund	5,468	5,785
Scholarship fund	1,000	3,000
Music Fund	5,000	1,600
Chaplain's Fund	-	5,000
Child programs	2,537	-
	$ 20,656	$ 20,354

Note 12 – Endowment

The Organization's endowment consists of one individual fund, the Josephine Endowment Fund, which was established to support and further the mission of the Organization. The endowment includes donor-restricted endowment funds. As required by generally accepted accounting principles, net assets associated with endowment funds are classified and reported based on the existence or absence of donor-imposed restrictions.

In prior years, the Organization transferred endowment funds in the amount of $200,000 to the Community Foundation of Snohomish County (CFSC) for their management. CFSC invests the funds in a mix of equity, fixed income, and real asset funds. At December 31, 2018 and 2017, the Organization's funds invested with CFSC were valued at $521,680 and $242,285, respectively. These funds decreased in value by $40,777 in 2018 and increased in value by $26,514 in 2017, as a result of unrealized capital gain earnings during the year.

In prior years, the Organization transferred endowment funds in the amount of $50,000 to the Thrivent Mutual Funds for their management. Thrivent invests the funds in a mix of equity and fixed income funds. At December 31, 2018 and 2017, the Organization's funds invested with Thrivent were valued at $0 and $79,323, respectively. These funds were transferred in to the CFSC in 2018. These funds increased in value by $2,767 in 2018 and $9,512 in 2017, as a result of unrealized capital gain earnings during the year.

In prior years, the Organization transferred endowment funds in the amount of $75,000 to the InFaith Community Foundation (InFaith) (formerly Lutheran Community Foundation) for their management. InFaith invests the funds in a pool with funds from other Lutheran social service organizations. At December 31, 2018 and 2017, the Organization's funds invested with InFaith were valued at $0 and $112,260, respectively. These funds were transferred in to the CFSC in 2018. These funds decreased in value by $578 in 2018 and increased in value by $13,841 in 2017, as a result of unrealized capital gain earnings during the year.

Endowment net assets at December 31:

	2018	2017
The portion of perpetual endowment funds that is required to be retained by explicit donor stipulation	$ 448,941	$ 448,891
Endowment net assets, end of year	$ 526,380	$ 564,177

Note 13 – Change in Endowment Net Assets

Changes in endowment fund net assets are as follows for the year ended December 31, 2018:

	Without Donor Restrictions	With Donor Restrictions	Total
Endowment net assets, beginning of year	$ -	$ 564,177	$ 564,177
Investment return (loss)			
Investment income	-	1,591	1,591
Unrealized (loss)	-	(32,787)	(32,787)
Total investment (loss)	-	(31,196)	(31,196)
Contributions	-	50	50
Appropriation of endowment assets for expenditure	-	(6,651)	(6,651)
Endowment net assets, end of year	$ -	$ 526,380	$ 526,380

Changes in endowment fund net assets are as follows for the year ended December 31, 2017:

	Without Donor Restrictions	With Donor Restrictions	Total
Endowment net assets, beginning of year	$ -	$ 512,181	$ 512,181
Investment return			
Investment income	-	4,948	4,948
Unrealized gain	-	52,017	52,017
Total investment return	-	56,965	56,965
Appropriation of endowment assets for expenditure	-	(4,969)	(4,969)
Endowment net assets, end of year	$ -	$ 564,177	$ 564,177

Note 14 – Concentrations

Approximately 51% and 44% of revenue in 2018 and 2017, respectively, was derived from a contract with the Department of Social and Health Services in the state of Washington to provide skilled nursing and assisted living/congregate care to medical recipient residents. Approximately 19% of revenue in 2018 and 2017, was derived from private pay or other third-party payors. Approximately 24% and 25% of revenue in 2018 and 2017, respectively, was derived from the federal government. The primary geographic source of patients for skilled nursing and assisted living includes Snohomish County and surrounding communities in the northern Puget Sound region.

In addition to skilled nursing and assisted living operations, the Organization derives approximately 7% of revenues in 2018 and 2017, by providing child day care and a Montessori school to the Stanwood community.

Approximately 40% and 39% of accounts receivable in 2018 and 2017, respectively, was derived from a contract with the Department of Social and Health Services in the state of Washington to provide skilled nursing and assisted living/congregate care to medical recipient residents. Approximately 18% and 19% of accounts receivable in 2018 and 2017, was derived from private pay or other third-party payors. Approximately 41% and 38% of accounts receivable in 2018 and 2017, respectively, was derived from the federal government.

Financial instruments that potentially subject the Organization to concentrations of credit risk consist of cash and cash equivalents, certificates of deposit, investments, and accounts receivable. At times, cash deposits, including amounts held as investments, exceed the federally insured limits of the financial institution and expose the Organization to credit risk.

Note 15 – Defined Contribution Plan

The Organization sponsors a defined contribution plan, in which employees who have completed one year of service and have attained age 21 are eligible to receive safe harbor contributions using the following formula:

- 100% of each participant's elective deferrals up to 3% of the participant's compensation (excluding grossed up bonuses and length of service awards).

- Plus 50% of each participant's elective deferrals in excess of 3% but not in excess of 5% of the participant's compensation (excluding grossed up bonuses and length of service awards).

The Organization has accrued $251,851 and $252,398 of employer contributions to be made to the Plan for the years ended December 31, 2018 and 2017, respectively.

Note 16 – Expenses by Functional Categories

	Program	General and Administrative	Fundraising Expenses	Total 2018
Salaries and wages	$ 10,476,083	$ 967,757	$ -	$ 11,443,840
Payroll taxes and benefits	1,882,332	169,472	-	2,051,804
Total salaries and related expenses	12,358,415	1,137,229	-	13,495,644
Supplies	1,389,909	128,128	1,250	1,519,287
Ancillary expenses	1,384,340	-	-	1,384,340
Depreciation and amortization	741,005	57,450	2,368	800,823
Utilities	506,223	13,376	-	519,599
Contract Labor	326,622	136,980	9,589	473,191
Repairs and maintenance	159,894	76,367	-	236,261
Interest expense	147,617	23,970	-	171,587
Miscellaneous expense	22,755	137,589	-	160,344
Insurance	71,006	65,467	-	136,473
Advertising and publications	68,945	35,730	-	104,675
Licenses and fees	8,979	87,223	-	96,202
Professional fees	1,944	85,798	-	87,742
Telephone	2,460	59,666	-	62,126
Property taxes	-	53,139	-	53,139
Safety net assessment	42,167	-	-	42,167
Education	29,634	7,182	-	36,816
Vehicle expense	30,333	-	-	30,333
Events	21,809	-	-	21,809
Program expenditures	16,968	-	-	16,968
Board expense	-	15,447	-	15,447
Postage	-	8,877	-	8,877
Public relations	-	3,377	-	3,377
State and local taxes	-	1,305	-	1,305
Travel	750	-	-	750
Total expenses	$ 17,331,775	$ 2,134,300	$ 13,207	$ 19,479,282
Comparative 2017 totals	$ 16,863,580	$ 2,144,915	$ 26,231	$ 19,034,726

Note 17 – Cost Reports

The Organization is contractually required to prepare an annual Medicaid cost report. The 2018 report has not been filed and is due March 31, 2019, and is subject to audit and possible adjustment.

The Organization is also contractually required to prepare an annual Medicare cost report. The 2018 report is due May 31, 2019, and is subject to audit and possible adjustment.

Note 18 – Medical Malpractice Insurance

The Organization maintains medical malpractice insurance coverage through “claims made” type policies for the benefit of its clinical employees and the Organization. Should the “claims made” policies not be renewed or replaced with equivalent insurance, claims related to occurrences during their terms, but reported subsequent to their termination, may be uninsured.

Accounting principles generally accepted in the United States of America require that a health care facility disclose the estimated costs of malpractice claims in the period of the incident of malpractice, if it is reasonably possible that liabilities may be incurred and losses can be reasonably estimated. A health care facility shall also recognize an insurance receivable at the same time that it recognizes the liability.

Management is unable to reasonably estimate the range of future costs, if any, of unasserted medical malpractice claims arising from incidents in current and prior periods.

Note 19 – Commitments and Contingencies

In the ordinary course of business, the Organization is a party to claims and legal actions by residents, providers, employees, and others. After consulting with legal counsel, the Organization’s management is of the opinion that any liability that may ultimately be incurred as a result of claims or legal actions will not have a material effect on the financial position or results of operations of the Organization.

Industry regulations – The health care industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditations, government health care program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Government activity continues with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by health care providers. Violations of these laws and regulations could result in expulsion from government health care programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management believes that the Organization is in compliance with fraud and abuse regulations, as well as other applicable government laws and regulations. Although no regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions known or unasserted at this time.

Accounting for conditional asset retirement obligations – ASC 410, *Asset Retirement and Environmental Obligations*, requires management to recognize the fair value of a liability related to environmental matters. Management cannot estimate the impact of this standard on the balance sheets for the Organization.

Supplementary Information

Josephine Caring Community
Summary of Revenue, Gains, and Support

	Years Ended December 31,	
	2018	2017
Nursing home resident revenue		
Medicaid, state portion	$ 7,524,304	$ 6,842,501
Medicaid, private portion	1,688,887	1,574,592
Private	1,947,413	2,120,864
Medicare	4,605,706	4,899,122
Total nursing home resident revenue	15,766,310	15,437,079
Boarding home resident revenue		
Medicaid, state portion	194,638	180,453
Medicaid, private portion	253,911	214,496
Private	1,626,132	1,624,072
Total boarding home resident revenue	2,074,681	2,019,021
Child care revenue		
Other	1,007,147	1,013,118
ECEAP contract	290,720	315,500
Total child care revenue	1,297,867	1,328,618
Contributions	39,071	63,491
Other revenue		
Miscellaneous	168,377	183,829
Interest income	143,783	115,327
Total other revenue	312,160	299,156
Total revenue, gains, and support	$ 19,490,089	$ 19,147,365

Josephine Caring Community
Schedules of Expenses

Nursing Home Expenses

	Years Ended December 31,	
	2018	2017
Salaries and wages	$ 8,792,680	$ 8,168,797
Payroll taxes and benefits	1,537,733	1,629,005
Ancillary expenses	1,384,340	1,693,998
Supplies	1,092,348	955,453
Depreciation and amortization	529,111	529,529
Utilities	340,622	335,626
Contract labor	323,659	217,250
Repairs and maintenance	153,001	147,635
Interest expense	88,167	61,339
Advertising and publications	68,366	76,347
Property insurance	46,555	42,152
Safety net assessment	42,167	42,978
Education	24,665	17,551
Vehicle expense	20,281	23,720
Events	15,313	15,478
Miscellaneous expense	11,433	11,922
	$ 14,470,441	$ 13,968,780

Boarding Home Expenses

	Years Ended December 31,	
	2018	2017
Salaries and wages	$ 902,569	$ 817,489
Supplies	199,649	197,392
Payroll taxes and benefits	181,427	180,216
Depreciation and amortization	186,729	188,735
Utilities	130,496	128,569
Interest expense	59,450	41,360
Miscellaneous expense	9,773	7,202
Insurance	8,663	8,351
Licenses and fees	6,890	6,890
Repairs and maintenance	5,993	6,365
Telephone	2,460	2,411
Education	2,039	1,686
Professional fees	1,944	2,034
Vehicle expense	1,456	1,108
Advertising and publications	-	2,254
	$ 1,699,538	$ 1,592,062

See report of independent auditors.

Child Care Expenses

	Years Ended December 31,	
	2018	2017
Salaries and wages	$ 780,834	$ 872,067
Payroll taxes and benefits	163,172	199,287
Supplies	92,741	115,665
Utilities	35,105	33,621
Depreciation and amortization	25,165	24,492
Insurance	15,788	8,218
Vehicle expense	8,596	3,220
Events	6,496	13,818
Contract labor	2,963	1,300
Education	2,384	6,610
Licenses and fees	2,089	2,295
Repairs and maintenance	900	1,688
Travel	750	1,188
Advertising and publications	545	1,595
Miscellaneous expense	504	1,389
	$ 1,138,032	$ 1,286,453

Home Health Expenses

	Years Ended December 31,	
	2018	2017
Supplies	$ 5,171	$ -
Miscellaneous expense	1,045	-
Education	546	-
Advertising and publications	34	-
	$ 6,796	$ -

Other Program Expenses

	Years Ended December 31,	
	2018	2017
Program expenditures	$ 16,968	$ 16,285
	$ 16,968	$ 16,285

General and Administrative Expenses

	Years Ended December 31,	
	2018	2017
Salaries and wages	$ 967,757	$ 897,926
Payroll taxes and benefits	169,472	145,911
Miscellaneous expense	137,589	159,944
Contract labor	136,980	152,596
Supplies	128,128	119,282
Licenses and fees	87,223	87,664
Professional fees	85,798	128,218
Repairs and maintenance	76,367	73,285
Insurance	65,467	60,390
Telephone	59,666	58,461
Depreciation and amortization	57,450	57,803
Property taxes	53,139	50,078
Advertising and publications	35,730	25,798
Interest expense	23,970	25,036
Board expense	15,447	38,154
Utilities	13,376	13,275
Postage	8,877	10,391
Education	7,182	33,273
Public relations	3,377	4,343
State and local taxes	1,305	3,087
	$ 2,134,300	$ 2,144,915

Fundraising Expenses

	Years Ended December 31,	
	2018	2017
Contract labor	$ 9,589	$ 7,226
Depreciation and amortization	2,368	2,554
Supplies	1,250	1,350
Salaries and wages	-	12,899
Payroll taxes and benefits	-	2,138
Events	-	64
	$ 13,207	$ 26,231


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REPORT OF INDEPENDENT AUDITORS
AND FINANCIAL STATEMENTS
WITH SUPPLEMENTARY INFORMATION

JOSEPHINE CARING COMMUNITY

December 31, 2017 and 2016

MOSSADAMS

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MOSSADAMS

Report of Independent Auditors

To the Board of Directors
Josephine Caring Community

Report on Financial Statements

We have audited the accompanying financial statements of Josephine Caring Community, which comprise the balance sheets as of December 31, 2017 and 2016, and the related statements of activities and changes in net assets 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 audits 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 Josephine Caring Community as of December 31, 2017 and 2016, and the results of its operations and its cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Our audit was conducted for the purpose of forming an opinion on the basic financial statements taken as a whole. The accompanying supplementary information on pages 24 through 27 is presented for purposes of additional analysis and is not a required part of the basic financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the basic financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the financial statements as a whole.

Moss Adams LLP

Tacoma, Washington
March 28, 2018

ASSETS

	December 31, 2017	December 31, 2016
CURRENT ASSETS		
Cash and cash equivalents	$ 1,800,435	$ 4,457,698
Assets restricted for use	141,271	85,371
Accounts receivable, net	1,413,976	1,787,958
Investments	6,679,836	4,074,645
Prepaid expenses	141,016	164,462
Inventory	71,949	77,021
Total current assets	10,248,483	10,647,155
ASSETS RESTRICTED FOR LONG-TERM USE	722,435	680,231
LAND, BUILDINGS, AND EQUIPMENT, net	6,273,214	6,788,350
OTHER ASSETS		
Land held for future development	4,081,487	2,580,085
Land held for sale	176,281	176,281
Total assets	$ 21,501,900	$ 20,872,102

LIABILITIES AND NET ASSETS

CURRENT LIABILITIES		
Accounts payable	$ 371,007	$ 446,214
Accrued payroll and vacation	587,514	521,676
Accrued payroll taxes and benefits	583,022	529,789
Other liabilities	42,109	23,592
Unearned revenue	2,226	32,616
Funds held for residents	20,312	17,003
Current portion of bonds payable	374,000	361,000
Current portion of capital lease	22,682	31,939
Total current liabilities	2,002,872	1,963,829
LONG-TERM DEBT AND OTHER LIABILITIES		
Bonds payable, net of current portion	4,077,188	4,451,188
Less loan fees, net of accumulated amortization of $140,269 and $122,025 for the years ended 2017 and 2016, respectively	182,445	200,689
	3,894,743	4,250,499
Capital lease, net of current portion	-	25,444
Deferred compensation	270,275	227,454
Total liabilities	6,167,890	6,467,226
NET ASSETS		
Unrestricted	14,748,335	13,871,738
Temporarily restricted	136,784	84,247
Permanently restricted	448,891	448,891
Total net assets	15,334,010	14,404,876
Total liabilities and net assets	$ 21,501,900	$ 20,872,102

See accompanying notes.

Josephine Caring Community
Statements of Activities and Changes in Net Assets
Year Ended December 31, 2017

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
REVENUE, GAINS, AND OTHER SUPPORT				
Nursing home revenue	$ 15,437,079	$ -	$ -	$ 15,437,079
Boarding home revenue	2,019,021	-	-	2,019,021
Child care revenue	960,011	-	-	960,011
Child care grant revenue	368,607	-	-	368,607
Other program revenue	127,237	-	-	127,237
Other revenue	56,592	-	-	56,592
Contributions	47,573	15,918	-	63,491
Interest and dividends	110,371	4,956	-	115,327
Net assets released from restriction	20,354	(20,354)	-	-
Total revenue, gains, and other support	19,146,845	520	-	19,147,365
EXPENSES				
Nursing home	13,968,780	-	-	13,968,780
General and administrative	2,144,915	-	-	2,144,915
Boarding home	1,592,062	-	-	1,592,062
Child care	1,286,453	-	-	1,286,453
Other program expense	16,285	-	-	16,285
Fundraising	26,231	-	-	26,231
Total expenses	19,034,726	-	-	19,034,726
EXCESS REVENUES OVER EXPENSES	112,119	520	-	112,639
UNREALIZED GAIN ON INVESTMENTS	764,478	52,017	-	816,495
CHANGE IN NET ASSETS	876,597	52,537	-	929,134
NET ASSETS, beginning of year	13,871,738	84,247	448,891	14,404,876
NET ASSETS, end of year	$ 14,748,335	$ 136,784	$ 448,891	$ 15,334,010

See accompanying notes.

Josephine Caring Community
Statements of Activities and Changes in Net Assets
Year Ended December 31, 2016

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
REVENUE, GAINS, AND OTHER SUPPORT				
Nursing home revenue	$ 17,098,417	$ -	$ -	$ 17,098,417
Boarding home revenue	1,978,456	-	-	1,978,456
Child care revenue	947,907	-	-	947,907
Child care grant revenue	366,347	-	-	366,347
Other program revenue	116,960	-	-	116,960
Other revenue	38,861	-	-	38,861
Contributions	31,636	7,344	-	38,980
Interest and dividends	81,134	3,368	-	84,502
Net assets released from restriction	13,533	(13,533)	-	-
Total revenue, gains, and other support	20,673,251	(2,821)	-	20,670,430
EXPENSES				
Nursing home	14,586,374	-	-	14,586,374
General and administrative	2,026,188	-	-	2,026,188
Boarding home	1,482,807	-	-	1,482,807
Child care	1,231,479	-	-	1,231,479
Other program expense	12,068	-	-	12,068
Fundraising	54,961	-	-	54,961
Total expenses	19,393,877	-	-	19,393,877
EXCESS (DEFICIENCY) REVENUES OVER EXPENSES	1,279,374	(2,821)	-	1,276,553
UNREALIZED GAIN ON INVESTMENTS	243,027	27,622	-	270,649
CHANGE IN NET ASSETS	1,522,401	24,801	-	1,547,202
NET ASSETS, beginning of year	12,349,337	59,446	448,891	12,857,674
NET ASSETS, end of year	$ 13,871,738	$ 84,247	$ 448,891	$ 14,404,876

See accompanying notes.

Josephine Caring Community
Statements of Cash Flows

	Years Ended December 31, 2017	2016
CASH FLOWS FROM OPERATING ACTIVITIES		
Change in net assets	$ 929,134	$ 1,547,202
Adjustments to reconcile change in net assets to net cash from operating activities		
Depreciation and amortization	803,113	806,707
Amortization of loan fees included in interest expense	18,244	18,244
Provision for bad debt	29,668	109,494
Loss on disposal of property and equipment	9,638	9,545
Unrealized gain on investments	(816,495)	(270,649)
Changes in operating assets and liabilities		
Accounts receivable	344,314	88,671
Prepaid expenses	23,446	(24,076)
Inventory	5,072	(3,603)
Accounts payable	(75,207)	(2,143)
Accrued payroll and vacation	65,838	20,753
Accrued payroll taxes and benefits	53,233	128,688
Other liabilities and deferred compensation	18,517	41,438
Unearned revenue	(30,390)	(2,227)
Funds held for residents	3,309	4,211
Net cash from operating activities	1,381,434	2,472,255
CASH FLOWS FROM INVESTING ACTIVITIES		
Proceeds from sale of investments	840,187	881,103
Purchase of investments	(2,628,883)	(883,758)
Purchase of land held for future development	(1,501,402)	-
Proceeds from sale of land, building and equipment	-	1,718
Purchase of land, building and equipment	(297,615)	(473,790)
Net cash from investing activities	(3,587,713)	(474,727)
CASH FLOWS FROM FINANCING ACTIVITIES		
Loss on investments restricted for use	(3,266)	(22,549)
Unrealized gain (loss) on endowment fund	(52,017)	(28,656)
Principal payments on bonds payable	(361,000)	(348,000)
Principal payments on capital lease obligation	(34,701)	(29,809)
Net cash from financing activities	(450,984)	(429,014)
INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	(2,657,263)	1,568,514
CASH AND CASH EQUIVALENTS, beginning of year	4,457,698	2,889,184
CASH AND CASH EQUIVALENTS, end of year	$ 1,800,435	$ 4,457,698
Cash paid for interest	$ 124,210	$ 98,728
SUPPLEMENTAL DISCLOSURE OF NON-CASH INFORMATION		
Increase in deferred compensation and assets limited for use	$ 42,821	$ 70,000

See accompanying notes.

Note 1 – Description of Operations

Josephine Caring Community (the "Organization") is a nonprofit, member-owned corporate affiliate of the Evangelical Lutheran Church in America. Corporate membership is composed of 18 local congregations. Members of the Organization's corporation are entitled to elect the board of directors and approve certain actions of the board of directors. The Organization operates a 160-bed skilled nursing facility, a 57-unit boarding home licensed for 65 residents, and a child care program licensed for a capacity of 111 children in Stanwood, Washington.

Note 2 – Summary of Significant Accounting Policies

Basis of accounting – The Organization maintains its financial records using the accrual basis of accounting, whereby revenues are recognized when earned and expenses are recognized when an obligation is incurred.

Basis of presentation – The Organization presents its financial statements in accordance with Accounting Standards Codification (ASC) 958, *Not-for-Profit Entities*. Under ASC 958, the Organization is required to report information regarding its financial position and activities according to three classes of net assets: unrestricted net assets, temporarily restricted net assets, and permanently restricted net assets.

Unrestricted net assets – Unrestricted net assets are funds controlled and designated by the board of directors that include the general, operating, and equipment accounts.

Temporarily restricted net assets – Temporarily restricted net assets are assets with donor-imposed restrictions that allow the use of the assets as specified or by the passage of time. (Note 10)

Permanently restricted net assets – Permanently restricted net assets are controlled by law or donor-imposed restrictions stating the resources be maintained permanently. (Note 10)

Federal income tax – The Organization is exempt from federal income tax under Section 501 (c)(3) of the Internal Revenue Code. Exemption has also been given by Snohomish County (the "County") from all personal property taxes. In addition, the County has granted exemption for real property associated with the nursing home, boarding home, and child care programs. Also, the Organization qualifies for the charitable contribution deduction under Section 170(b)(l)(A) and has been classified as an organization that is not a private foundation under Section 509(a)(2).

The Organization accounts for uncertain tax positions whereby the effect of the uncertainty would be recorded if the outcome was considered probable and was reasonably estimable. As of December 31, 2017, the Organization had not identified any uncertain tax positions requiring accrual or disclosure.

Cash and cash equivalents – Cash and cash equivalents consist of highly liquid investments with remaining maturity at the date of purchase of three months or less.

Note 2 – Summary of Significant Accounting Policies (continued)

Investments – The Organization records its investments in accordance with ASC 958, Not-for-Profit Entities. Under ASC 958, investments in marketable securities with readily determinable fair values and all investments in debt securities are reported at their fair values in the balance sheets. Unrealized gains and losses are included in the statements of activities and changes in net assets (Note 5).

Inventory – Inventory consists mainly of dietary supplies, central supplies, food, and gift shop merchandise and is stated at the lower of cost (first-in, first-out method) or market.

Accounts receivable – The Organization carries its accounts receivable at standard rates less an allowance for uncollectible accounts. On a periodic basis, the Organization evaluates its accounts receivable and establishes an allowance for uncollectible accounts, based on a history of past write-offs and collections. The allowance is $93,246 and $80,930 at December 31, 2017 and 2016, respectively.

The Organization can charge interest of 12% per annum on skilled nursing and boarding home private past due accounts. Other nursing home and boarding home late fees may be assessed according to the resident financial agreements in place during the year. Approximately $3,065 and $3,017 of child care accounts receivable and $172,407 and $93,660 of skilled nursing and boarding home accounts receivable are greater than 90 days at December 31, 2017 and 2016, respectively.

Land, buildings, and equipment – Land, buildings, and equipment are stated at cost, less accumulated depreciation. The Organization capitalizes fixed assets with a cost greater than $750. Maintenance and repair costs are expensed as incurred. The cost and related accumulated depreciation of significant assets sold or retired are removed from the property accounts, and any resulting gain or loss is reported as an increase or decrease in net assets as explained in the revenue recognition section.

Depreciation is provided on the straight-line method over the assets' estimated useful lives, which, for land improvements, is 5 to 25 years, for buildings is 25 to 30 years, for building improvements is 10 to 26 years, for furniture and equipment is 3 to 20 years, and for vehicles is 4 to 10 years.

During 2013, the Organization entered into a capital lease for equipment. Total assets under capital lease were approximately $147,187 with accumulated amortization of $122,656 and $93,218 as of December 31, 2017 and 2016, respectively.

The Organization, using its best estimates based on reasonable and supportable assumptions and projections, reviews for impairment of long-lived assets when indicators of impairment are identified. The review addresses the estimated recoverability of the assets' carrying value, which is principally determined based on projected undiscounted cash flows generated by the underlying tangible assets.

When the carrying value of an asset exceeds estimated recoverability, an asset impairment is recognized. No impairment losses were present for the years ended December 31, 2017 and 2016.

Note 2 – Summary of Significant Accounting Policies (continued)

Endowments – The Organization has interpreted the Washington Uniform Prudent Management of Institutional Funds Act as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, the Organization classifies as permanently restricted net assets (1) the original value of gifts donated to the permanent endowment, (2) the original value of subsequent gifts to the permanent endowment, and (3) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by the board of directors in accordance with the endowment spending policy.

The Organization has adopted investment and spending policies for endowment assets that attempt to provide a predictable stream of funding to programs supported by its endowment while seeking to maintain the purchasing power of the endowment assets. Endowment assets include those assets of donor-restricted funds that the Organization must hold in perpetuity or for a donor-specified period, an accumulation of earnings on the fund in accordance with the endowment fund investment policy, and board-designated funds (if any). Under this policy, as approved by the board of directors, the endowment assets are invested in a manner that is intended to produce results that exceed the price and yield results while assuming a low level of investment risk. The Organization expects its endowment funds, over time, to provide a consistent rate of return. Actual returns in any given year may vary. The Organization has a policy that allows spending of annual interest earned on the corpus of the endowment fund. The amount of interest earnings to be released annually for distribution is specified by the board as soon as equitably possible after fiscal year-end. The interest funds are spent as authorized by the board on programs or capital expenditures to benefit the Organization in accordance with the endowment policy.

Revenue recognition – Revenues are reported as increases in unrestricted net assets unless use of the related assets are limited by donor-imposed restrictions. Expenses are reported as decreases in unrestricted net assets. Gains and losses on investments and other assets or liabilities are reported as increases or decreases in unrestricted net assets unless their use is restricted by explicit donor stipulation or by law. Expirations of temporary restrictions on net assets are reported as transfers between the applicable classes of net assets.

The Organization is reimbursed for services provided to qualifying residents of the nursing and boarding homes under contracts and is reimbursed at rates that may be different from its standard charge. Unearned revenue at year-end consists of prepaid room and board fee payments from individuals for the month following year-end.

The Organization provides child care services to individuals at standard rates. The Early Childhood Education and Assistance Program is a state-funded kindergarten preparedness program for limited-income four-year-olds provided by a grant through the Snohomish County Human Services Department. During 2017, the grant was renewed and expires on June 30, 2018.

Note 2 – Summary of Significant Accounting Policies (continued)

Contributions – The Organization records contributions according to ASC 958, *Not-for-Profit Entities*. In accordance with ASC 958, contributions, including unconditional promises to give, are recorded in the period made. All contributions are available for unrestricted use unless specifically restricted by the donor. Conditional promises to give are recognized when the conditions on which they depend are substantially met. Unconditional promises to give due in the next year are recorded at their net realizable value. Unconditional promises to give due in subsequent years are reported at the present value of their net realizable value, using risk-free interest rates applicable to the years in which the promises are to be received.

Recognition of donor-restricted contributions – Support that is restricted by the donor is reported as an increase in unrestricted net assets if the restriction expires in the reporting period in which the support is recognized. All other donor-restricted support is reported as an increase in temporarily or permanently restricted net assets, depending on the nature of the restriction. When a restriction expires, temporarily restricted net assets are reclassified to unrestricted net assets.

During 2017, more than 80 volunteers contributed significant amounts of time and effort in assisting to carry out the programs and activities of the Organization. The time contributed by volunteers is not reflected in the financial statements.

Land held for future development – Land, and costs attributable to the development activities of the land, which are held for future development where no significant development has been undertaken are stated at cost less impairment costs, if any. As of December 31, 2017, Management does not believe this land has been impaired.

Land held for sale – Land which is held for sale is stated at cost less impairment costs, if any. As of December 31, 2017, Management does not believe this land has been impaired.

Loan issuance fees – Loan issuance fees are amortized on the straight-line basis over the term of the debt. Straight-line calculation of loan fees is not significantly different than the effective interest method. Amortization included in interest expense was $18,244 for the years ended December 31, 2017 and 2016, respectively. Accumulated amortization was $140,269 and $122,025 as of December 31, 2017 and 2016, respectively.

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, and disclosure of contingent assets and liabilities at the date of the financial statements and reported amounts of revenue and expense during the reporting period. Actual results could differ from those estimates.

Performance indicator – Changes in excess revenues over expenses as reflected in the accompanying statements of activities is a performance indicator. Changes in excess revenues over expenses include changes in unrestricted net assets other than net realized and unrealized losses (gains) on investments.

Note 2 – Summary of Significant Accounting Policies (continued)

Expense allocation – Directly identifiable expenses are charged to program, fund raising, and general and administrative expenses (Note 15). Expenses relating to more than one function are charged to the function based on an estimate of utilization, square footage, or revenue on each function. General and administrative expenses include those expenses that are not directly identifiable with any specific function but to provide for the overall support of the Organization.

Recent accounting pronouncements – In February 2016, the FASB issued Accounting Standards Update No. 2016-02 (ASU 2016-02), *Leases (Topic 842)*. ASU 2016-02 requires lessees to recognize a right-of-use asset and lease liability in the balance sheet for all leases, including operating leases, with terms of more than twelve months. The new guidance will be effective for nonpublic company fiscal years beginning on or after December 15, 2019 with early adoption permitted. The amendment must be applied on a modified retrospective basis.

In May 2014, the FASB issued authoritative guidance for revenue from contracts with customers, which provides a single comprehensive revenue recognition model to apply in determining how and when to recognize revenue. The core principle of the guidance is that an entity should recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. When applying the new revenue model to contracts with customers, the guidance requires five steps to be applied, which include: 1) identify the contract(s) with a customer, 2) identify the performance obligations in the contract, 3) determine the transaction price, 4) allocate the transaction price to the performance obligations in the contract and 5) recognize revenue when (or as) the entity satisfies a performance obligation.

The guidance also requires both quantitative and qualitative disclosures, which are more comprehensive than existing revenue standards. The disclosures are intended to enable financial statement users to understand the nature, timing and uncertainty of revenue and the related cash flow. For nonpublic entities the new guidance will be effective for fiscal years beginning on or after December 15, 2018, with early adoption permitted. The amendment must be applied on a modified retrospective basis.

The Organization is currently evaluating the impact of the adoption of these standards on the financial statements.

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

The Organization did not have any subsequent events through March 28, 2018, which is the date the financial statements were available to be issued, for events requiring recording or disclosure in the financial statements for the year ended December 31, 2017.

Reclassification – Certain reclassifications have been made to the prior financial statements to conform to the current presentation. Such reclassifications have no effect on previously reported net income.

Note 3 – Assets Restricted for Use

The following assets are limited in use for specific purposes by donor designation, board designation, or by trustee under trust indenture as of December 31:

	2017	2016
Josephine Endowment Fund	$ 564,176	$ 512,180
Scholarship Fund	1,191	(256)
Good Samaritan Fund	22,462	22,361
Resident trust accounts	20,042	17,920
Nonqualified deferred compensation plan	255,835	213,397
	$ 863,706	$ 765,602

The assets restricted for use are invested in the following at December 31:

	2017	2016
Deposit accounts	$ 174,003	$ 169,204
Mutual funds	79,323	68,810
Other investments	610,380	527,588
	$ 863,706	$ 765,602

Josephine endowment fund – The Josephine Endowment Fund was established to support and further the mission and ministry of the Organization (Note 11).

Scholarship fund – The Organization maintains a scholarship fund that is used to help fund the education of employees wishing to further their education in a field that benefits the Organization.

Good Samaritan fund – The Good Samaritan Fund was established to provide for quality of life enhancements to residents in financial need.

Resident trust accounts – The Organization maintains two resident trust bank accounts for its residents as required by the Department of Social and Health Services of Washington State (Note 7).

Nonqualified deferred compensation plan – The Organization adopted a nonqualified deferred compensation plan in 2013 for a certain highly paid employee. This deferred compensation arrangement is unfunded, unsecured and subject to a vesting schedule that begins when the employee reaches 62 years of age. The Plan allows for both an elective deferral and an employer deferral. Benefits are reported on the employee's W-2 and subject to FICA tax as vesting occurs.

Note 3 – Assets Restricted for Use (continued)

The Participant's entire accrued benefit is subject to the following vesting schedule:

Year	Age	Vesting %
2024	62	20%
2025	63	40%
2026	64	60%
2027	65	80%
2028	66	100%

Plan assets are included in assets restricted for long term use on the balance sheet. Deferred compensation liability on the balance sheet includes accrued employer taxes. The total amount accrued under the deferred compensation plan was $270,275 and $227,454 at December 31, 2017 and 2016, respectively.

Employer contributions consist of premiums paid for a life insurance contract having a face value of $800,000, with a cash surrender value of $37,080 and $25,723 at December 31, 2017 and 2016. The Organization is both owner and beneficiary of this policy which insures the life of the plan participant. Employer contributions totaled $12,000 in both, 2017 and 2016. Premiums anticipated to be paid to keep the policy's underlying contracts in force are $12,000 annually until 2020.

Note 4 – Inventory

Inventory consists of the following at December 31:

	2017	2016
Central supplies	$ 47,485	$ 55,577
Food	17,779	16,148
Dietary supplies	4,497	3,017
Gift shop	2,188	2,279
	$ 71,949	$ 77,021

Note 5 – Assets at Fair Value

ASC 820, *Fair Value Measurements and Disclosures*, provides the framework for measuring fair value. That framework provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurement) and the lowest priority to unobservable inputs (Level 3 measurement). The three levels of the fair value hierarchy under ASC 820 are described as follows:

Basis of fair value measurement

Level 1 – Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Organization has the ability to access.

Level 2 – Quoted prices in markets that are not considered to be active or financial instruments without quoted market prices, but for which all significant inputs are observable, either directly or indirectly.

Level 3 – Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

The asset or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

Following is a description of the valuation methodologies used for assets measured at fair value. There have been no changes in the methodologies used at December 31, 2017.

Cash and cash equivalents – Cash and savings accounts held in federally insured institutions. The carrying amount reported in the balance sheets for cash and cash equivalents approximates fair value.

Registered Investment Companies (Mutual Funds) – Valued at the net asset value (NAV) of shares held in the fund at year-end using prices quoted by the relevant pricing agent.

Index-based securities – The principal protected securities are purchased based on a unit price, determined at the offering date, adjusted by the index's underlying observable market information, based on an average of the index's performance over the unit's life.

Note 5 – Assets at Fair Value (continued)

Other investments – The other investments include pooled investment accounts and a life insurance policy. The pooled investment accounts are valued using the net asset value (NAV) of the fund as reported by the fund managers and they are classified within Level 2 and Level 3 of the valuation hierarchy. The NAV is based on the fair value of the underlying assets owned by the fund, minus its liabilities. The net asset value of a pooled investment account is calculated based on a compilation of primarily observable market information. The pooled investment accounts include beneficial interests in assets of others. The life insurance policy is classified within Level 3 of the valuation hierarchy. The changes in fair value of the Level 3 asset were not significant.

The Organization accounts for its investment in life settlement contracts in accordance with the investment method, using the contract value of the policy. Cash disbursements related to this investment are classified in the cash flow statement under operating and non-cash activity as it is used as deferred compensation.

Common stock – Common stock is valued at the closing price reported on the active market on which the individual securities are traded. Common stock is generally classified within Level 1 of the valuation hierarchy.

The following table discloses, by level, the fair value hierarchy of the Organization's investments and assets limited to use at fair value as of December 31, 2017 and 2016, respectively:

	Fair Value Measurement at December 31, 2017			
	Level 1	Level 2	Level 3	Total
Registered investment companies	$ 3,873,014	$ -	$ -	$ 3,873,014
Common stock	2,886,145	-	-	2,886,145
Other investments	-	112,260	498,120	610,380
	$ 6,759,159	$ 112,260	$ 498,120	$ 7,369,539

	Fair Value Measurement at December 31, 2016			
	Level 1	Level 2	Level 3	Total
Registered investment companies	$ 2,484,433	$ -	$ -	$ 2,484,433
Common stock	1,514,379	-	-	1,514,379
Other investments	-	98,420	429,168	527,588
Index-based securities	-	144,643	-	144,643
	$ 3,998,812	$ 243,063	$ 429,168	$ 4,671,043

Note 6 – Land, Buildings, and Equipment

The following represents the amounts of land, buildings, equipment, vehicles, and construction in progress for the Organization at December 31:

	2017	2016
Buildings and improvements	$ 15,883,622	$ 15,802,456
Furniture and equipment	2,028,711	1,991,833
Major movable equipment	932,281	929,716
Land and improvements	675,804	671,877
Construction in progress	461,147	348,326
Vehicles	313,121	292,353
	20,294,686	20,036,561
Less accumulated depreciation	14,021,472	13,248,211
	$ 6,273,214	$ 6,788,350

Depreciation expense is $803,113 and $806,707 for the years ended December 31, 2017 and 2016, respectively.

Note 7 – Funds Held for Residents

The Organization maintains resident trust bank accounts for its residents under an agency arrangement as required by the Department of Social and Health Services of Washington State. The associated asset is recorded under assets restricted for use. The combined balance of these accounts was $20,312 and $17,003 as of December 31, 2017 and 2016, respectively. Interest is credited to individual resident accounts as earned.

Note 8 – Bonds Payable

	2017	2016
Low income housing assistance revenue bonds, 2005, payable to Housing Authority of Snohomish County, due in varying principal installments from approximately $256,000 in 2013 to $523,188 in 2027, plus interest at the floating rate established on the Index Reset Date; secured by real property and the assignment of leases. The floating rate is equal to the product of (a) the sum of (i) the Applicable Spread plus (ii) the product of (1) the LIBOR Index multiplied by (2) the Applicable Factor multiplied by (b) the Margin Rate Factor. At December 31, 2017 this rate was 2.44% per annum. This bond matures in January 2028.	$ 4,451,188	$ 4,812,188
Less current portion	374,000	361,000
	$ 4,077,188	$ 4,451,188

Interest expense totaled $124,171 and $111,424 in 2017 and 2016, respectively.

Included under the terms of the bond financing are covenants that require the maintenance of various minimum financial ratios and filing requirements for annual audited financial statements. Management represents that the organization is in compliance with these requirements.

Scheduled principal repayments of long-term debt are as follows:

2018	$ 374,000
2019	390,000
2020	402,000
2021	418,000
2022	434,000
Thereafter	2,433,188
	$ 4,451,188

Note 9 – Capital Lease

The Company's lease commitments are primarily for equipment. The future minimum capital lease payments at December 31, 2016 are as follows:

2018	$ 23,275
	23,275
Less amounts representing interest	593
Capital lease obligations	22,682
Less current portion	22,682
	$ -

Interest expense totaled $3,525 and $5,510 in 2017 and 2016, respectively.

Note 10 – Net Assets

As of December 31, 2017 and 2016, respectively, temporarily restricted net assets are available for the following purposes:

	2017	2016
Josephine Endowment Fund	$ 115,286	$ 63,289
Good Samaritan Fund	17,709	17,942
Child Programs	1,878	706
Scholarship Fund	1,191	660
Construction Fund	720	50
Music Fund	-	1,600
	$ 136,784	$ 84,247

Permanently restricted net assets have been restricted by donors for the Josephine Endowment Fund and are to be maintained by the Organization in perpetuity. The income from these funds will be temporarily restricted to support the capital improvements within the property, grounds, buildings, and programs of the Organization.

Note 10 – Net Assets (continued)

Permanently restricted net assets are available for the following purposes:

	2017	2016
Josephine Endowment Fund	$ 448,891	$ 448,891

Net assets were released from donor restrictions by incurring expenses satisfying the purpose or time restrictions specified by donors as follows at December 31:

	2017	2016
Josephine Endowment Fund	$ 4,969	$ 4,565
Good Samaritan Fund	5,785	2,568
Scholarship Fund	3,000	3,000
Music Fund	1,600	3,400
Chaplain's Fund	5,000	-
	$ 20,354	$ 13,533

Note 11 – Endowment

The Organization's endowment consists of one individual fund, the Josephine Endowment Fund, which was established to support and further the mission of the Organization. The endowment includes donor-restricted endowment funds. As required by generally accepted accounting principles, net assets associated with endowment funds are classified and reported based on the existence or absence of donor-imposed restrictions.

In prior years, the Organization transferred endowment funds in the amount of $200,000 to the Community Foundation of Snohomish County (CFSC) for their management. CFSC invests the funds in a mix of equity, fixed income, and real asset funds. At December 31, 2017 and 2016, the Organization's funds invested with Thrivent were valued at $242,285 and $215,771, respectively. These funds increased in value by $26,514 in 2017 and $13,747 in 2016, as a result of unrealized capital gain earnings during the year.

In prior years, the Organization transferred endowment funds in the amount of $50,000 to the Thrivent Mutual Funds for their management. Thrivent invests the funds in a mix of equity and fixed income funds. At December 31, 2017 and 2016, the Organization's funds invested with Thrivent were valued at $79,323 and $69,811, respectively. These funds increased in value by $9,512 in 2017 and $6,410 in 2016, as a result of unrealized capital gain earnings during the year.

In prior years, the Organization transferred endowment funds in the amount of $75,000 to the InFaith Community Foundation (InFaith) (formerly Lutheran Community Foundation) for their management. InFaith invests the funds in a pool with funds from other Lutheran social service organizations. At December 31, 2017 and 2016, the Organization's funds invested with InFaith were valued at $112,260 and $98,420, respectively. These funds increased in value by $13,841 in 2017 and decreased in value by $6,099 in 2016, as a result of unrealized capital gain earnings during the year.

Note 11 – Endowment (continued)

Endowment net assets at December 31:

	2017	2016
Permanently restricted net assets		
The portion of perpetual endowment funds that is required to be retained permanently by explicit donor stipulation	$ 448,891	$ 448,891
Temporarily restricted net assets		
Temporary endowment funds	$ 115,286	$ 63,290

Note 12 – Change in Endowment Net Assets

Changes in endowment fund net assets are as follows for the year ended December 31, 2017:

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets, beginning of year	$ -	$ 63,290	$ 448,891	$ 512,181
Investment return				
Investment income	-	4,948	-	4,948
Unrealized gain	-	52,017	-	52,017
Total investment return	-	56,965	-	56,965
Appropriation of endowment assets for expenditure	-	(4,969)	-	(4,969)
Endowment net assets, end of year	$ -	$ 115,286	$ 448,891	$ 564,177

Changes in endowment fund net assets are as follows for the year ended December 31, 2016:

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets, beginning of year	$ -	$ 36,869	$ 448,891	$ 485,760
Investment return				
Investment income	-	3,368	-	3,368
Unrealized loss	-	27,618	-	27,618
Total investment return	-	30,986	-	30,986
Appropriation of endowment assets for expenditure	-	(4,565)	-	(4,565)
Endowment net assets, end of year	$ -	$ 63,290	$ 448,891	$ 512,181

Note 13 – Concentrations

Approximately 44% and 40% of revenue in 2017 and 2016, respectively, was derived from a contract with the Department of Social and Health Services in the state of Washington to provide skilled nursing and assisted living/congregate care to medical recipient residents. Approximately 19% of revenue in 2017 and 2016, was derived from private pay or other third-party payors. Approximately 25% and 31% of revenue in 2017 and 2016, respectively, was derived from the federal government. The primary geographic source of patients for skilled nursing and assisted living includes Snohomish County and surrounding communities in the northern Puget Sound region.

In addition to skilled nursing and assisted living operations, the Organization derives approximately 7% and 6% of revenues in 2017 and 2016, respectively by providing child day care and a Montessori school to the Stanwood community.

Approximately 39% and 38% of accounts receivable in 2017 and 2016, respectively, was derived from a contract with the Department of Social and Health Services in the state of Washington to provide skilled nursing and assisted living/congregate care to medical recipient residents. Approximately 19% and 15% of accounts receivable in 2017 and 2016, was derived from private pay or other third-party payors. Approximately 38% and 48% of accounts receivable in 2017 and 2016, respectively, was derived from the federal government.

Financial instruments that potentially subject the Organization to concentrations of credit risk consist of cash and cash equivalents, certificates of deposit, investments, and accounts receivable. At times, cash deposits, including amounts held as investments, exceed the federally insured limits of the financial institution and expose the Organization to credit risk.

Note 14 – Defined Contribution Plan

The Organization sponsors a defined contribution plan, in which employees who have completed one year of service and have attained age 21 are eligible to receive safe harbor contributions using the following formula:

- 100% of each participant's elective deferrals up to 3% of the participant's compensation (excluding grossed up bonuses and length of service awards).

- Plus 50% of each participant's elective deferrals in excess of 3% but not in excess of 5% of the participant's compensation (excluding grossed up bonuses and length of service awards).

The Organization has accrued $252,398 and $238,553 of employer contributions to be made to the Plan for the years ended December 31, 2017 and 2016, respectively.

Note 15 – Expenses by Functional Categories

	2017	2016
Program	$ 16,863,580	$ 17,312,728
General and administrative	2,144,915	2,026,188
Fundraising	26,231	54,961
	$ 19,034,726	$ 19,393,877

Note 16 – Cost Reports

The Organization is contractually required to prepare an annual Medicaid cost report. The 2017 report has not been filed and is due March 31, 2018, and is subject to audit and possible adjustment.

The Organization is also contractually required to prepare an annual Medicare cost report. The 2017 report is due May 31, 2018, and is subject to audit and possible adjustment.

Note 17 – Medical Malpractice Insurance

The Organization maintains medical malpractice insurance coverage through “claims made” type policies for the benefit of its clinical employees and the Organization. Should the “claims made” policies not be renewed or replaced with equivalent insurance, claims related to occurrences during their terms, but reported subsequent to their termination, may be uninsured.

Accounting principles generally accepted in the United States of America require that a health care facility disclose the estimated costs of malpractice claims in the period of the incident of malpractice, if it is reasonably possible that liabilities may be incurred and losses can be reasonably estimated. A health care facility shall also recognize an insurance receivable at the same time that it recognizes the liability.

Management is unable to reasonably estimate the range of future costs, if any, of unasserted medical malpractice claims arising from incidents in current and prior periods.

Note 18 – Commitments and Contingencies

In the ordinary course of business, the Organization is a party to claims and legal actions by residents, providers, employees, and others. After consulting with legal counsel, the Organization's management is of the opinion that any liability that may ultimately be incurred as a result of claims or legal actions will not have a material effect on the financial position or results of operations of the Organization.

Industry regulations – The health care industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditations, government health care program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Government activity continues with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by health care providers. Violations of these laws and regulations could result in expulsion from government health care programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management believes that the Organization is in compliance with fraud and abuse, as well as other applicable government laws and regulations. Although no regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions known or unasserted at this time.

Accounting for conditional asset retirement obligations – ASC 410, *Asset Retirement and Environmental Obligations*, requires management to recognize the fair value of a liability related to environmental matters. Management cannot estimate the impact of this standard on the balance sheets for the Organization.

Supplementary Information

Josephine Caring Community
Summary of Revenue, Gains, and Support

	Years Ended December 31,	
	2017	2016
Nursing home resident revenue		
Medicaid, state portion	$ 6,842,501	$ 6,345,143
Medicaid, private portion	1,574,592	1,658,790
Private	2,120,864	2,500,083
Medicare	4,899,122	6,594,401
Total nursing home resident revenue	15,437,079	17,098,417
Boarding home resident revenue		
Medicaid, state portion	180,453	188,274
Medicaid, private portion	214,496	255,623
Private	1,624,072	1,534,559
Total boarding home resident revenue	2,019,021	1,978,456
Child care revenue		
Other	1,013,118	1,007,004
ECEAP contract	315,500	307,250
Total child care revenue	1,328,618	1,314,254
Contributions	63,491	38,980
Other revenue		
Miscellaneous	183,829	155,821
Interest income	115,327	84,502
Total other revenue	299,156	240,323
Total revenue, gains, and support	$ 19,147,365	$ 20,670,430

Josephine Caring Community
Schedules of Expenses

Nursing Home Expenses

	Years Ended December 31,	
	2017	2016
Salaries and wages	$ 8,168,797	$ 8,120,371
Ancillary expenses	1,693,998	2,153,018
Payroll taxes and benefits	1,629,005	1,563,755
Supplies	955,453	1,067,188
Depreciation and amortization	529,529	543,834
Utilities	335,626	343,918
Contract labor	217,250	162,162
Repairs and maintenance	147,635	169,283
Advertising and publications	76,347	246,470
Interest expense	61,339	53,959
Safety net assessment	42,978	45,894
Property insurance	42,152	39,230
Vehicle expense	23,720	33,654
Education	17,551	10,661
Events	15,478	19,109
Miscellaneous expense	11,922	13,868
	$ 13,968,780	$ 14,586,374

Boarding Home Expenses

	Years Ended December 31,	
	2017	2016
Salaries and wages	$ 817,489	$ 734,917
Supplies	197,392	209,312
Depreciation and amortization	188,735	178,095
Payroll taxes and benefits	180,216	155,006
Utilities	128,569	132,015
Interest expense	41,360	36,384
Insurance	8,351	7,538
Miscellaneous expense	7,202	8,002
Licenses and fees	6,890	7,190
Repairs and maintenance	6,365	3,644
Telephone	2,411	2,399
Advertising and publications	2,254	2,060
Professional fees	2,034	2,457
Education	1,686	2,410
Vehicle expense	1,108	1,378
	$ 1,592,062	$ 1,482,807

See report of independent auditors.

Child Care Expenses

	Years Ended December 31, 2017	2016
Salaries and wages	$ 872,067	$ 810,522
Payroll taxes and benefits	199,287	180,558
Supplies	115,665	137,248
Utilities	33,621	32,206
Depreciation and amortization	24,492	22,774
Events	13,818	13,020
Insurance	8,218	5,595
Education	6,610	9,205
Vehicle expense	3,220	475
Licenses and fees	2,295	1,886
Repairs and maintenance	1,688	2,404
Advertising and publications	1,595	12,496
Miscellaneous expense	1,389	-
Contract labor	1,300	750
Travel	1,188	2,340
	$ 1,286,453	$ 1,231,479

Other Program Expenses

	Years Ended December 31, 2017	2016
Program expenditures	$ 16,285	$ 12,068
	$ 16,285	$ 12,068

General and Administrative Expenses

	Years Ended December 31, 2017	2016
Salaries and wages	$ 897,926	$ 851,975
Miscellaneous expense	159,944	105,179
Contract labor	152,596	169,196
Payroll taxes and benefits	145,911	142,747
Professional fees	128,218	119,133
Supplies	119,282	117,225
Licenses and fees	87,664	85,153
Repairs and maintenance	73,285	66,834
Insurance	60,390	60,200
Telephone	58,461	58,183
Depreciation and amortization	57,803	59,450
Property taxes	50,078	51,940
Board expense	38,154	24,754
Education	33,273	36,059
Advertising and publications	25,798	20,856
Interest expense	25,036	26,629
Utilities	13,275	13,408
Postage	10,391	10,101
Public relations	4,343	6,022
State and local taxes	3,087	1,144
	$ 2,144,915	$ 2,026,188

Fundraising Expenses

	Years Ended December 31, 2017	2016
Salaries and wages	$ 12,899	$ 43,126
Contract labor	7,226	-
Depreciation and amortization	2,554	2,554
Payroll taxes and benefits	2,138	5,591
Supplies	1,350	2,357
Events	64	728
Advertising and publications	-	366
Miscellaneous expense	-	164
Education	-	75
	$ 26,231	$ 54,961


MOSSADAMS

Date: Aug 13, 2020
Time: 14:33:57 EDT
User: Shannon Ellerton

Josephine Caring Community
Net Operating Income-By Segment
7/1/2020 to 7/31/2020

Facility # 4114302

Include Adjustment Periods: NO **Include Closing Periods:** NO

	CURRENT PERIOD Actual $	YEAR TO DATE Actual $
Skilled Nursing Segment		
SNF Revenues	**1,303,795**	**9,576,404**
SNF Expenses	**(1,262,969)**	**(8,697,265)**
TOTAL Skilled Nursing Segment	**40,826**	**879,139**
The Suites Segment		
The Suites Revenue	**179,290**	**1,300,898**
The Suites Expenses	**(136,615)**	**(958,214)**
TOTAL The Suites Segment	**42,674**	**342,684**
Home Health Segment		
Home Health Revenue	**5,263**	**38,434**
Home Health Expense	**(27,854)**	**(150,273)**
TOTAL Home Health Segment	**(22,592)**	**(111,839)**
Josie's Learning Center Segment		
Josie's Learning Center Revenue	**55,420**	**557,857**
Josie's Learning Center Expense	**(67,114)**	**(535,404)**
TOTAL Josie's Learning Center Segment	**(11,694)**	**22,453**
Other Operating Income(Loss)	**99,486**	**109,145**
Total Net Operating Income(Loss)	148,701	1,241,582
Interest Expense		
SNF Interest Expense	**(3,560)**	**(32,566)**
Suites Interest Expense	**(2,281)**	**(20,861)**
TOTAL Interest Expense	**(5,841)**	**(53,427)**
Depreciation Expense		
Depreciation-SNF	**(38,894)**	**(277,525)**
Depreciation-The Suites	**(14,280)**	**(100,922)**
Depreciation-Home Health	**(294)**	**(2,060)**
Depreciation-Josie's Learning Center	**(1,748)**	**(12,237)**
TOTAL Depreciation Expense	**(55,216)**	**(392,745)**
Other Rev/Exp-Covid Summary		
OthInc/Exp-Covid Worked	(105,393)	(444,775)
OthInc/Exp-Covid Leave	(11,172)	(208,576)
OthInc/Exp-Covid Expenses	(38,146)	(122,021)
TOTAL Other Rev/Exp-Covid Summary	**(154,712)**	**(775,373)**
Other Income(Expense)	**545,428**	**1,142,906**
Increase(Decrease) in Net Assets	478,360	1,162,944

Exhibit 14

Staff In-Service Training Plan

In-service Training ACHC Direct Caregivers

Topics

- ✓ Cultural Awareness
- ✓ Emergency/Disaster
- ✓ How to handle complaints/grievances
- ✓ HIPPA
- ✓ Infection Control
- ✓ Communication Barriers
- ✓ Workplace/Patient safety (OSHA)
- ✓ Patient rights/responsibilities
- ✓ Corporate Compliance
- ✓ Ethics
- ✓ TB/Blood borne Pathogens
- ✓ Medical Device Act

INSTRUCTIONS FOR COMPLETION:

1. This training packet will be completed on hire and annually for all direct care employees.
2. The employee will read the materials included and complete the post test.
3. An office employee will grade the test and determine that the employee has successfully comprehended the information by at least a 75% passing score on the test.
4. The training certificate will be completed and the post-test along with the certificate will be placed in the personnel file.

Cultural Awareness

Cultural Diversity History

First introduced in 2000 by the Department of Health and Human Services' Office of Minority Health, and then updated in 2010, the National Standards for Culturally and Linguistically Appropriate Services in Health Care work to increase cultural competence in the health care industry. Among these standards is a cultural diversity training recommendation. Since then, a number of federal agencies, including the Joint Commission on Accreditation of Health Care Organizations and the Centers for Medicare and Medicaid Services, have adopted the national standards and require health care professionals to receive cultural competence training.

Workforce Diversity Training

- Internal training focuses on the beliefs, attitudes and expectations of a culturally diverse workforce. The emphasis is on teamwork, developing good interpersonal relationships and maintaining effective work performance.
- Cultural diversity is essential to maintaining a balanced organization. In global organizations whose operations include business dealings and affiliations in other countries, understanding cultural differences is key to successful business partnerships.
- Employees should be aware of the importance of respecting the cultural differences of others, and employers can offer training to increase awareness and to better equip employees to function in a diverse workplace.

Importance of Cultural Diversity

- Recognizing and respecting cultural differences in the workplace is essential to a company’s organizational structure and the health of its human resources.
- Companies with employees of culturally diverse backgrounds recognize the benefits of having people with different perspectives, problem-solving skills and creativity.
- Many companies benefit from multilingual employees.
- Training is key to helping employees with different backgrounds understand and respect each other's differences so they learn to collaborate and achieve the company's goals.

Common Diversity Issues

- It is not uncommon for companies to hire employees of various nationalities and ethnic groups.
- Issues such as differences in pay or differing treatment of employees because of cultural differences could be perceived as discrimination.
- By emphasizing awareness of and promoting sensitivity to cultural issues, employers can show they recognize the contributions and value of all workers.

Importance of Cultural Competence

- Cultural competence relates to the quality of the day-to-day interactions and relationships between health care providers and patients.
- Unlike workforce diversity training, which affects patients indirectly, cultural competence affects patients directly.
- For example, the quality of patient interactions, including communication, determines how well or whether a patient is able to communicate symptoms, follow instructions and participate in his care. It also affects whether a patient feels respected or disrespected, as both an individual and a member of a cultural group.

Cultural Competence Training

- Working with a diverse patient population requires ongoing training that provides workers with specific knowledge, abilities and skills.
- For example, health care workers must understand common cultural barriers to preventing and treating conditions or disease.
- When interacting with patients, an ability to ask questions tactfully and respectfully and negotiate between a patient's cultural interpretation of a condition or disease and treatment expectations and options is crucial to good patient care.
- Practical skills such as using a telephone or working with an interpreter are also important.

Employee Relations

- The lack of cultural diversity or the perception of disrespect for other cultures can be detrimental to partnerships.
- Organizational leaders can benefit from understanding the differences in the way operations at other organizations are structured.
- Cultural differences are not limited to ethnicity and race relations; they extend to areas of religious views, sexuality and even differences in geographical differences pertaining to the location of one's upbringing.
- Consideration should be given to each of these areas when evaluating the organizational balance.
- Managers should demonstrate sensitivity to employees who express concern regarding the ability to interact with others in the group.
- In some cases, communication may be hindered due to cultural differences.
- Moving past these barriers requires training and sensitivity to the differences of the employees and ensuring that other employees recognize this importance as well.

Prevention and Education

- A complete understanding of cultural diversity is imperative for successful business operations.
- Mandatory diversity training for managers should be incorporated as part of a developmental learning process to ensure managers can effectively deal with diversity issues.
- By staying abreast of federal guidelines governing employment discrimination and the importance of cultural diversity and employment practices, managers become equipped on how to handle conflicts in the organization that may stem from these differences.
- Managers with an understanding of the importance of cultural diversity also can key in on employee relations and retention.

Workplace Discrimination Laws

- A company's leaders are charged with ensuring compliance with federal laws that govern the equal treatment of employees regardless of race, ethnicity, religious views and many other individual traits.
- When employees believe they are treated differently because of their individualism, this perception could lead to legal trouble for the company.
- The U.S. Equal Employment Opportunity Commission prohibits companies from discriminating against employees for any reason.
- Allegations of discrimination in the workplace, if proved, could result in financial penalties for the company.
- The EEOC website provides information about employment laws and ways to avoid discrimination for both employers and employees. www.eeoc.gov.

Customer Service

- Cultural diversity training and education is important to support the customer service efforts of an organization.
- Providing quality customer service across many cultures requires a solid understanding of what different cultures consider appropriate behavior.
- Diversity training will help businesses understand what barriers are affecting key customer relationships as well as improve communication between employees and their clients.

Tips on Culture Diversity in the Workplace

- Attempts at cultural diversity in the workplace have been met with mixed reviews, according to AdminSecret.com.
- To a small business owner, diversification may mean hiring only a handful of workers from different cultural backgrounds.
- However, due to the highly interdependent nature of the small-business work force, it is critical that diversity is implemented successfully.

Learn to Communicate

- You may need to communicate differently with workers from other cultures.
- For example, some cultures do not openly praise workers in front of others, preferring that it be done in private.
- You may need to read and study about the differences in your worker home culture to build trust and avoid offending them.

Train Frequently

- To ensure that workers fully understand policies and procedures, you may need to spend additional time on training and orientation so that there are no ambiguities.
- For example, you may need to spend extra time covering areas such as sexual harassment or general behavior so employees are clear as to how you expect them to act.
- If you have a dress code, you may also need to clarify what attire is appropriate.
- Cultural diversity training can help employees improve their performance by creating a workplace free of judgments and stereotypes. Although employees may have certain opinions about their co-workers, diversity training will help employees recognize the behaviors that could possibly create a hostile or uncomfortable work environment.
- Educational activities about cultural variations also provide employees with a level of understanding about other cultures they may not have had before.

Orient Current Workers

- You may also need to spend some time getting your current workers to accept a more diverse work force.
- This may include sensitivity or diversity training that allows employees to understand the difficulties people from different cultures may have in adapting.
- You should also attempt to identify any issues your current workers may have with the implementation of a multicultural work force.

Assign Mentors

- Some of your workers may have an easier time and will be more receptive to adapting to a diverse work culture than others.
- These individuals could fill a valuable role as mentors.
- Pair them with workers from different cultures to provide training and help with assimilation into the work environment.
- Finding common ground in an environment rich with varying opinions and perspectives can be challenging to some employees.
- Education initiatives that teach employees how to succeed and perform optimally across a multi-cultural workforce can directly support diversity efforts in the workplace.
- Diversity education encourages thoughtfulness and consideration between co-workers of different nationalities and backgrounds.

Leadership Role

- The business owner and managers, bear the ultimate responsibility for developing a more diverse work culture.
- If they show strong leadership during this adjustment period by demonstrating commitment to diversity and including everyone in the process, the chances of attaining success in diversification are likely to increase.
- Supervisors are in a position where they have to manage the diverse perspectives of workers and customers.
- Managers are obligated to treat their people equally, but sometimes fall short of communicating effectively with individuals from diverse backgrounds or experiences.
- Training that focuses on managing a diverse workforce will help supervisors connect with all team members and include every worker in the activities that support the agency's bottom line.

Examples of Cultural Differences in the Workplace

- Workplace diversity trainers often mention that there are more similarities among employees than there are differences; however, despite the many common attributes employees share, there still exist cultural differences.
- Culture is defined as a set of values, practices, traditions or beliefs a group shares, whether due to age, race or ethnicity, religion or gender.

- Other factors that contribute to workplace diversity and cultural differences in the workplace are differences attributable to work styles, education or disability.

Generations

- There are cultural differences attributable to employees' generations.
- A diverse workplace includes employees considered traditionalists, baby boomers, Generation X, Generation Y and Millennials.
- Each generation has distinct characteristics.
- For example, employees considered baby boomers tend to link their personal identity to their profession or the kind of work they do. Baby boomers are also characterized as being committed, yet unafraid of changing employers when there's an opportunity for career growth and advancement. Employees considered belonging to Generation Y, on the other hand, also value professional development, but they are tech-savvy, accustomed to diversity and value flexibility in working conditions.

Education

- Differences exist between employees who equate academic credentials with success and employees whose vocational and on-the-job training enabled their career progression.
- The cultural differences between these two groups may be a source of conflict in some workplace issues when there's disagreement about theory versus practice in achieving organizational goals.
- For instance, an employee who believes that a college degree prepared him for managing the processes and techniques of employees in the skilled trades may not be as effective as he thinks when compared to employees with years of practical knowledge and experience.

Personal Background

- Where an employee lives or has lived can contribute to cultural differences in the workplace.
- Many people would agree that there is a distinct difference between the employee from a small town and the employee from a large metropolis. New York, for example, is known for its fast pace and the hectic speed of business transactions. Conversely, an employee from a small, Southern town may not approach her job duties with the same haste as someone who is employed by the same company from a large city where there's a sense of urgency attached to every job task.

Ethnicity

- Ethnicity or national origin are often examples of cultural differences in the workplace, particularly where communication, language barriers or the manner in which business is conducted are obviously different.
- Affinity groups have gained popularity in large organizations or professional associations, such as the Hispanic Chamber of Commerce or in-house groups whose members are underrepresented ethnicities, such as the Chinese Culture Network at Eli Lilly. The pharmaceutical conglomerate organizes affinity groups to bridge cultural differences and establish productive working relationships within the workplace and throughout its global locations. In his article "Winning with Diversity," author Jason Forsythe explains that Eli Lilly's many affinity groups are necessary: "Because the company currently markets products in 156 countries and has affiliates in many of them, multicultural competency is a priority."

How to Resolve Cultural Communications in the Workplace

- Differences in race, sex, religious beliefs, lifestyle and sexual orientation are among many cultural differences that may affect how people communicate in the workplace.
- Resolving communications problems caused by cultural differences requires patience, understanding and respect.
- A major mistake is forming opinions before even engaging in communications.
- Opinions reached before an opportunity to discuss the matter makes resolving conflict difficult.

Respect

- Treating people as individuals regardless of culture is sometimes a key to resolving communication issues.
- For example, it is improper to assume that a woman takes a certain position on a subject because she is a woman. Such generalizations can cause conflict in communication.
- Not all people who are members of the same culture will react to communication in the same way or offer the same opinion on a subject.
- However, it is true that cultural backgrounds may affect how people act, behave and communicate.
- But that does not mean people of a certain culture will all communicate or react to events in the same way.

Knowledge

- Learning more about other lifestyles and cultures helps people avoid conflict in communication, particularly in multicultural settings. Information on cultural awareness is widely available in books at public libraries.
- Open and honest discussions about cultural differences with friends and colleagues are helpful as well.
- Learning more about cultural differences helps avoid jumping to unfair or wrong assumptions about a person's statements or other communication efforts.

Blame

- Conflict in communications between cultures also is avoidable when all parties resist assigning blame.
- Two companies merging staffs in a business transaction may have different styles of managing and working. Putting the teams together can cause an immediate clash of cultures, with problems intensified if both sides always blames the other for problems and breakdown in communication.
- Simply placing the blame on others is not constructive and can make communication problems worse.

Listening Skills

- Focusing on listening well with an open mind also helps resolve cultural communications problems.
- Paying close attention to words used in a conversation or other form of communication can help resolve these problems.
- It's also important to pay attention to the context of the discussion and the tone of the communication.

Cultural Diversity Policy

- The Agency will provide care to patients and families regardless of their cultural background and beliefs.
- Cultural considerations for all patients/clients shall be respected and observed. Where such considerations impede the provision of prescribed health care or treatment, personnel shall notify the supervisor and physician in an effort to accommodate the patient/client.

- Different cultural backgrounds, beliefs and religions impact the patient's lifestyles, habits, and view of health and healing. Employees must be able to identify differences in their own beliefs and the patient's beliefs and find ways to support the patient.
- Upon admission, staff will identify the patient's individual beliefs based on their cultural background and develop the plan of care accordingly.
- The Agency will not assign personnel unwilling to comply with the Agency's policy, due to cultural values or religious beliefs, to situations where their actions may be in conflict with the prescribed treatment or the needs of the patient.
- Cultural diversity training will be completed for all employees at time of orientation and annually thereafter.

Emergency/Disaster

The Emergency/Disaster Plan provides an orderly procedure to be implemented in an emergency to assure that the health care needs of patients continue to be met. The plan comprehensively describes its approach to a disaster. The Agency must maintain documentation of compliance with emergency preparedness. The Agency is not required to physically evacuate or transport a patient in the event of an emergency. All employees shall be oriented to the plan and their responsibilities in carrying out the plan. Possible emergency or risk factors will be identified for each patient and appropriate emergency plans discussed with the patient and/or the responsible person at the time of admission as indicated. The name and telephone number of an emergency contact will be obtained by the Agency.

The Agency has taken the following actions to develop, maintain and implement an Emergency Preparedness and Response Plan as follows:

1. The Agency must involve the Administrator, Director of Nursing, if applicable, and, based on the Agency's organizational chart, other Agency leaders designated by the Administrator.

2. The Administrator of the Agency is designated as the Agency's disaster coordinator. In his/her absence, the Alternate Administrator is designated as the alternate disaster coordinator.

3. The Agency has a continuity of operations business plan to address emergency financial needs, essential functions for the patient services, critical personnel and how to return to normal operations as quickly as possible.

4. The Agency has a risk assessment to identify the potential disasters from natural and man-made causes most likely to occur in the Agency's service area.

5. The Agency has determined the actions and responsibilities for Agency staff in each phase of emergency planning, including mitigation, preparedness, response, and recovery. The response and recovery phases include actions and responsibilities when warning of an emergency is not provided.

6. The Agency has a plan to monitor disaster-related news and information including after hours, weekends, and holidays, to receive warnings of imminent and occurring disasters.

7. The Agency has implemented the following for the response and recovery phases of the Plan:

    a. The Agency Administrator is responsible for initiating each phase of the Plan. In his/her absence the office manager is responsible.

    b. The Agency has procedures for communicating with staff, patients or responsible representative, local, state and Federal emergency management agencies and other entities as applicable including:

        i. Emergency medical services.

        ii. State regulatory departments.

        iii. Other healthcare providers and suppliers.

        iv. Primary and alternate modes of communication or alert systems in the event of telephone or power failure.

8. The patient is provided with the following:

    a. A copy of the Agency's policy on how to handle disaster related emergencies in the home.

    b. Patient responsibilities in the Agency's Emergency Preparedness and Response Plan.

    c. A list of community disaster resources that can assist during a disaster-related emergency.

    d. Survival tips and plans for evacuation and sheltering in place.

9. The patients are categorized into groups determined by the need for continuity of services, the acuity level of the patient, and the availability of someone to assume responsibility for the patient's Emergency Response Plan if needed by the patient.

10. The Agency has identified patients who may need evacuation assistance from local or state jurisdictions and can readily access recorded information about a patient's triage category in the event of an emergency to coordinate and communicate as required.

11. All employees including contractors are oriented about their responsibilities in the Agency's Emergency Preparedness and Response Plan on hire and the plan is reviewed at least annually with an emergency drill performed.

12. The Agency reviews its Disaster Plan as needed and after every response, but at least yearly through its Professional Advisory Committee. The Agency discusses the plan and the procedures for communicating with staff.

13. The Agency will follow the emergency requirements during a disaster and will document in the Agency's records attempts of staff to follow procedures in the event they are unable to comply with any of the requirements.

14. The Agency will present its best efforts to provide care to patients in emergency situations. However, if the Agency is unable to comply with situations beyond its control making it impossible to provide services, such as when roads are impassable or when a patient relocated to a place unknown to the Agency, the Agency is not required to continue to provide care.

Our community is vulnerable to a wide range of emergencies, including natural, technological, and man-made disasters, all of which threaten the life, health and safety of its people; damage and destroy property; disrupt services and everyday business and recreational activities; and impede economic growth and development. This vulnerability is exacerbated by the state's growth and population, especially the growth in the elderly population, in the number of seasonal vacationers, and in the number with persons of special needs.

State policy for responding to disasters is to support local emergency response efforts

1. To reduce the vulnerability of the people and the property of this state to damage, injury, and loss of life and property.

2. To prepare for prompt and efficient rescue, care and treatment of threatened or affected persons.

3. To provide for the rapid and orderly rehabilitations of persons, and for the restoration of services and properties.

4. To provide for the coordination of activities relating to emergency preparedness with public and private agencies in the community.

5. A comprehensive emergency plan is prepared, reviewed annually and revised as necessary.

Emergencies:

1. Any occurrence, or threat thereof which results or may result in substantial injury or harm to the population, or substantial damage to or loss of property.

2. In the event of an emergency that disrupts the Agency's ability to provide care, needs shall be prioritized to determine those which are the greatest. Patients will continue to receive care, if possible, with minimal disruption of schedule. Patients will be instructed in emergency measures if nursing availability is limited.

3. If an emergency occurs, either within the Agency causing staffing limitation (such as labor disputes, staff illnesses) or within the environment (such as floods, hurricanes, fires or other natural disasters), the Director of Nursing or designee will be responsible for reviewing patients and prioritizing them. When the demand for personnel exceeds available resources, the following factors should be considered in deciding priorities with the safety of the patient being the first priority:

    a. Availability of appropriate alternative coverage (family, friends, etc.) for the hours of service in question. A patient who has no other appropriate person to assist should receive a higher priority that those with appropriate alternatives.

    b. Level of priority of the patient's medical and nursing needs. Those patients whose medical and nursing needs are more acute should receive higher priority than those with less acute needs.

    c. Usual number of personnel hours that the patient routinely receives from nursing services. Those patients receiving a greater number of personnel hours should receive a higher priority than those receiving less.

    d. If an emergency occurs, either within the Agency causing staffing limitation (such as labor disputes, staff illnesses) or within the environment (such as floods, blizzards, hurricanes, fires or other natural disasters), the DON or his/her designee will be responsible for reviewing patients and prioritizing them according to the following classifications:

Class I Emergency:

When the patient has a condition which is potentially life threatening, requires ongoing medical treatment, or requires assistance of a medical device to sustain life (i.e., there is a potential wide spread power black-out and the patient is on ventilator), the home environment and support system will be reviewed. When appropriate, arrangements for evacuation to an acute care facility will be made. These patients will be seen immediately. The Agency will obtain assistance from emergency personnel as necessary. (Examples: Oxygen, Multiple Assistive Devices, Infusion)

Class II Emergency:

The patient has in-home support that may be mobilized in the event of disaster. The family is responsible for evacuation and care of patient. Patients with the greatest need for care will be seen as soon as possible by available staff. Patients requiring daily insulin injections, IV medications, sterile wound care of a wound with a large amount of drainage.

Class III Emergency:

Services could be postponed 24-48 hours without adverse effects on the patient. (Examples: a new, insulin dependent diabetic able to self-inject, patient under cardiovascular and/or respiratory assessment, and a patient that requires sterile wound care to a wound with minimal amount or no drainage.)

Class IV Emergency:

The patient has maximum in home support through the family structure. The family is totally responsible for the care and transfer. Services could be postponed 72-96 hours without adverse effect on the patient (Examples: a postoperative patient with no open wound, a patient who is anticipated to be discharged within the next 10-14 days, a patient who requires routine catheter changes.)

1. In the event evacuation of the patient is required, the local authority responsible for coordinating disaster preparedness and emergency response will be contacted. The Agency is not responsible for evacuating patients.

2. If some patient visits cannot be made and it is not a life threatening situation, contact will be maintained by phone if possible. If office phone service is disrupted, phones will be turned over to the answering service, if possible. A staff member will be assigned to remain in contact with the answering service to receive and send messages.

TYPES OF EMERGENCIES

Man-Made Emergencies:

Those that are caused by acts against persons or society, including but not limited to enemy attack, sabotage, terrorism, civil unrest and bio-terrorism.

Natural Emergencies:

Those that are caused by natural events, including but not limited to winter storms, hurricane, flood, mudslides, severe wave action, drought and earthquakes.

Technological Emergencies:

Those caused by a technological failure or accident, including but not limited to explosions, transportation accidents, radiological accidents, chemical and/or other hazardous materials incident.

STAFF EMERGENCY PREPAREDNESS PLAN

Know your Agency's Emergency Preparedness Plan:

1. Know who to report to and procedures to follow.
2. Be prepared to assume tasks/roles out of your ordinary job description.
3. Ensure credentials are up to date and with you.
4. Know how supplies will be procured for patients.
5. Know the Agency's communication procedures.

Have the automobile equipped:

1. A full tank of gas.
2. A shovel.
3. Blankets.
4. Portable battery operated or crank flashlight.
5. Portable battery operated or crank radio.
6. A list of gas stations with emergency/backup power.
7. A cell phone charger.
8. Booster cable.
9. A tire repair kit.
10. Bottled water and non-perishable high energy foods, such as granola bars, raisins and peanut butter.
11. Fire extinguisher (5 lbs.; "A-B-C" type).
12. Flares.

Have alternative communication devices available for use:

1. Charged cell phone.
2. Portable phone.
3. CB Radio (hand held).
4. Satellite phone.

Establish a family preparedness:

1. Escape routes.
2. Evacuation plan.

3. Have a family communication plan.
4. Have a point of contact that is out-of-town.
5. A plan for pets.
6. For a laptop computer have a converter that plugs into the cigarette lighter.

DAMAGE OF WRITTEN RECORDS

1. If written records are damaged during a disaster, the Agency must not reproduce or recreate patient records except from existing electronic records. Records reproduced from existing electric record must include:

    a. The date the record was reproduced.

    b. The Agency staff member who reproduced the record.

    c. How the original record was damaged.

2. The Agency is responsible to notify the State licensing unit, by fax or email, no later than five working days after any of the following temporary changes resulting from the effects of an emergency or disaster:

    a. Temporary relocating address including date of temporary relocation.

    b. License number, physical address and phone number.

    c. Date the Agency plans to returns to its permanent location.

3. If the Agency is temporarily expanding its service area to assist in the emergency, the state should be notified of:

    a. License number, and revised boundaries of the original service area.

    b. Date of temporary expansion.

    c. Date temporary expansion of the service area ends.

Handling Complaints and Grievances

Definition

A grievance is a concern relating to patient care conditions or to relationships between a patient and the Agency or a caregiver in which the patient believes that he/she has been wronged and wants the wrong corrected. It is regarding problem areas in the delivery of care which appear to threaten the health and well-being of the patient.

Policy

All patients will be informed of their right to voice a complaint/grievance against anyone furnishing services on behalf of the Agency.

All patients will receive verbally and in writing the Agency's process for receiving, investigating and resolving complaints.

All patients receive the state regulatory hotline number, ACHC's telephone number as well as the appropriate person/department within the Agency to contact regarding a complaint/grievance regarding services furnished by the Agency and/or concerns regarding the implementation of Advance Directive requirements.

The Agency will investigate any complaint made by patient or patient's family or guardian regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the Agency. Both the existence of the complaint and the resolution of the complaint will be documented.

A summary of grievances, complaints and concerns will be reported to the Governing Body quarterly.

Patient grievances, complaints and concerns will be included in the (PI) annual report.

Agency staff will be educated on patient grievance policies at orientation and annually thereafter.

All complaints/grievances are retained for a minimum of three years.

Procedure

1. When a patient is admitted to the Agency, he/she is to be given an admission packet that includes a copy of the Agency Bill of Patient Rights and Responsibilities. This policy indicates that grievances are to be filed with the Agency Administrator. The fact that the policy was given to the patient is to be recorded in the clinical record.

2. All grievances and concerns are to be dealt with by the Administrator or his/her designee.

3. Any employee receiving a complaint/grievance will complete and submit a report to the Administrator. If the complaint is received after business hours, the supervisor on call will be notified and the complaint form will be submitted the next business day.

4. When a grievance is received, whether written or verbal, it is to be documented in the patient's clinical record by the Administrator or his/her designee. It is also to be noted in a log kept by the Administrator.

5. The resolution of the problem is also to be documented in the same manner.

6. Each written grievance received is to be responded to in writing by the Agency within ten (10) days.

7. Grievance received after hours, on weekends and holidays and whenever the office is closed are handled on the next business day.

8. Each written or verbal grievance received is to be responded to in writing by the Administrator within ten (10) days. This information is reviewed by the Administrator and a complaint form is completed by the Administrator. Each person involved is interviewed by the Administrator who then evaluates all collected information.

9. After thorough evaluation, The Administrator makes a determination and formulates a decision notifying all persons involved. All information regarding activities, investigation, analysis, resolution and outcomes are documented in the Administrator's log and in the patient's chart.

10. The response is to explain the decision rendered by the Agency and it is to notify the patient of his/her right to appeal.

11. A copy of the outcome is to be filed in the clinical record and noted in the Administrator's log.

12. If the patient files an appeal, it is to be reviewed and responded to by a member of the Governing Body within thirty (30) days of its receipt by the Agency.

13. The response to the appeal is to be filed in the patient's clinical record and noted in the Administrator's log.

Staff Rights

All employees have rights and are entitled to fair, consistent and professional treatment including but not limited to the following:

1. Staff may request a change in assignment because of a personality conflict.

2. Staff may complain without fear of repercussion.

3. Staff has the right to special consideration to accommodate personal requests arising from cultural or religious practices provided the Agency can cover the needs of the patient/clients.

4. Staff has a right to be treated in accordance with the Agency mission and vision.

5. Staff is to receive information in a timely manner.

6. Staff is entitled to a workplace free from solicitation and distribution of unsolicited material.

Grievance Procedures

1. Any person(s) who believes that he/she or any class of individuals has been subject to discrimination may file a complaint pursuant to procedures set forth below, on behalf of him or herself another person or handicapped persons as a class. Filing of a complaint will not subject employees to any form of adverse action, reprimand, retaliation or otherwise negative treatment by the Agency.

2. Accordingly, the Agency has adopted an internal grievance procedure providing for the prompt and equitable resolution of complaints alleging any action prohibited by the United States department of Health and Human Services regulation 45 CFR part 84, 29 USC 794. The law and

regulations may be examined in the office of the Director of Nursing who has been designated to coordinate the efforts of the agency to comply with the regulation.

3. Complaint processing procedures are as follows:

    a. All complaints involving matters prohibited shall first be filed with the Director, who shall render an initial resolution within seven days of receipt of the complaint.

    b. If the complaint is not satisfied with the results achieved in step ‘a,’ the complainant may file an appeal with the President/CEO, who shall render a decision within five days.

    c. A complaint should be in writing, contain the name and address of the person filing it and briefly describe the action(s) alleged to be prohibited.

    d. All complaints should be filed as set forth above within three days after the complaining party becomes aware of the action(s) allegedly prohibited by the regulations.

    e. All complaints should also be referred to the office of the Coordinator, who shall maintain the files and records of the Agency relating to complaints filed hereunder. The Coordinator may assist persons with the preparation and filling of complaints, participate in the investigation of complaints and advise the President/CEO concerning their resolution.

    f. The President/CEO, or his designee, shall take steps to insure an appropriate investigation of each complaint to determine its validity. These rules contemplate informal but thorough investigations, affording all interested persons and their representatives, if any, an opportunity to submit evidence relevant to the complaint. The right of a person to prompt and equitable resolution of the complaint filed hereunder shall not be impaired by the person's pursuit of other remedies such as the filing of a Complaint with the Office for Civil Rights of the United States Department of Health and Human services. Utilization of this grievance procedure is not a prerequisite to the pursuit of other remedies.

4. These rules shall be liberally construed to protect the substantial rights of interested persons, to meet appropriate due process standards and to assure Agency compliance with regulations.

COMPLAINT FORM

Date the complaint was received: _____

Name of patient: _____

Name of person filing the complaint if not the patient:_____

Relationship to the patient: _____

Name/title of who received the initial complaint:_____
Date: _____

Was the complaint logged? ❑ Yes ❑ No

Description of the complaint:_____

_____

_____

_____

_____

Resolution of the compliant (action taken):_____

_____

_____

Follow up needed:_____

_____

Was the person making the complaint satisfied with the resolution and/or action plan?
❑ Yes ❑ No

If no what follow up was implemented?_____

I have reviewed and ensured the implementation related to this complaint including any follow up needed that is needed.

Signature and title_____

Date_____

HIPAA

Purpose/Goals:

This learning module is designed to provide practicing nurses with the nuts and bolts about the requirements of the Health Insurance Portability and Accountability Act (HIPAA) particularly as it relates to patient privacy. HIPAA also contains legislation aimed at reducing health care related administrative costs, eliminating pre-existing clauses and waiting periods for individuals changing insurance coverage, and increasing access to insurance for individual purchasers. Strict guidelines for maintaining privacy, confidentiality, and security of health information are also part of HIPAA legislation. The implications HIPAA has for researchers are also discussed.

Objectives:

Upon completion of this module, the learner will be able to complete the following objectives:

1. Explain the components of the HIPAA legislation.
2. Discuss how HIPAA expands availability of health care coverage.
3. Describe who is affected by the privacy and confidentiality requirements.
4. Explain what is meant by protected health information (PHI) and individually identifiable health information (IIHI).
5. Describe processes that must be used to assure patient information is kept confidential and secure.
6. Describe how HIPAA influences informed consent and the use of patient data for research.

Introduction:

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), also known as "Kennedy-Kassebaum", passed congress rapidly and with great bipartisan support in 1996. Many aspects of the legislation have been implemented in the ensuing years; the deadline for full implementation of the privacy and confidentiality requirements was April 14, 2003. Health care providers and organizations have strict guidelines that must be followed to remain within the law. While this module and most of our attention now is focused on the provisions of the legislation that deal with privacy, confidentiality, and security of patient records, HIPAA also contains other requirements that have an impact on employers, insurance companies, and purchasers of health insurance coverage.

HIPAA was designed to address public concerns about managed care, insurance availability, and insurance affordability. For example, HIPAA prohibits insurance companies from denying coverage because of:

1. preexisting conditions,
2. a family member's health status, or
3. whether or not an individual has been covered under a group policy and is seeking a personal health insurance policy.

Further, HIPAA ensures immediate coverage without regard to pre-existing conditions for individuals who change jobs and insurance carriers. HIPAA also established a pilot program for

medical savings accounts (MSAs) that allows individuals to create a “health insurance individual account” to purchase health services and retain unspent funds rather than paying monthly premiums. Further, to encourage the purchase of long-term care insurance, HIPAA allows employers to deduct premiums and most benefits are tax-free to the beneficiary. Additionally, to facilitate purchase of health insurance by self- employed persons, the law allows 80% of the annual premiums to be tax- deductible by 2006. While many health policy analysts agree that these provisions have little impact on reducing the number of uninsured, they do, however, think these efforts are worthwhile. At this time, however, attention to HIPAA is riveted on implementing and paying for the privacy, confidentiality, and security aspects of the legislation (DiBenedetto, 2003).

In 1996, HIPAA was viewed as a way to reduce administrative costs, provide better access to health information, reduce fraud, and guaranty privacy of health information. However, the American Hospital Association estimates that it may cost between $4 billion and $22 billion to implement the tenets of the law. A search of the literature failed to produce specifics regarding cost; however, according to Gue and Upham (2004), the majority of costs are associated with developing and implementing software that integrates providers, payers, and governmental agencies.

As part of the HIPAA rule promulgation, the Centers for Medicare and Medicaid Services CMS mandated standardization of transaction and code sets (TSC) to reduce duplication, confusion, and non-compliance. CMS standards rely on use of ICD-9 codes for disease classification, CPT codes for procedures, and national drug codes (NDC) for medications. CMS admits that problems with these coding sets exist; new ICD-10-CM and ICD-10-PCS are thought to reduce the ambiguity and facilitate full implementation of electronic processing. The industry is working toward integrating HIPAA fully, it is just taking longer than they hoped to get the electronic interfaces coordinated (Gue and Upham 2004).

HIPAA is just the beginning of the ultimate conversion of healthcare information into an electronic health record (EHR). The Bush administration projects it will cost $100 million a year for 10 years primarily to fund demonstration projects and trial programs aimed at achieving four major goals:

1. establish routine use of EHRs in clinical practice,
2. connect health care workers in information exchange for clinical decision making,
3. enhance patients’ ability to choose providers based on quality, and
4. integrate public health surveillance systems into an interoperable network to support new research and better care (Scott 2004, p. 34).

The Basics

HIPAA contains provisions for both privacy and security. Privacy rules have been promulgated and compliance was required by most health plans by April

14, 2003; plans with less than $5 million in annual receipts had until April 14,

2004 to fully comply. These rules have gone through several iterations, some as recently as March 2003 and refinements continue. Security rules that detail further requirements for the health care industry and patients were issued in October 2004.

A key factor for all health care providers and organizations to keep in mind is that, while HIPAA rules are strict, if state law covering the same topic is more stringent, the state law must be followed (Herrin, 2003). Health providers are well advised not to overlook state law as they accommodate HIPAA. Providers and organizations must remain up-to-date with both HIPAA and state law changes.

The intent of HIPAA is to protect patients from unauthorized or inappropriate use and access to their health information. Further, the rules protect patients by giving them access to their health information so they know what has been documented about their health status. Proposed by-products of HIPAA are to improve quality of care, restore trust in the health care system, and improve the efficiency and effectiveness of information dissemination by building on existing legal frameworks. HIPAA also contains an administrative simplification section designed to improve the efficiency of health information coding to facilitate digital transfer of information between and among health care providers, payers, and health plans.

HIPAA creates safeguards so that only those people or entities having a real need to know health information will be able to access it (Calloway and Venegas 2002). The HIPAA rules complement other standards that protect patients' rights. Compliance with privacy rules promises to be a cornerstone of future JCAHO and Medicare/Medicaid surveys. Remember, compliance is mandatory, not voluntary.

WHY HIPAA IS NEEDED

Health care professionals have long realized the need to protect patients from unauthorized use of their health information; at the same time, they want to have access to needed information when treating a patient. Widespread use of electronic data is facilitating the rapid transfer of information and the Institute of Medicine has urged the creation of standards so electronic records can be available (Follansbee, 2002).

Similarly, the public is greatly concerned about the privacy of their medical records. Prior to the electronic medical record, patient information was maintained in paper form and neatly locked away, accessible only to those who had authorized access. With computerized records information can be accessed, changed, distributed, and copied with far less regard for appropriate authorization (Follansbee, 2002).

Serious breaches of record confidentiality have occurred. An employee of the Hillsborough county health department was able to carry home a disk with the names of 4000 HIV positive patients. People have purchased used computers that contained prescription records of patients; Eli Lilly recently sent out an email with the names of patients taking Prozac; the University of Montana inadvertently placed the medical records of some 62 people on the internet. Consequently, patients, health care providers, and other health care entities are very concerned about confidentiality, restoring the public trust, and protecting themselves from lawsuits.

Yet, the ability of multiple providers to access a patient's record can significantly improve the overall quality of care. Think about the chronically ill individual who receives care from more than one or two specialist providers. If each provider has access to the most recent treatment plan, it stands to reason that care will be more coordinated, efficient, and effective.

UNDERSTANDING HIPAA - WHAT IS INCLUDED IN THE LAW

HIPAA describes those affected by the law as “covered entities”. Included under this umbrella are health care providers, health plans, health care clearinghouses, and business associates.

Health care providers are defined as anyone who is paid for health care services or bills for services provided. The list is all inclusive: physicians, licensed health care providers, hospitals, outpatient physical therapists, social workers, certified nurse midwives, technicians administering X-rays done at home, home health agencies, pharmacists, providers of home dialysis supplies and equipment, nursing homes, nurses, and nurse administrators. This list means that any hospital or health facility worker who may see confidential patient information is included.

A health plan is any individual or group that pays for health care services. Included are health maintenance organizations (HMOs), insurance companies, Medicare/Medicaid, self-insured plans, employee group plans, federal plans such as CHAMPUS, military, veteran’s administration, and Indian health services.

Clearinghouses are those entities that receive health information from providers and health plans. They typically are responsible for standardizing the information to improve claims processing. Included in this group are third-party administrators, billing services, and re-pricing agencies

The **business associates** category covers a broad range of professionals and services. Included are attorneys, consultants, auditors, accountants, billing firms, data processing companies, and practice management firms. Nurses working as independent contractors, i.e., case managers, legal nurse consultants, and educators are included and subject to compliance with HIPAA law. A contract between the business associate and hiring agent must be in place before the associate can see any patient information.

WHAT HEALTH INFORMATION IS PROTECTED?

HIPAA created two new phrases to describe information protected by the legislation. The medical record is now referred to as protected health information (PHI). This includes all information that is created by any covered entity. All forms of the information are part of protected health information, i.e., paper, electronic, video tapes, photos, audiotapes, and any information that has been duplicated, discussed, read from a computer screen, or shared over the internet.

The other new HIPAA phrase is individually identifiable health information (IIHI). Included in this category is any information that could reasonably be linked to a specific patient, such as a photo, name, address, date of birth, next of kin or responsible relative, medical record identifier, social security number, driver's license number, health beneficiary, account number, employer, finger, or voice prints.

The law specifies that some information that is not individually identifiable can remain. Age that is reported as 60+ if the patient is older than 60, zip code if the patient lives within a zip code with greater than 20,000 people in it, race, gender, ethnicity, marital status, and the year only of the health care occurrence are not considered individually identifiable information and these data may be used in the aggregate.

All facilities must limit access to information only to those who have a need to know. A nurse who seeks information about a patient not under her care is violating the HIPAA rules. Similarly, health information can only be used for health purposes. Employers cannot use the information to screen candidates for hire or promotion. Financial institutions may not use it to determine lending practice. Only the patient can explicitly authorize employers, banks, and individuals to have access to his/her medical information.

HIPAA also established the "minimum necessary rule" which stipulates that only the minimum necessary information may be shared, even with the patient authorization. A classic example would involve treatment for a case of child or domestic abuse; the provider would, rather than providing an entire medical record, furnish the pertinent data furnished in the form of an abstract outlining the information that is necessary to provide treatment and protect the victim(s). The abstracted information could be provided to legal and law enforcement entities. Health providers involved in the treatment of patients are not subject to the minimum necessary rule and can have full access to all information that is needed to provide patient care. Health information that has implications for the public health and safety can be shared without consent. There are several situations where medical information can be shared: In Emergency 911 situations, when communicable diseases are involved, when law enforcement agencies participate, or if national defense or security is a factor.

The public health department is deemed a legitimate recipient of certain personal health information and providers may, in fact in some instances, must report some findings to the proper public health agency. Included are:

1. cause of death even when the patient dies at home
2. reportable communicable diseases
3. child abuse
4. reporting an adverse drug reaction to the Federal Drug Administration
5. occurrence of cancer in a state with a cancer registry
6. meningitis, and
7. immunizations for children.

These examples are thought to be important to the health of the public (Campos-Outcalt 2004).

PATIENT CONSENT AND AUTHORIZATION

HIPAA makes a distinction between informed consent and patient authorization. Patients are entitled to know exactly how an entity plans to use the information.

Informed consent is signed at the first encounter the patient has with the provider/health care facility; the consent covers treatment, payment, and other health care information. The meaning and use of the patient's consent must be carefully explained to the patient. Facilities must explicate their disclosure process in a document called Information Practices. The American Hospital Association published a sample consent and explanation document that was 10 pages long. The document explains patient rights, as well as a description of how patient information is collected and used. Facilities must decide how and when the information concerning consent is presented to patients and how patients can use their right to revoke consent. Patients must also be advised about the agency's policy that covers conditions for admission that are related to consent.

Patients may also sign authorizations. These are required when information is used by the agency for purposes outside of treatment. Agencies must assess their policies and procedures to assure that they are always using an authorization when it is needed; some agencies may not realize that information sharing policies violate the patient's right to restrict release of data (Cichon, 2002). Patients must be fully informed about the way agencies use a signed authorization and are entitled to receive a free accounting every twelve months describing how their health information has been used.

HIPAA privacy regulations also mandate specific patient rights that include the following:

1. Right to privacy notice requires disclosure and reasonable effort to assure that the patient understands the agency's policy concerning privacy of information.

2. Right to request restrictions means that patients may specify health information that cannot be released and/or, they may restrict to whom information can be released.

3. Right to access of PHI means that patients must be allowed to inspect and copy information contained in the agency's record.

4. Right to know what disclosures have been made means the agency must track all information released and be able to provide documentation to the patient.

5. Right to amend the PHI means that while patients may request amendments to the PHI and the agency must allow amendments, the agency may deny some requests.

All covered entities are required to comply with certain procedural rules. Most have had to develop new policies and procedures to address the many aspects covered under these rules. The following are some of the rules:

1. Agencies must appoint a privacy officer who will monitor and audit compliance.

2. Agencies must develop an internal compliance process that will assure no patient rights are violated, complaints are addressed and investigated, and that a process for remediation is in place.

3. Training must be provided to employees to assure that they are informed about patient rights and disclosure of information.

4. HIPAA requires that agencies document any and all violations and that sanctions parallel other disciplinary policies.

5. Agencies must have a process for mitigating any harmful effect of disclosure.

6. All forms of communication must be addressed in administrative safeguards.

7. Agencies must agree and have policies that specify no retaliation for an employee or consumer who files a complaint.

PRACTICAL IMPLICATIONS

Questions about the implications HIPAA rules have been numerous. Can an office or laboratory have a patient sign in sheet? Can you use a patient's name to call him into a treatment room? Can the patient's name be posted outside the hospital door? At this point, there is some agreement about some of these. As long as personal information regarding the patient's care or procedures to be done remain confidential, names can be outside hospital room doors, patients can be verbally called to treatment rooms, etc. New questions will undoubtedly arise in the future. Staying informed about the rules and regulations concerning HIPAA will be every health care worker's obligation.

Sign-in sheets, once disallowed, can now be used along with bedside charts as long as reasonable precautions are taken to safeguard patient information. Sign in sheets can only have the name and time; no information about the nature of the appointment can be included. The patient can give consent or may decline to have information given to family members; facility staff is not obligated to verify the identity of relatives.

HIPAA retains the rights of parents as the personal representative for minor children. There are exceptions, however. Parents may decide that the child and provider have a confidential relationship that excludes the parent from receiving information. A provider may choose to exclude the parent when abuse is suspected or when including the parent would endanger the child.

Patients have the right to restrict clergy visits and religious information. If the patient does want the clergy to visit, health care individuals should provide only the name and location of the patient. They should not provide any information about the patient's medical condition. Further, patients have the right to restrict informing callers or visitors that they are in the hospital. Most patients are asked on admission to the facility if they want such restrictions and, if they do, hospital workers may not acknowledge that a patient is in the hospital even including visitors, florists delivering flowers, etc.

Some information can be provided to law enforcement without patient consent. Emergency technicians can contact the police at a crime scene and convey nature and location of the crime. Information about a suspicious death may also be reported to the police. HIPAA has a one call rule that permits contacting an organ procurement agency following a death.

Repositories that store human tissue and fluids for future scientific analysis, i.e., genotyping, cell lines, other biotechnologies, express concern that HIPAA will fundamentally change how these commercial repositories function. At question is whether property rights continue to apply to human tissue after removal from the body. Prior to HIPAA, the Supreme Court in California ruled on the side of future research and determined that property rights end when tissue is removed from the body (Allen 2004). However, depending on how HIPAA rules are interpreted, informed consent may be required in order for research to be conducted on removed tissue.

HIPAA AND RESEARCH

Patients must sign an authorization to allow their information to be included in research projects. Information can only be disclosed in accordance with a research protocol approved by an institutional review board. All identifying individual information must be removed. One difficulty researchers may experience is the lack of specific guidance from HIPAA regarding construction of compliant, de-identified data sets, at this point researchers are developing strategies that they believe comply with the intent of privacy under HIPAA. Ongoing analysis of medical information is critical for developing strategies to improve patient outcomes and reduce medical errors (Clause, S.L.; Triller, D.M.; Bornhorst, C.P.; Hamilton, R.A.; Cosler, L.E. 2004). Information that can be used in compliance with HIPAA includes: gender, race, ethnicity marital status, dates of treatment if reported in years, age (for individuals older than 60, one must use 60+), and zip code if more than 20,000 reside in that zip code (Erlen, J.A. 2004)

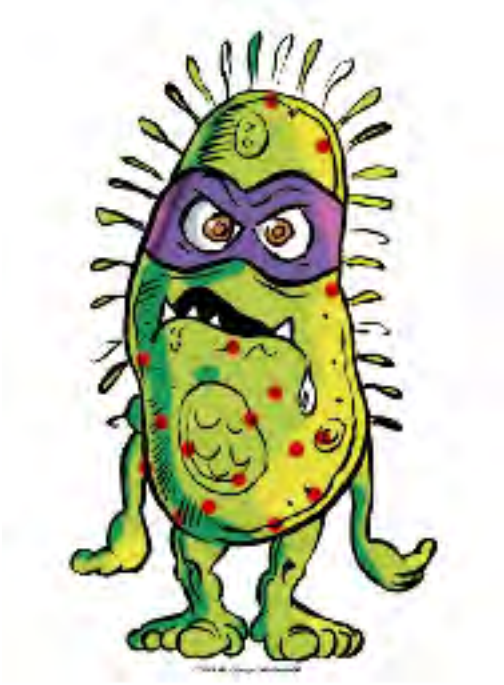
CONCLUSION

HIPAA regulations require new behavior from health care professional and health care facilities. Close coordination with other partners in health care delivery and reimbursement is mandatory to assure a continuous process of patient privacy.

Restrictions and the ability to amend IIHI give patients new control over their health information. Health care professionals may be challenged. Involving patients as active participants in their care will dispel and avoid potential problems.

Administrators are advised to be sure staff is well-trained and knowledgeable about the requirements of HIPAA. Similarly, they many want to scrutinize day- to-day practices to evaluate whether violations of patient rights are occurring.

Infection Control



The patient receiving home care services may have less clinical “acuity” (i.e.; intensity or degree of care needed) but may have substantial host risk factors, including advanced age, chronic illness, or immunosuppression. Much of home care is provided by family members in a setting that is less structured and controlled than the hospital environment. Plumbing, sanitation and ventilation may be poor or absent. The Agency shall ensure that patients with potential for occupational exposure will be instructed in the following:

a. Personal hygiene
b. Exposure to blood borne pathogens
c. Infection control procedures
d. Hazards of TB transmission
e. Isolation precautions
f. Signs and symptoms of TB
g. Aseptic technique
h. Medical surveillance and therapy
i. Standard precautions
j. Protocol for tuberculosis care
k. Transmittable infections
l. Other topics as required.

Standard precautions will be followed for all home acquired infections.

Material appropriate in content and vocabulary to educational level, literacy and language of patient shall be used to teach the patient and family the prevention, control, symptoms and treatment of home acquired infections.

a. An accessible copy of the regulatory text of this standard and an explanation of its contents.
b. An explanation of modes of transmission of these diseases.
c. An explanation of the Agency’s exposure control plan.
d. An explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and other potentially infectious materials.
e. An explanation of the use and limitations of methods that will prevent or reduce exposure including appropriate engineering controls, work practices and personal protective equipment.
f. Information on the appropriate actions to take and persons to contact in an emergency involving blood or other potentially infectious materials.

Standard Precautions for Direct Care Employees

1. Standard Precautions shall be observed by every health care worker for all patients receiving care. Standard Precautions is a system of infection control developed and based on the degree of exposure, not diagnosis. Assume that blood and all body fluids, with or without visible blood, from all patients are potentially infectious. Therefore, the need to use personal protective equipment must focus on health care worker's interaction with the patient's blood and/or body fluids at the time of treatment or procedure, rather than on the diagnosis. Standard Precautions are utilized to prevent reasonably anticipated parenteral, skin, eye and mucous membrane exposure to blood and other potentially infectious body fluids that may result during the performance of a health care worker's duties.

2. WASH HANDS – Hands must be washed before and after contact with each patient, if hands become soiled with body fluids, before the donning (putting on) of sterile gloves, after the removal of all gloves, after contact with non-intact skin and wound dressings and if moving from a contaminated area to a clean area. This is completed following the Agency handwashing policy.

3. GLOVES, such as vinyl or latex medical gloves, must be worn when cleaning reusable equipment, when having direct contact with blood, body fluids, mucous membrane or non-intact skin, when handling items soiled with blood, or when handling equipment contaminated with blood or body fluids. This includes, but is not limited to the following:

    a. Suctioning procedures.

    b. Dressing changes.

    c. Providing oral hygiene.

    d. Cleaning patient rooms, bathrooms, emptying trash or changing linens on patient's bed.

    e. Handling of contaminated linen.

    f. Catheter care and removal of catheters.

    g. Starting and stopping intravenous infusions.

    h. Enema administration.

    i. Collection and emptying of all suction and drainage devices, e.g., Foley catheter bags, Gomcos, and Hemovacs.

    j. Venipuncture/other vascular access procedures.

4. Gloves should be changed after each patient contact. When gloves are removed, thorough hand washing (per Agency policy) is required. Gloves do not take the place of hand washing.

5. GOGGLES or protective glasses should be worn when there is a potential for a splash with blood or body fluids. Examples include dental cleaning, venipunctures, arterial punctures, catheter or nasogastric tube insertions, and intubation.

6. GOWNS or APRONS should be worn when there is a potential for blood or body fluid splatters or sprays. Examples include venipunctures, arterial punctures, catheter or nasogastric tube insertions, and intubation.

7. MASKS are usually not necessary if contact is only casual but should be worn if there is a chance of splash or splatters or the patient is on respiratory precautions.

8. AIRWAYS – Although saliva has not been implicated in HIV transmission, a one-way airway, mouthpiece, resuscitation bag or other ventilation device should be in the home when resuscitation is predictable for use during actual resuscitation.

9. To prevent needle stick injuries, needles should never be recapped, bent, broken or manipulated by hand. These items and other sharp items such as scalpels, razor blades, etc. should be considered potentially infectious and handled with extraordinary care. Used needles should be placed intact into puncture resistant containers which are provided by the Agency. The containers, when three quarters full, are to be returned to the Agency for proper disposal or disposed of in accordance with state or local regulations.

10. In the event of contamination with blood or body fluids, body surfaces should be washed immediately with soap and water.

11. All laboratory specimens should be treated as if they were contaminated with either HIV or HBV. All specimens should be labeled with patient information, placed in sealable plastic bags and transported in an appropriate secured container.

12. For disposal of contaminated supplies other than needles, double bagging technique should be used as described in the Infection Control Policy. Areas and equipment contaminated with blood should be cleaned immediately with 1:10 bleach solution (10%). Equipment can also be cleaned thoroughly and soaked in isopropyl alcohol for ten minutes to inactivate HIV. A fresh solution must be used daily.

13. Soiled linens should be handled as little as possible and with minimum agitation to prevent gross microbial contamination of the air and of persons handling the linens. Linens soiled with blood or body fluids should be placed and transported to the Agency or disposal container in bags that prevent leakage.

14. Personnel cleaning biological spills or contaminated equipment should wear gloves and take care not to contaminate clothing. Disinfectant-detergent formulations registered by EPA can be used for cleaning environmental surfaces, but the actual physical removal of microorganisms by scrubbing is probably at least as important as any antimicrobial effect of the cleaning agent used.

15. Employees will be prohibited from eating, drinking, smoking and storage of food in any area where patient care is performed or in an area where lab testing is performed.

16. Health care workers with exudative lesions or weeping dermatitis should refrain from all direct patient care and from handling patient care equipment until the condition resolves.

17. As indicated, the Agency shall maintain a log describing the collection, transportation and disposition of hazardous waste.

18. Corrective actions are implemented and evaluated as indicated and necessary.

Reportable Diseases

Purpose:

To comply with state law and support public health policy.

Policy:

Patients with reportable infections occurring in the home will be reportable to the local health department in accordance with state law, if they have not been previously reported.

Procedure:

1. The Agency will obtain a list of infectious diseases which are reportable to the public health department and reporting forms from the state department of health.

2. When an Agency staff member becomes aware of a reportable infection in a patient, he/she informs the Agency's Director of Nursing or Director of Quality Improvement.

3. After confirming the reportable infection via clinical record review, interview, and/or discussion with the physician, the Director of Nursing or the Director of Quality Improvement completes a reporting form and forwards it to the health department.

4. A copy of the reporting form is sent to the patient's physician.

5. A log is kept of all reported infections.

6. The Director of Nursing or the Director of Quality Improvement maintains reporting forms and current information to assure compliance with most recent state reporting regulations.

HAND WASHING POLICY–IN PATIENT'S HOMES

Policy:

It is the practice of this agency to assure that every effort is made to reduce the risk for infection in clients and staff members. Thorough hand washing/hand antisepsis is required of all employees. The agency has established guidelines for all staff and will provide education and direction on accepted practices.

Purpose:

To improve hand-hygiene practices of agency staff and reduce transmission of pathogenic microorganisms to clients and personnel in the home care setting.

Special Instructions:

1. Use of alcohol-based hand sanitizer is preferred (until dry). If antimicrobial hand soap is used, it must be for a period of at least 15 seconds. (www.cdcgov/handhygiene/training/interactiveEducation).
   a. Before and after caring for clients, or when coming in contact with inanimate objects/equipment in the immediate vicinity of the client.
   b. Between tasks on the same client and particularly when there is prolonged or intense contact with client; i.e. bathing,
   c. After removing gloves,
   d. After touching objects that are potentially contaminated,
   e. After caring for a client who is infected with drug resistant organisms; i.e. C-Diff and MRSA (CDC recommendation for C-Diff:
      In a setting in which there is an outbreak or an increased CDI rate, visitors and healthcare workers must wash hands with soap (or antimicrobial soap) and water after caring for or contacting patients with CDI ***(B-III).***
   f. After using the toilet, blowing the nose or covering a sneeze,
   g. After assisting client with using the bathroom,
   h. Before eating, drinking, handling food, or serving food,
   i. When hands are visibly dirty/soiled or contaminated with proteinaceous material and/or blood or other body fluids soap and water should be used first,
      (1) An alcohol-based hand rub for routinely decontaminating hands all other clinical situations is acceptable.
   j. Before donning sterile gloves to insert urinary catheters, vascular catheters or other invasive devices,
   k. Before eating and after using a restroom.

2. Antimicrobial impregnated wipes (towelettes) may be used as an alternative to washing hands with non-antimicrobial soap and water. They are not as effective as alcohol based hand rubs or washing hands with antimicrobial soap and water.

3. Paper towels should be used to dry hands after soap and water washing; paper towel used to turn off faucet then discarded in trash.

OTHER ASPECTS OF HAND HYGIENE:

1. Caregivers are not to wear artificial fingernails or extenders when having direct contact with client at risk (i.e. immunosuppressed, etc.).

2. Natural nail tips are to be kept less than 1/4-inch long.

3. Gloves are to be worn during client care when there is risk of contact with blood or other potentially infectious materials, mucus membranes, and non-intact skin could occur.

4. Rings are discouraged with the exception of a plain wedding band.

BAG TECHNIQUE

Policy:

The Agency provides guidelines for use of the bag used to carry equipment and supplies into the client's home. It is the policy of this Agency that all staff shall utilize proper bag technique, following the agency procedure, when conducting home visits. This procedure is reviewed during Agency orientation and with competency evaluations.

Purpose:

To maximize infection control and minimize potential for cross contamination of infectious microorganisms.

ALL FIELD STAFF ARE EXPECTED TO:

1. Select and prepare adequate work space from which to use the bag. Since floors are considered to be highly contaminated, bags are never to be placed on floor.
2. In order to keep the bag as clean as possible, bag is to be kept zipped and in a clean protected area in home and car.
3. When carrying bag into the home it is to be kept on the shoulder until a barrier can be placed on a table or a hard chair. Barrier is discarded after use.
4. When virulent organism infection or vermin are present, place the supplies you will need in 2 plastic bags to take into the home. After caring for the patient/client, take your supplies by pulling the inside bag out of the outside one. The outside bag becomes "dirty" and is discarded in the home.
5. The most effective form of infection control is good hand washing. Employees must cleanse hands before entering/removing supplies from bag, before examination and place on clean side of barrier.
6. To minimize the need for rummaging through the bag and decreasing the potential for the introduction of organisms, the bag is to be kept as orderly as possible, with a minimum of necessary items, so that items can be easily found and reached (such as tape measure or flashlight).
7. If additional supplies are needed during the visit, hands are to be cleansed before re-entering bag. Alcohol- based hand sanitizer gel may be used. Careful planning limits this occurrence.
8. Thermometer technique: In order to minimize cross infection, thermometer covers are always used. The thermometer is cleansed with disinfectant wipe in between patients/clients.
9. All equipment is cleansed with disinfectant after use and before returning to the bag. Example: scissors after removal of a dressing and bell of stethoscope. A disposable tape measure is used if part measured is an open wound.
10. It is recommended to use plastic measuring sheets to measure pressure sores, etc. and that these sheets should be left in the home.
11. In order to keep the bag as clean as possible, once a week (or as indicated), the outside of the bag is wiped with a disinfectant solution such as Lysol wipes.
12. Once a month (or as indicated), all supplies are removed from the bag and the bag is thoroughly cleansed, dried and clean equipment returned.
13. When breaks in technique occur all staff will be instructed by the Director regarding proper bag technique and will be required to perform a return demonstration of correct bag technique. A joint visit with the Director is required. An additional joint visit is made in six months to ensure continued compliance.

Communication Barriers

Communication is a process beginning with a sender who encodes the message and passes it through some channel to the receiver who decodes the message. Communication is fruitful if and only if the messages sent by the sender is interpreted with same meaning by the receiver. If any kind of disturbance blocks any step of communication, the message will be destroyed. Due to such disturbances, managers in an organization face severe problems. Thus the managers must locate such barriers and take steps to get rid of them.

Effective communication requires messages to be conveyed clearly between communicators, but along the way there are many communication barriers that can create misunderstandings and misinterpretations of your message.

There are several barriers that affects the flow of communication in an organization. These barriers interrupt the flow of communication from the sender to the receiver, thus making communication ineffective. It is essential for managers to overcome these barriers. The main barriers of communication are summarized below.

Successful communication requires knowing what barriers to communication exist and how to navigate around these roadblocks.

Physical Barriers – These barriers are those that separate people from each other and mark territories. This type of barrier can often be seen in the workplace where offices and closed doors stop communication.

Language Barriers – Not using words another can understand will certainly stop your message from being conveyed. This not only applies to actual languages, but that of expressions, buzz words, and other jargon. If one is not familiar with your language, misinterpretation will occur.

Gender Barriers – Variation exists among masculine and feminine styles of communication. While women often emphasize politeness, empathy, and rapport building, male communication is often more direct. Meshing these two styles without awareness could be become a barrier.

Interpersonal Barriers – These are barriers are created to distance themselves from others. These can be done through withdrawal, meaningless rituals which keep one devoid of real contact, superficial activities through pastimes, and more.

Perceptual Barriers – Different world views can create misunderstanding. Without thinking, one might only view a message from their mindset rather than looking to see it from another viewpoint.

Cultural Barriers – Ethnic, religious, and social differences can often create misunderstandings when trying to communicate. These differences can also affect perceptual factors, as mentioned above.

Emotional Barriers – Trouble listening can occur if one is consumed with emotion. Hostility, anger, fear, and other emotions make it hard to hear outside of one's self.

Overcoming these barriers to communication is no easy task. It takes great awareness and a willingness to adapt and look at communication from new perspectives. But, if you begin to focus on how these communication barriers are affecting your everyday conversation, you will be well on your way to becoming an effective communicator.

WRITTEN COMMUNICATION

Written communication has great significance in today's business world. It is an innovative activity of the mind.

Effective written communication is essential for preparing worthy promotional materials for business development. Speech came before writing. But writing is more unique and formal than speech. Effective writing involves careful choice of words, their organization in correct order in sentences formation as well as cohesive composition of sentences. Also, writing is more valid and reliable than speech. But while speech is spontaneous, writing causes delay and takes time as feedback is not immediate.

Advantages of Written Communication

- ✓ Written communication helps in laying down apparent principles, policies and rules for running of an organization.
- ✓ It is a permanent means of communication. Thus, it is useful where record maintenance is required.
- ✓ It assists in proper delegation of responsibilities. While in case of oral communication, it is impossible to fix and delegate responsibilities on the grounds of speech as it can be taken back by the speaker or he may refuse to acknowledge.
- ✓ Written communication is more precise and explicit.
- ✓ Effective written communication develops and enhances an organization's image.
- ✓ It provides ready records and references.
- ✓ Legal defenses can depend upon written communication as it provides valid records.

Disadvantages of Written Communication

- ✓ Written communication does not save upon the costs. It costs huge in terms of stationery and the manpower employed in writing/typing and delivering letters.
- ✓ Also, if the receivers of the written message are separated by distance and if they need to clear their doubts, the response is not spontaneous.

- ✓ Written communication is time-consuming as the feedback is not immediate. The encoding and sending of message takes time.

- ✓ Effective written communication requires great skills and competencies in language and vocabulary use. Poor writing skills and quality have a negative impact on organization's reputation.

- ✓ Too much paper work and e-mails burden is involved.

Non Verbal Communication

Non-verbal communications are the communication of feelings, emotions, attitudes, and thoughts through body movements / gestures / eye contact, etc.

The components of non-verbal communication include:

- **Kinesics:** It is the study of facial expressions, postures & gestures. Did you know that while in Argentina to raise a fist in the air with knuckles pointing outwards expresses victory, in Lebanon, raising a closed fist is considered rude?
- **Oculesics:** It is the study of the role of eye contact in non-verbal communication. Did you know that in the first 90 secs - 4 min you decide that you are interested in someone or not. Studies reveal that 50% of this first impression comes from non-verbal communication which includes oculesics. Only 7% of comes from words - that we actually say.
- **Haptics:** It is the study of touching. Did you know that acceptable level of touching vary from one culture to another? In Thailand, touching someone's head may be considered as rude.
- **Proxemics:** It is the study of measurable distance between people as they interact. Did you know that the amount of personal space when having an informal conversation should vary between 18 inches - 4 feet while, the personal distance needed when speaking to a crowd of people should be around 10-12 feet?
- **Chronemics:** It is the study of use of time in non-verbal communication. Have you ever observed that while AN employee will not worry about running a few minutes late to meet a colleague, a manager who has a meeting with the CEO, a late arrival will be considered as a nonverbal cue that he / she does not give adequate respect to his superior?
- **Paralinguistics:** It is the study of variations in pitch, speed, volume, and pauses to convey meaning. Interestingly, when the speaker is making a presentation and is looking for a response, he will pause. However, when no response is desired, he will talk faster with minimal pause.
- **Physical Appearance:** Your physical appearance always contributes towards how people perceive you. Neatly combed hair, ironed clothes and a lively smile will always carry more weight than words.

Remember, "what we say" is less important than "how we say it" as words are only 7% of our communication. Understand and enjoy non-verbal communication as it helps forming better first impressions.

Language Barriers

Language barrier is a figurative phrase used primarily to indicate the difficulties faced when people who have no language in common attempt to communicate with each other.

More than 46 million people in the United States do not speak English as their primary language, and more than 21 million speak English less than "very well." Persons who have limited English proficiency are less likely to have a regular source of primary care and are less likely to receive preventive care. They also are less satisfied with the care that they do receive are more likely to report overall problems with care and may be at increased risk of experiencing medical errors.

Since federal laws stipulate no one can be denied or forced to wait for medical care due to language barriers, some healthcare providers resort to secondary strategies like drawings and hand signals to compensate for gaps in communication. Still, the possibility for error is simply too high. To help alleviate these issues, patients are often urged to bring a bilingual friend or familiar member to explain their medical problems. Hospitals and healthcare facilities, based on the population they serve, translate documents to ensure patients complete all required paperwork properly. Brochures and resources are provided to those who speak limited English to help facilitate their participation in American society and encourage them to take ownership of their health.

Because most health care organizations provide either inadequate interpreter services or no services at all, patients who have limited English proficiency do not receive needed health care or quality health care. Often, persons enlisted to help patients communicate with health care providers are not trained interpreters; instead, they are fellow patients or are family members, friends, untrained nonclinical employees, or non-fluent health care professionals. Reliance on such ad hoc services has been shown to have negative clinical consequences.

Many health care providers do not provide adequate interpreter services because of the financial burden such services impose. However, these providers fail to take into account both the consequences of not providing the services and the potential cost benefits of improving communication with their patients. The failure of health care providers to consider these issues is at least partially attributable to the paucity of data documenting the full costs and benefits of interpreter services. To acquire a better understanding of these costs and benefits, we assessed the impact of implementing a new interpreter service program on the cost and utilization of health care services among patients with limited English proficiency.

Tips for Communicating with Deaf and Hard-of-Hearing People

Deafness is a fact of many people's lives … more than 22 million Americans have some form of hearing loss. Like their hearing counterparts, deaf people build successful careers, have families, watch television, go to the movies, talk on the telephone, play sports, and travel throughout the world.

Most deaf people don't view their deafness as a disability or as a problem that should be fixed. For many of them, it's a natural part of a cultural experience that they share with friends, both deaf and hearing.

Deaf culture is a sense of community among deaf people. Cultural activities can include communicating in American Sign Language (ASL), sharing information about resources that can enhance deaf people's lives, performing and attending theatrical events with no spoken language, joking about the experience of being deaf, and reflecting on role models and events important to deaf people.

All of us have our own way of doing things, and deaf people are no different.
Deaf people communicate in different ways, depending on several factors: age at which deafness began; type of deafness; language skills; amount of residual hearing; speech reading skills; speech abilities; personality; family environment; educational background; and personal preference.
Some deaf people use speech or sign language only … or a combination of sign language, Finger spelling, and speech … or writing … or body language and facial expression. You can communicate with deaf people in several ways. The key is to find out which combination of techniques works best with each deaf person. Keep in mind that it is not how you exchange ideas, but that you do.

To Communicate with a Deaf Person in a One—to-One Situation:

Get the deaf person's attention before speaking. Call out the person's name; if that is not successful, a tap on the shoulder, a wave, or another visual signal usually does the trick.

Key the deaf person in to the topic of discussion. Deaf people need to know what subject matter will be discussed in order to pick up words that help them follow the conversation. This is especially important for deaf people who depend on speechreading.

Speak slowly and clearly, but do not yell, exaggerate, or over pronounce. Exaggeration and overemphasis of words distort lip movements, making speechreading more difficult. Try to enunciate each word without force or tension. Short sentences are easier to understand than long ones.

Look directly at the deaf person when speaking. Avoid turning away to write on the board, look at a computer screen, or pull something from a file while speaking.

Do not place anything in your mouth when speaking. Mustaches that obscure the lips, smoking, pencil chewing, and putting your hands in front of your face all make it difficult for deaf people to follow what is being said.

Maintain eye contact with the deaf person. Eye contact conveys the feeling of direct communication. Even if an interpreter is present, continue to speak directly to the deaf person. He/she will turn to the interpreter as needed.

Use the words —Ill and —youl when communicating through an interpreter, not "Tell him…" or "Does she understand?"

Avoid standing in front of a light source, such as a window or bright light. The glare and shadows created on the face make it almost impossible for the deaf person to speech read.

First repeat, then try to rephrase a thought if you have problems being understood, rather than repeating the same words again. If the person only missed one or two words the first time, one repetition usually helps. Don't hesitate to communicate by pencil and paper if necessary, as particular combinations of lip movements sometimes are difficult to speech read. Getting the message across is more important than the medium used.

Use pantomime, body language, and facial expression to help supplement your communication. A lively speaker always is more interesting to watch.

Be courteous to the deaf person during conversation. If the telephone rings or someone knocks at the door, excuse yourself and tell the deaf person that you are answering the phone or responding to the knock. Do not ignore the deaf person and carry on a conversation with someone else while the deaf person waits.

Use open-ended questions that must be answered by more than "yes" or "no". Do not assume that deaf people have understood your message if they nod their heads in acknowledgement. A coherent response to an open-ended question ensures that your information has been communicated.

The Americans with Disabilities Act (ADA) guarantees equal opportunities in the workplace for people with disabilities. Accommodations made will vary depending on deaf employees' job responsibilities, technical skills, and communication preferences as well as the characteristics of the organization.

It generally is not necessary to make major modifications in the work area to accommodate a deaf employee. There are some things you can do, however, to make the work area more accessible and therefore more comfortable for a deaf employee.

Consider the deaf person's sensitivity to noise. It is a myth that deaf people can work in noisy environments that hearing people cannot tolerate. Most deaf people have some residual hearing and are bothered by loud noises. A noisy environment may create a barrier to communication for someone who wears a hearing aid. Loud or background noises can interfere with and distort the sound amplification of a person's hearing aid, making speech discrimination difficult. Loud noises also may further damage whatever residual hearing the deaf person has.

Consider the buddy system for a new deaf employee. This can make the job transition much easier for the deaf person. A co-worker can be asked to check a deaf employee's awareness of emergency situations; such as fires or evacuation.

Use signaling devices if a deaf employee works alone in an area. Most of these devices are inexpensive and can be incorporated easily into existing alarm systems. Alarms to warn of fire or gas leaks by use of a flashing light and audio signal can plug into regular electrical outlets. Other devices indicate machine malfunction, doorbells, and ringing telephones.

Minimize vibration in the work area. Vibration can distort the sound being received by a hearing aid, making it difficult for the deaf person to concentrate on work or a conversation. Since it is not always possible to eliminate vibration, it is best to arrange meetings in a location where vibration can be minimized.

Use visual clues to enhance communication. Use of a round or oval table during meetings will facilitate the line of sight between people, as will semicircular seating arrangements. Open doors or panels in offices allow deaf people to see into rooms before entering. A good line of sight between the deaf employee and the secretary also will facilitate telephone communication.

Use paging devices to contact deaf employees in the field. Radio frequencies have been set aside by the Federal Communications Commission to permit the use of "tactile pagers" vibrating paging devices that can be used to contact or warn deaf employees in the field or in remote locations. Such pagers usually can be incorporated into existing security paging systems.

Always ask deaf people if they prefer written communication. Do not assume that this is the preferred method. When using writing as a form of communication with deaf people, take into consideration English reading and writing skills. Their skills may depend on whether they were born deaf or became deaf later in life, what teaching method was used in their education, and which communication method they prefer.

Keep your message short and simple. Establish the subject area, avoid assumptions, and make your sentences concise.

It is not necessary to write out every word. Short phrases or a few words often are sufficient to transfer the information.

Do not use yes or no questions. Open-ended questions ensure a response that allows you to see if your message was received correctly.

Face the deaf person after you have written your message. If you can see each other's facial expressions, communication will be easier and more accurate.

Use visual representations if you are explaining specific or technical vocabulary to a deaf person. Drawings and diagrams can help the person comprehend the information.

COMMUNICATIONS BARRIERS AND CULTURAL CONSIDERATIONS

In order to provide optimal quality care to our patients/clients, the Agency will facilitate communication with sensory-impaired patients/clients and patients/clients with limited formal education. The Agency shall attempt to arrange for bilingual staff members or an interpreter to work with non-English speaking patients/clients.

1. When the Agency assigns a staff member who does not speak the patient/client's language, the Agency will provide the services of a qualified interpreter at no charge to the patient at any home visit. The Limited English Proficiency (LEP) person may prefer or request to use a family member, friend or significant other. Children and other patients will not be used to interpret in order to ensure confidentiality of information and accurate communication.

2. Interpreters will be used when no one is available in the home to provide interpretive services.

3. Cultural considerations for all patients/clients shall be respected and observed. Where such considerations impede the provision of prescribed health care or treatment, personnel shall notify the supervisor and physician in an effort to accommodate the patient/client.

4. Every effort will be made to obtain the services of an available interpreter when necessary for persons using sign language. The Agency will advise/refer regarding telecommunications devised for the deaf.

5. Educational materials, visual aids and/or special devices will be used as needed to facilitate communication.

6. Written and verbal communication will be at an educational level that the patient/client will understand.

7. When a significant portion of the caseload does not speak English, written materials are provided in a language understandable to patients/clients.

8. Obtaining an outside interpreter if a qualified interpreter on staff is not available. An interpreter will be obtained from one of the following:

   Accredited Language Services - 1-800-322-0284
   Verbatim Solutions 1-800-575-5702
   www.languageline.com

9. Communicating with persons who are deaf or hard of hearing the agency will use the state relay system.

Workplace/Patient Safety (OSHA)

What is OSHA?

The Occupational Safety and Health Act (OSH Act) of 1970 was passed to prevent workers from being killed or seriously harmed at work. The law requires employers to provide their employees with working conditions that are free of known dangers. The Occupational Safety and Health Administration (OSHA) was created, as a result, to set and enforce protective workplace safety and health standards. OSHA provides information, training and assistance to workers and their employers. Workers may file a complaint to have OSHA inspect their workplace if they believe that their employer is not following OSHA standards or that there are serious hazards (1-800-321-6742).

Workers are entitled to working conditions that do not pose a risk of serious harm. To help assure a safe and healthful workplace, OSHA also provides workers with the right to:

- Ask OSHA to inspect their workplace'
- Use their rights under the law without retaliation and discrimination'
- Receive information and training about hazards, methods to prevent harm and OSHA standards that apply to their workplace;
- Get copies of test results done to find hazards in the workplace;
- Review records of work-related injuries and illnesses;
- Get copies of their medical records.

The Agency is responsible for implementing a formal, comprehensive and active safety program with written records of program activities.

1. Every safety program shall include as a minimum the following elements: (Reference the Safety Manual for appropriate management techniques and examples)
    a. New employee hiring practices, which include:
        i. Completion of an employment application.
        ii. A check of listed references.
        iii. Completion of a voluntary medical questionnaire.
    b. The assignment of responsibility and accountability for employee safety to appropriate supervisors who are responsible for:
        i. Operating procedures and job safety rules for tasks that are written within each department and will include guarding procedures and rules regarding the use of required personal protective equipment.
        ii. Training of all new and transferred employees with respect to safe job procedures and rules.
        iii. Safety training will be continually refreshed for all employees as needed.
        iv. A self-inspection program by responsible supervisors to detect and correct unsafe conditions or acts.
2. Safety management is the responsibility of each employee at all times in the work place, and when in the patient's home. All appropriate employees and patients/caregivers shall receive instruction in safety management including but not limited to:
    a. Electrical safety
    b. Environmental
    c. Bathroom safety
    d. Hand washing
    e. Infection control
    f. Refrigeration
    g. Use of gloves

h. Trans-filling of medical gases
i. Transfers and ambulation safety
j. Use of medical equipment
k. Disposal of needles in a non-penetrable non-glass container
l. Double boxing and bagging
m. Hazardous waste handling and disposal
n. Storage, handling, delivery and access to supplies, medical gases and drugs, especially chemotherapeutic agents, controlled substances, parenteral and enteral nutrition solutions and needles.

3. Patients/caregivers shall acknowledge in writing the receipt of verbal and written instructions regarding safety management. Patient care employees shall monitor the patient/caregiver's understanding and compliance with safety management on an ongoing basis. Appropriate instructions will be provided. All patient care employees will attend in service education on safety management upon employment, annually and as the need for further instruction is identified by their supervisor.

4. Patient related safety hazards will be documented in the clinical record and brought to the attention of the supervising nurse. All accidents or injuries will be reported to the supervising nurse and documented on an incident report. If the accident involves the patient, appropriate actions will be initiated and the physician will be notified to obtain specific follow-up orders. A report of safety related incidents will be presented to the Advisory Committee and governing body including the causal factors and actions to prevent a similar incident.

5. If an accident or incident involves equipment malfunction and serious injury, illness or death, the incident will be reported to the Food and Drug Administration (FDA) within 10 days of notification of the incident.

6. An annual report summarizing incidents occurring in the previous 12 months must be filed with the FDA. The form 3419 is located on your USB.

Employers have the responsibility to provide a safe workplace that does not have serious hazards and to follow all relevant OSHA safety and health standards. Employers must find and correct safety and health problems. OSHA further requires employers to try to eliminate or reduce hazards first by making changes in working conditions rather than relying on masks, gloves or other types of personal protective equipment (PPE).

Employers MUST also:

- Inform employees about hazards through training, labels, alarms, color-coded systems, chemical information sheets and other methods;
- Keep accurate records of work-related injuries and illnesses;
- Perform tests in the workplace, such as air sampling required by some OSHA standards;
- Provide hearing exams or other medical tests required by OSHA standards;
- Post OSHA citations, injury and illness data, and the OSHA poster in the workplace where workers will see them;
- Notify OSHA within 8 hours of a workplace incident in which there is a death or when three or more workers go to a hospital;
- Not discriminate or retaliate against a worker for using their rights under the law.
- Recordkeeping Requirements for the Survey of Occupational Injuries and Illnesses
  As in the past, OSHA requires that all recordable work-related injuries and illnesses information be reported, utilizing Bureau of Labor Statistics Survey of Occupational Injuries and Illnesses (SOII) recordkeeping requirements annually. These forms (OSHA 300, Log of Work-Related Injuries and Illnesses) have changed to include an additional column on (M5) on Hearing Loss.

As of January 1, 2015, all employers must report:

a. All work-related fatalities within 8 hours.

b. All work-related inpatient hospitalizations, all amputations and all losses of an eye within 24 hours.

OSHA Hazardous Communication Standard

OSHA has revised its Hazard Communication Standard, March 2012, 77 FR 17574, (HCS) concerning classification and labeling of chemicals. This is recognized by health care providers as Material Safety Data Sheets (MSDS) and will now be called Safety Data Sheets (SDSs). Two significant changes contained in the revised standard require the use of new labeling elements and a standardized format for Safety Data Sheets (SDS). Effective December 1, 2013, employers must have trained their workers on the new label elements and SDS format. It is important that employees understand the new label and SDS formats. The specific requirements of the revised standard will be phased in over several years (December 1, 2013 to June 1, 2016)

Minimum Topics for Training:

Product Identifier:
This can be the chemical name, code number or batch number. The manufacturer decides the identifier and must print the identifier on both the label and in Section 1 of SDS (Identification).

Signal Word:
This will be used to indicate the relative level of severity of hazard and alert the reader to a potential hazard on the label. There are only 2 signal words, “Danger” and “Warning”. Only one will appear on the label.

Danger - used for the more severe hazards
Warning - less severe hazards

Pictogram:
The required pictograms will be in the shape of a square set at a point and will include a black hazard symbol on a white background with a red frame. A square red frame without a hazard symbol is not a pictogram and is not permitted on the label. OSHA has designated 8 pictograms which can be used under this standard.

Hazard Statements(s):
This will describe the nature, and where appropriate, the degree of the hazard(s). i.e. “Causes damage to kidneys through prolonged or repeated exposure when absorbed through the skin”. The hazard statements are specific to the hazard classification categories, and chemical users should always see the same statement for the same hazards, no matter what the chemical s or who produces it.

Precautionary Statement(s):
A phrase that describes recommended measures to be taken to minimize or prevent adverse effects resulting from exposure to or improper handling/storage of a hazardous chemical.

Name, address and phone number of the chemical manufacturer, distributor, or importer:
How the employee might use the labels in the workplace, for example,

- How information on the label can be used to ensure proper storage
- How the information might be used to quickly locate information on first aid when needed by employees or emergency personnel.

General understanding of how the elements work together. For example,

- That where a chemical has multiple hazards, different pictograms are used to identify various hazards.
- When precautionary statements are similar, the one providing the most protective information will be included on the label.

The Hazard Communication Standard (HCS) requires chemical manufacturers, distributors, or importers to provide Safety Data Sheets (SDSs, formerly known as MSDSs) to communicate the hazards of hazardous chemical products. Employers must ensure that SDSs are readily accessible to employees. By June 1, 2015, the HCS will require new SDSs to be in a uniform format and include the section numbers, the headings, and associated information under the headings below:

Hazard Communication Safety Data Sheets

Section 1, Identification, includes product identifier; manufacturer or distributor name, address, phone number; emergency phone number; recommended use; restrictions on use.
Section 2, Hazard(s) identification includes all hazards regarding the chemical; required label elements.
Section3, Composition/information on ingredients includes information on chemical ingredients; trade secret claims.
Section 4, First-aid measures includes important symptoms/effects, acute, delayed; required treatment.
Section 5, Fire-fighting measures lists suitable extinguishing techniques, equipment; chemical hazards from fire.
Section 6, Accidental release measures lists emergency procedures; protective equipment; proper methods of containment and cleanup.
Section 7, Handling and storage lists precautions for safe handling and storage, including incompatibilities.
Section 8, Exposure controls/personal protection lists OSHA's Permissible Exposure Limits (PELs); Threshold Limit Values (TLVs); appropriate engineering controls; personal protective equipment (PPE).
Section 9, Physical and chemical properties lists the chemical's characteristics.
Section 10, stability and reactivity lists chemical stability and possibility of hazardous reactions.
Section 11, Toxicological Information includes routes of exposure; related symptoms, acute and chronic effects; numerical measures of toxicity.
*OSHA will not be enforcing sections 12 -15 as other agencies are responsible
Section 16, other information includes the date of preparation or last revision

NOTE:
Training on the format of the SDS must include:

- Standardized 16-section format, including the type of information found in the various sections (see previous example)

For example, the employee should be instructed that with the new format, Section 8 will always contain information about exposure limits, engineering controls and ways to protect self, including personal protective equipment,

- Section 8, Exposure controls/Personal Protection will always contain information about exposure limits, engineering controls and ways to protect self, including personal protective equipment,
- Precautionary statements on label would be the same on the SDS.

OSHA requires employers to present information in a manner and language that their employees can understand. If the employee speaks/reads a language other than English, the employer will

need to provide safety and health training in that language. OSHA's Hazard Communication website (http://www.oshagov/dsg/hazcom/index.html) has the following "quick cards" and OSHA briefs in English and Spanish to assist employers with training:

- Label QuickCard
- Pictogram QuickCard
- Safety Data Sheet QuickCard
- Safety Data Sheet OSHA Brief
- Label/;Pictogram OSHA Brief

Safety Committee

1. An Ad Hoc Safety committee will be organized within the agency to establish a network for communication of safety information pertaining to the work environment.

2. The Committee will be organized to distribute safety information, observe and monitor compliance with OSHA standards, determine safety needs, review problems and develop means to improve or resolve those problems.

3. The Committee will be composed of representatives appointed by the Professional Advisory Committee.

4. The Safety Committee will be responsible for distributing safety related information, monitoring compliance, maintaining and updating OSHA compliance as per OSHA standards.

2. The Safety Committee will be knowledgeable in safety subject matter and conduct training in-services.

3. Safety Committee meetings will be scheduled once yearly and as needed to address special issues or situations.

4. The Administrator sets the dates and times for the meetings of the Safety Committee and plans the agendas for the meetings.

5. The minutes of the Safety Committee meetings are reported to the Professional Advisory Committee and to the Governing Body. They are filed by the Administrator along with any and all safety reports, papers, and written recommendations. They are maintained for a minimum of five (5) years and made available upon request.

6. The Administrator is responsible for informing the employees of the decisions, actions, and recommendations of the Safety Committee.

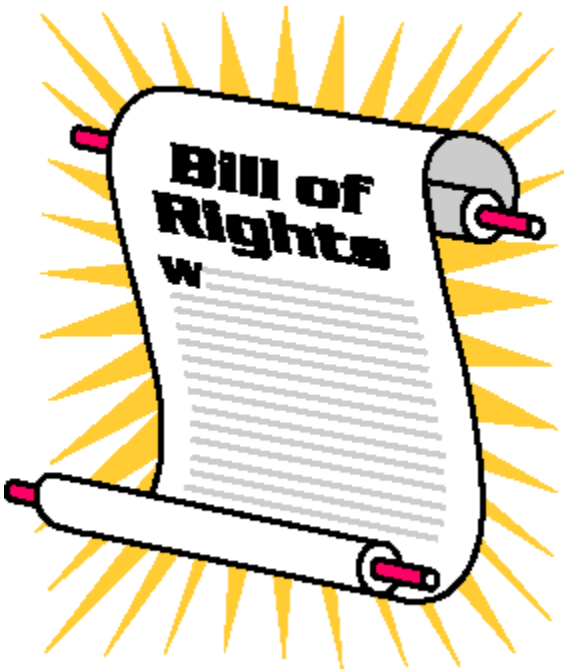
7. Each employee of the Agency may submit suggestions, complaints, or questions to his/her supervisor to submit to the Safety Committee.

8. The Safety Committee discusses all such suggestions, complaints, and questions and takes actions when necessary.

9. The Safety Committee reviews as required, all reports of work-related injuries and loss reports in order to design, develop and implement corrections as needed, to eliminate and prevent injuries at work.

10. The Safety Committee reviews every work-related injury to determine what caused the injury, what could have been done to prevent it and what has been done to prevent a recurrence.

Patient Rights and Responsibilities



Patient Rights and Responsibilities

Patient Rights are an integral part of healthcare today.
All clients come to our Agency with different healthcare experiences and may or may not be aware of their rights.
Protections are afforded by federal and state legislation and as health care providers we must educate our client about their rights and the manner in which they may exercise them. For ease of access and teaching, the patient's rights are clearly stated in one document that is called The Patient's Bill of Rights.

Accessibility and Education

The Bill of Rights must always be accessible to the client, family, public and staff. It can be found posted in the office and in the client's admission packet. If a client would like an additional copy, they are located in the office.
Upon admission, the nurse will explain the Bill of Rights to the client and/or caregiver. The client/caregiver must be given the opportunity to ask questions.
Receipt of the Bill of Rights is documented in the clinical record. The client must also be informed that he/she has the right to excursive the rights at any time without fear
of reprisal.
Any questions about the protections afforded by the Bill of Rights may be directed to the Administrator if the employee/ contractor cannot answer it.

Key Areas

Key things to remember about the Bill of Rights are:

- ✓ The rights can be exercised at anytime.
- ✓ Clients are to receive the best quality care without regard to race, creed, nationality/origin, lifestyle choice and diagnosis.
- ✓ The client/caregiver ALWAYS has the right to refuse care.
- ✓ The client/caregiver must be informed of care prior to initiation.
- ✓ Privacy, including protection of PHI is paramount.
- ✓ The client/caregiver must be informed of charges prior to initiating service.
- ✓ The client has the right to be safe.
- ✓ The client has the right to be treated with respect.
- ✓ The client has the right to make concerns/ grievances known without the fear of reprisal.

Specific questions about patients' rights may be directed to the Administrator.

Interacting with Clients
Client rights not only govern what the client may do and when, but how Agency staff interacts with the client and their environment. Appropriate and professional interaction can increase client confidence and overall satisfaction.

When you are in a client's home, remember:

- ✓ Address the client using his or her name and the appropriate title. Nicknames like sweetie and honey are well meaning but it can come across as demeaning. Terms of endearment should never be used and nicknames should only be used if and when the client gives permission.
- ✓ Treat the client's property with respect. Remember although you are working, you are in someone's home! Observe cultural considerations and do not slam doors or damage personal property.
- ✓ Clients have the right to know who you are and what you are doing.
    - Always introduce yourself when you enter into a client's environment and at the beginning of telephone conversations.
    - ALWAYS wear your ID badge.
    - Explain procedures prior to starting them.
    - Answer questions honestly.

- Be professional and smile.

Complaints/ Grievances

The client has the right to make concerns known. The Agency has a responsibility to investigate the problem and resolve the issue to the client's satisfaction in a timely manner.
Upon admission the client is given a copy of the grievance process and rights pertaining to having problems resolved. If a client is upset, it is important to remember:

- ✓ Remain calm and objective.
- ✓ Respond to questions and problems promptly
- ✓ Do not take complaints personally
- ✓ Remain professional
    - Do not yell
    - Do not name call
    - Do not make accusations
    - Do not accept or assign blame

Responsibilities

For every right, there is a responsibility to assure that the right is exercised in a safe manner. As a healthcare provider you have the responsibility to:

- ✓ Listen to you patient when they tell you what they need. Do not assume you know what they need or want.
- ✓ Explain what you are going to do with the patient prior to starting in language that is appropriate for his/her level of development/ national origin.
- ✓ Be honest. If you do not know the answer to a question, redirect the question to the office.
- ✓ Remember client privacy!

Do

- ✓ Secure documents with client information.
- ✓ Use the assigned number in place of identifying information when you can.

Don't

- ✓ Gossip about clients.
- ✓ Hold conversations with or about clients in public.
- ✓ Encourage independence.

Statement of Purpose:

It is anticipated that observance of these rights and responsibilities will contribute to more effective care and greater satisfaction for the patient as well as the staff. The rights will be respected by all personnel and integrated into all Home Care programs. A copy of these rights will be given to patients and their families or designated representative. If the patient or his/her designated representative is unable to read the Bill of Rights and Responsibilities, it will be read to them. If the patient or his/her representative does not speak English, a copy of these rights will be provided in a language that is understood. The patient or his/her designated representative has the right to exercise these rights. In the case of a patient adjudged incompetent, the rights of the patient are exercised by the person appointed by law to act on the patient's behalf. In the case of a patient who has not been adjudged incompetent, any legal representative may exercise the patient's rights to the extent permitted by law.

Each patient receives a copy of the Bill of Rights and Responsibilities on or before admission to the agency.

The Bill of Rights are based on payers and state specific requirements.

Included are the some of the rights below:

1. To be fully informed in advance about care/service to be provided, including the disciplines that furnish care and the frequency of visits, as well as any modifications to the plan of care.

2. To choose a health care provider.

3. To access necessary professional services 24 hours a day, 7 days a week. This care will be appropriate and professional care relating to physician orders.

4. Be informed, both orally and in writing in advance of care being provided, of the charges, including payment for care/service expected from the third parties including Medicare, Medicaid, or any other federally funded or aided program known to the organization, Charges for services that will not be covered by the payer.

5. Receive information about the scope of services that the HHA will provide and specific limitations on those services.

6. Participate in the development and periodic revision of the plan of care.

7. Refuse care or treatment after the consequences of refusing care or treatment are fully presented.

8. To be advised that the agency complies with Subpart 1 of 42 CFR 489 and receive a copy of the organization's written policies and procedures regarding advance directives, including a description of an individual's right under applicable state law and to know that the Agency will honor the patient's advance directives in providing care.

9. Be informed of patient rights under state law to formulate an Advance Directive.

10. Have one's property and person treated with respect, consideration, and recognition of patient dignity and individuality.

11. Have patient's family or guardian exercise the patient's rights when the patient has been judged incompetent.

12. Be able to identify visiting personnel members through proper identification.

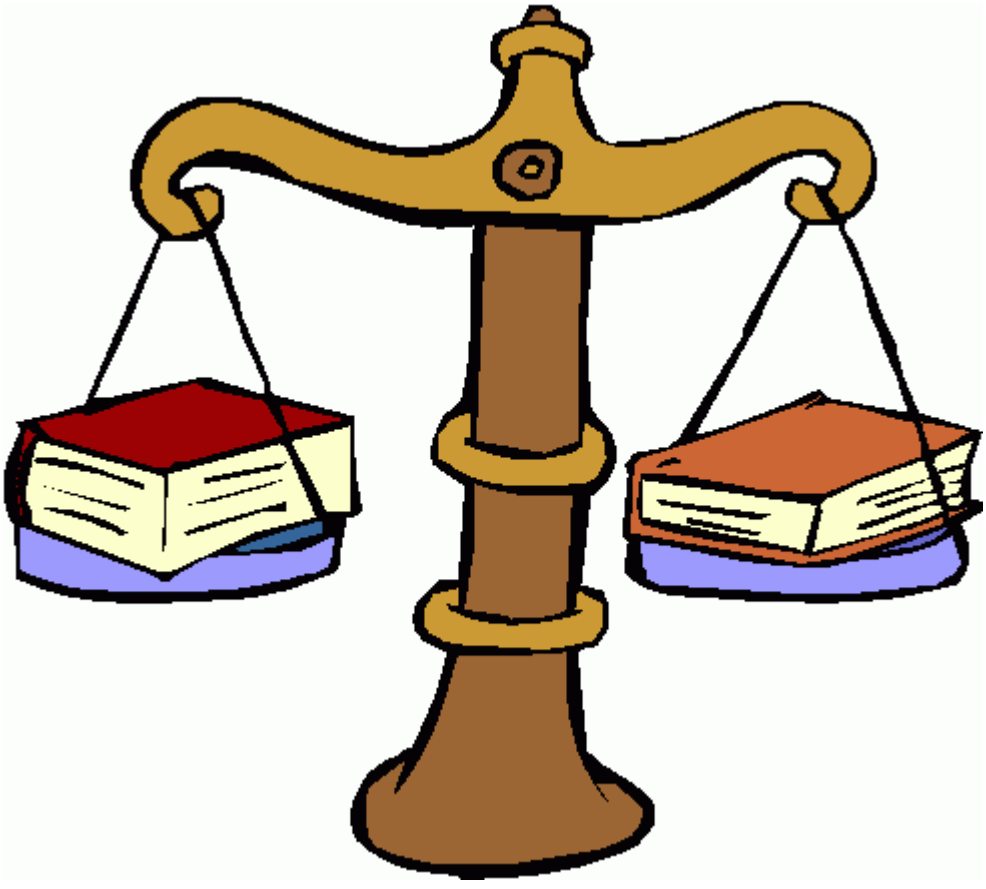
13. Be free of mistreatment, neglect, or verbal, mental, sexual and physical abuse, including injuries of unknown source, and misappropriation of patient property.

14. Voice grievances/complaints regarding treatment or care that is (or fails to be) furnished, lack of respect of property or recommend changes in policy, personnel, or care/service without restraint, interference, coercion, discrimination or reprisal and to know that grievances will be resolved and the patient notified of the resolution within 30 days.

15. Have grievances/complaints investigated regarding treatment or care that is (or fails to be) furnished, or lack of respect of property.

16. Confidentiality and privacy of all information contained in the patient record and of Protected Health Information.

Corporate Compliance



What is a Corporate Compliance program?

A Corporate Compliance program is a system which is designed to detect and prevent violations of law by the agents, employees, officers and directors of a business.

Although we use the general term "corporate compliance", the need for an effective compliance program is not limited to corporations. Any form of business entity is well served by having an effective compliance program.

Why does my organization need one?

In 1991, the federal government enacted the Organizational Sentencing Guidelines (Chapter 8 of the Federal Sentencing Guidelines), in an effort to make the penalties for corporate crime both uniform and predictable, so as to encourage "good corporate citizenship".

Penalties under the guidelines include fines and imprisonment, as well as "corporate probation", which is mandatory in the case of a business which does not have an effective compliance program in place. Probation involves intrusive federal monitoring of the organization and adoption of a government authored compliance program, which can be far more expensive and invasive than a voluntary compliance program could have been.

The Guidelines take a carrot and stick approach in order to encourage businesses to police themselves. Each crime or violation is assigned a base fine, which is either increased or decreased based upon the presence of certain aggravating and mitigating factors. One such mitigating factor is the existence of an effective corporate compliance program.

Under the Guidelines, an organization which has such a program may receive a substantially reduced fine, and maybe able to avoid corporate probation and criminal prosecution altogether.

What Are the Potential Penalties Companies Face?

Among the penalties which apply to organizations are:

- prison
- fines
- restitution
- sanctions
- forfeiture
- Corporate probation

An effective corporate compliance program is designed to prevent and detect violations of law and that the organization exercised due diligence in seeking to prevent and detect criminal conduct by its employees and other agents.

Due diligence requires at a minimum that the organization has a policy that is implemented and monitored for compliance.

Employees can report fraud, waste and abuse to the OIG in HHS programs and be protected under the Whistleblower Protection Act.

The agency must post information for the employee in the office.

OIG Office of Inspector General
U.S. Department of State • Broadcasting Board of Governors

HELP FIGHT

FRAUD.

WASTE.

ABUSE.

If you suspect wrongdoing, contact:

1-800-409-9926

OIG.state.gov/HOTLINE

If you fear reprisal:

Federal employees and employees of contractors, subcontractors, and grantees are protected by law from reprisal for reporting wrongdoing to a recipient authorized by law to receive such reports.

Contact the OIG Whistleblower Ombudsman to learn more about your rights:

OIGWPEAOmbuds@state.gov

Corporate Compliance Policy

Purpose:

The Agency is committed to conducting its business in full compliance with all applicable laws and regulations, be they state or Federal. Interpretation unlike many laws that effect our daily lives, the laws and regulations by which the Agency must abide, cannot always be clearly interpreted by using the concept of right versus wrong. Misinterpretation, even it is unintentional, can subject the Agency to fines and other penalties and also impact its reputation in the marketplace. In such, the purpose of the Corporate Compliance Plan is to provide a corporate culture under which the Agency and its employees, from the President/CEO to the Home Health Aide, will not conduct themselves in a manner, be it wittingly or unwittingly, that would violate applicable laws and regulations.

At a minimum the Corporate Compliance Program will address the following areas:

1. Implementation of written policies, procedures and standards of conduct
2. Designation of a Compliance Officer and Compliance Committee
3. Conducting effective training and education programs
4. Develop open lines of communication between the Compliance Officer or Committee and Agency personnel for receiving complaints and protecting callers from retaliation
5. Performing internal audits to monitor compliance
6. Establishing and publicizing disciplinary guidelines for failing to comply with Agency standards and policies and applicable statutes and regulations
7. Prompt response to detected offenses through corrective action.

Policy:

Clearly, the policy of this Agency is to obey all laws, regulations and guidelines and the Agency's existing Policies and Procedures manuals do set forth and address the issues include in a corporate compliance plan.

However, while these subjects are in virtually all cases already addressed in the sections of Policies listed below, the need for a distinct Corporate Compliance Plan is an obvious one and that is to assure that Corporate Compliance has its own individual focus so it can be made to work effectively.

Further, it is the Agency's goal to have its Corporate Compliance Program adhere to the "best practices" of its industry

The sections of the Policies and Manuals that address corporate compliance issues include but are not limited to:

1. ADMINISTRATIVE POLICIES
2. PATIENT CARE POLICIES
3. FINANCIAL MANAGEMENT POLICIES
4. PERSONNEL POLICIES
8. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT POLICY (QAPI) – all sections are pertinent.

Responsible Personnel

1. While it is the responsibility of all staff to implement the Agency's Corporate Compliance Plan, monitoring its compliance is the responsibility of senior staff, in particular the Administrator and the Board of Directors.

2. Further, as it has been noted above, the interpretation of laws and regulations is often complicated. While lower ranking staff will be able to make clear cut determinations, they cannot be expected to make those interpretations which are complicated or "lie in a gray area."

3. It therefore becomes important to instruct staff not only on which matters they are allowed to resolve on their own but also to report to their supervisors any instances which they come across that involve matters of law or regulation that are not entirely clear cut.

4. Such "interpretive cases" must be reported up the chain of command until they are resolved and when appropriate brought to the attention of the Board of Directors.

5. The Corporate Compliance Plan will be implanted under the direction of the Administrator, but the Board of Directors, itself has ultimate responsibility. The Administrator will be the Corporate Compliance Officer (CCO), or the position may be designated.

6. The Board of Directors/Governing Body will appoint a committee (The Corporate Compliance Committee) to oversee corporate compliance. It members will include:

    a. The Board of Directors/Governing Body or a representative
    b. The Administrator
    c. The Chief Executive Officer or a designee
    d. Regional Managers (if any) or designees
    e. The Chief Financial Officer or a consultant
    f. The Director of Human Resources, if such position has been established
    g. Ad Hoc Members as necessary.

7. The Corporate Compliance Committee will meet at least annually. Ad Hoc meetings may take place with a two-week notice given to the members. Emergency Ad Hoc meetings may be called if necessary. Telephone conferencing for absent Board members is permissible.

8. The Corporate Compliance Committee agenda for its scheduled meetings:

    a. A review of the report of the Corporate Compliance Officer (CCO).
    b. Review of fraud alerts issued by the Officer of the Inspector General.
    c. Review of topical issues with respect to corporate compliance in the health care industry in general and in the Home Health Care industry in particular.
    d. Review of "Hot-line referrals" made to the CCO.
    e. It will make recommendations with respect to the improvement of compliance efforts, which will be subject to final approval by the Board of Directors.
    f. It will review the effectiveness of recommendations that were implemented as the result of previous meetings.

9. The CCO will be the Administrator or a designee. His/her duties will be discussed below under the sections devoted to principle and the section devoted to procedures in greater detail but broadly will consist of efforts to assure that individual policies established by the Agency with respect to corporate compliance topics are considered to "best practice" that they are being obeyed consistently.

Principles

The basic principle of the Agency's Corporate Compliance Plan is that it should always act as a good corporate citizen. It will do this by:

1. Maintaining honesty and integrity in all of its operations by adhering to a high standard of conduct.

2. Maintaining confidentiality of Agency and patient records.

3. Avoiding unauthorized use of Agency assets.

4. Maintaining job accountability at every level.

5. Avoiding conflicts of interest.

6. Refraining from patient abuse and reporting too appropriate authorities any abuse that does occur, regardless of who perpetrates it.

7. Maintaining appropriate communication with patients by assuring the integrity of patient satisfaction surveys and assuring that patients are aware of their rights and know who to call inside and outside the Agency if they feel their rights have been violated or if their care has been inadequate.

8. Adhering to the Patient's Plan of Care and following all regulations and guidelines concerning the administration of that care.

9. Adhering strictly to policies concerning the control of medication.

10. Refraining from misrepresentation in any manner be it with a patient, a contractor or any government agency or third party.

11. Refraining from the engagement in illegal or unfair trade practices such as the solicitation of patients.

12. Complying with all standards regarding billing.

13. Preparing all financial reports in a manner consistent with accepted accounting practices.

14. Complying with all labor and employment laws, including those involving job discrimination and providing for Workman's Compensation and Unemployment Insurance, when required by law.

15. Complying with all payroll practices including those involved with withholding tax and avoiding improper withholding as detailed in the Fair Labor Standards Act (FLSA) and other statutes.

16. Maintaining employee privacy.

17. Maintaining a working environment that is both safe and free of abuse and harassment.

18. Investigating promptly any abuse or violation of policy or complaint and taking corrective action.

19. Preventing individuals who have been involved in illegal activities from exercising any discretionary authority by screening them at the time they submit an employment application. With respect to The Medical Director and other applicable professional staff, the Agency will check the National Practitioner Data Bank and Cumulative Sanction Report. Members who have been sanctioned or excluded by the any federal health program or who have been debarred from contracting with any other federal agency will not be hired or contracted.

20. Committing the Agency and it contractors to abide by all state and Federal laws and regulations including, but not limited to the following:

a. The Federal False Claims Act

b. The Stark Bill

c. State licensure requirements

d. Federal, state and local Civil Rights Laws

Procedure

It is the duty of the CCO to assure adherence to all of the principles laid out in the previous paragraph. He/she will do this by:

1. Assuring that each staff member has been advised by his/her supervisor of the existence and importance of the Agency's Corporate Compliance Plan as well as their responsibilities to assure adherence to the policy.

2. Assuring that each supervisor and each and every person that the supervisors report to (together, "Senior Staff") fully understand the Corporate Compliance Plan and sign a statement (copy provided below) attesting to their understanding and agreement to obey it.

3. Reviewing all existing Agency policies which relate to corporate compliance to include those noted in the Policy section, above, paragraphs 1-4. The CCO will:

    a. Assure that the policies are adequate, up to date and are of "best standards quality".

    b. Coordinate additions or corrections to policies as needed, report such changes to the Corporate Compliance Committee and arrange for their presentation to Board of Directors for approval.

    c. The CCO will also assure that the policies are being adhered to, by noting exceptions and asking randomly questioning staff members, their supervisors and Senior Staff.

    d. The CCO will act as a focal point for all matters concerning corporate compliance:

        i. Any violation of law, regulation or Agency policies will be reported to the CCO by the supervisor of Senior Staff person promptly, once that person becomes aware of the violation.

            1. The CCO will make his view known as to the appropriate action that should be taken once a violation has been discovered. If the CCO feels that the corrections are inadequate, he/she will notify the Corporate Compliance Committee and/or the Board of Directors.

        ii. All inquiries with respect to the interpretation of specific policies made by staff to their supervisors will also be reported to the CCO. The CCO will track and record these inquires (as well as the violations) to ascertain if there is a trend among employees as it relates to the understanding of laws, rules and policies:

            1. To the extent that trends do exist the CCO will hold discussions with appropriate Senior Staff and if necessary coordinate the preparation of policies additions, as in 3.b above.

        iii. The Agency will encourage its Senior Staff to provide any and all input with respect to compliance to the CCO. The CCO will track all such information and any suggestions made by staff.

4. In addition to advising the CCO of violations and staff inquires with respect to corporate compliance, each department and subsidiary shall submit a well-documented status report to the Compliance Committee as part of the annual evaluation. The status report should also contain a self-assessment addressing the department or subsidiary's corporate compliance posture and experience as well as any other matters concerning corporate compliance that are relevant.

5. The CCO will prepare reports for the Corporate Compliance Committee at the time of each meeting. The report will make note of the violations that have occurred and the staff inquires and suggestions that have been made. It will include any other observations that the CCO has made with respect to Agency procedures as they affect compliance. The CCO will also make note of experiences of other Agencies as well as industry developments.

6. CCO reports will be more frequent when necessary. Such reports can be made to be coincident with AD Hoc meetings of the Corporate Compliance Committee or they can be completely separate if dictated by urgency.

7. The CCO reports will include recommended changes to policy subjects in the Agency's manuals. It will also include any other recommendations for changes in the Agency's procedure or in the Corporate Compliance Program itself.

Training and Continuing Education

1. All employees, agents representing this Agency and independent contractors providing health care services on behalf of the Agency shall receive a copy of the Corporate Compliance Policy and have an opportunity to review the program along with specific policies contained in other manuals that relate to their job functions.

2. All new employees, agents and independent contractors will likewise be so oriented, within two weeks of hiring contract date.

3. Any of the individuals listed above who have questions regarding the program or his/her obligation under it should contact the CCO.

4. All employees, agents or independent contractor must sign and return an acknowledgment form. This acknowledgment form will become part of the personnel folder or agent/ independent contractor file.

5. Employee, agent and independent contractor training is as follows:

    a. Initial Training: All employees, agents and independent contractors providing health care services will be required to complete an orientation of this program within one month following their employment or engagement.

    b. Certain company employees, agents or independent contractors may receive specialized training if their job activity requires it. This specialized training may focus on complex areas or on areas in which the CCO or the Corporate Compliance Committee has identified as high risk with respect to misconduct or error.

    c. As new developments or concerns arise with respect to corporate compliance issues the CCO or the Corporate Compliance Committee may require additional training for some individuals.

    d. All persons in supervisory positions are responsible for ensuring that each employee, agent and independent contractor reporting to them has attended the orientation/training sessions applicable to that person's job duties.

    e. Medical Directors shall be strongly encouraged to attend training sessions and review all relevant compliance policies and sign an Acknowledgment form affirming their understanding of the Program policy.

Compliance Statement

The Corporate Compliance Statement provided below is to be acknowledged and signed by every Agency employee as well as every employee working for the Agency on a contractual basis.

CORPORATE COMPLIANCE POLICY
Acknowledgment of Receipt and Understanding
As you know, our Agency and our Staff members have always been committed to providing exceptional health care and upholding ethical conduct standards and legal compliance.
Our policy formally and clearly states that there is a zero tolerance to any form of fraud or misconduct. This Agency believes that every employee or agent plays a key and active role in maintaining its image and reputation.
I hereby acknowledge that I have apprised of and agree to comply with the Agency's Corporate Compliance Policy. I understand that in no way does this create an obligation or contract of employment and that I, as well as the Agency, have the right to end the employment relationship at any time.
Employee's printed name:
Employee's signature:
Date:

Ethics

Ethical Issues in Healthcare

Healthcare ethics involves making well researched and considerate decisions about medical treatments, while taking into consideration a patient's beliefs and wishes regarding all aspects of their health.

The healthcare industry, above any other, has a high regard for the issues surrounding the welfare of their patients.

Doctors, nurses, and other professionals who have the ability to affect a patient's health are all forced to make ethical decisions on a daily basis.

This power over a patient's wellbeing creates a mandatory need for all healthcare organizations to develop an ethics committee.

Health care professionals practice in an environment that is complex, with many regulations, laws and standards of practice.

Performing an abortion is legal but may not be considered ethical by other health care professionals or members of the public at large.

Other ethical dilemmas arise at the end of life, when a decision must be made to turn off life-support machines and allow death to occur.

Other common ethical issues a health care professional might face are confidentiality, relationships with patients and matters related to consent, especially in the treatment of minors.

The agency's goal is to establish a written code of ethics that details the policies and procedures that determine proper conduct for all employees.

The Ethics committee meets and gives direction to assist the staff, patients and their families; all working together cohesively to identify, understand, and resolve difficult ethical decisions.

There are many ethical issues that may arise in regards to a patient's healthcare.

These major issues as well as ways to manage them are as follows:

- **Confidentiality**- Confidentiality is both an ethical and a legal issue. Keeping information about a patient confidential is a way of showing respect for the person's autonomy; releasing information can damage the patient. There are also specific laws regarding the release of information under the Health Insurance Portability and Accountability Act, or HIPAA. The laws define exactly what information can be released and to whom. Insurance companies, for example, may not have the right to certain aspects of a patient's medical record. However, if there is risk to a third party, an ethical health care professional may need to break confidentiality to prevent harm. The Administrator needs to make sure that its patients' medical records are safeguarded.

- **Transmission of diseases**- The risk posed to healthcare professionals of acquiring a communicable disease from patients is a concern to those serving on ethical committees. This is especially true if a patient's health history is not made available to the providers. While healthcare providers do not want to make the patient uncomfortable by taking obvious protective measures, they still have every right to protect themselves from any pathogens that may be able to spread by direct or indirect contact.

- **Aggressive marketing practices** - Certain guidelines, ethics, and standards need to be adhered to when promoting and marketing an agency's services. It is extremely inappropriate for agencies to recommend unnecessary services to a patient just for the sake of profit. The main goal of the agency should be patient care, not marketing schemes. Ethical committees should always be involved in the agency's marketing practices in some way so that the result of any marketing campaign is tasteful and sincere.

- **Provided information**- The information that an agency provides to advertising needs to be 100% accurate and honest. It is important that the advertisements for the agency and its services are not misleading or false. Again, the patients' welfare is most important.

- **Patient welfare** - A doctor, nurse, and any other type of healthcare professional involved in the care of a patient needs to remember their main motive: safeguarding the welfare of their patients. All personal information needs to be kept private. It is also important that physicians are honest with their patients. No matter what the healthcare provider's personal beliefs are; a patient should never be discriminated against based on race, income, or sex. Reports of such discrimination should be taken very seriously.

- **Elderly patients**- Dealing with patients of advanced age may sometimes pose problems in regards to ethical decision making since they are not capable of making rational decisions on their own. As a result, their families are left with the responsibility of making difficult choices. This task can be incredibly difficult when the patient is terminally ill and wants to end their life in order to avoid unnecessary suffering. Even if the ethical committee has a difference of opinion regarding such matters, proper ethical protocol needs to be adhered to at all times. It is always best to check if the patient has a living will so that unnecessary confusion can be avoided.

- **Terminally ill patients** - As with elderly patients, terminally ill patients may have specific wishes for the manner in which they want their lives to end. Dealing with an issue such as euthanasia is very difficult and therefore requires a deep understanding of ethical processes.

- **Sexual harassment** - The ethical committee should be very strict about sexual harassment of any kind at the healthcare facility. There is a risk of occurrence not only between a patient and a doctor, but also between two medical practitioners. When such situations arise, the ethical committee should involve a branch of ethics called sexual ethics, which involves any issue regarding sexuality and sexual behavior.

- **Therapies** - There are different techniques and therapies that can be performed with a patient or victim so that any trauma or stress related to an offending incident can be alleviated. Hearings and investigations into the incident may also occur.

- **Relationships-** Relationships with patients, particularly sexual relationships, are forbidden by both the medical and nursing code of ethics. Such actions are considered serious misconduct and can result in expulsion from the profession and losing the license to practice. A sexual relationship is considered to be an abuse of power on the part of the physician or nurse, as patients are dependent and vulnerable. A sexual relationship with a patient can be very harmful, and an ethical practitioner will avoid even the appearance of sexual interest in a patient.

- **Malpractice-** Health care practitioners of all sorts face the risk of being sued for malpractice. A lawsuit may be brought from an injury related to surgery, defective equipment or medical products, care that was omitted or a deliberate act that caused harm to a patient. The risk of litigation is such that many health care professionals practice what is called defensive medicine -- for example, ordering a test or performing a procedure primarily to ensure that the patient cannot allege negligence.

- **Consent-** Patients must provide informed consent for treatment to be legal. A surgery performed without proper consent is generally considered assault, according to a 2009 article in the "Internet Journal of Surgery." When treating an adolescent, the health care professional faces potential conflict between ethics and the law in certain situations. The professional might believe that parents should be kept informed of their child's health issues. In California, however, a 12-year-old can consent to medical care and counseling related to the treatment of a drug or alcohol problem, the National Center for Youth Law reports. The treating doctor cannot disclose information to the parents without the child's consent except in very specific circumstances, such as risk to another person.

- **Discrimination-** Discrimination is also another very serious issue in medical ethics. Discrimination can be because of race, gender, color, or even religion. This may happen between a patient and a medical practitioner or between a medical practitioner and another member of the healthcare team. All members of the team must always protect the welfare of the patients and of themselves as well.

- **Honesty-** Being honest and giving out authentic pieces of information to the concerned parties are also common ethical issues in healthcare. When results of diagnostic tests are available, these pieces of information must be relayed to the patients and their families. Their diagnosis and other important data should also be discussed properly by the physician and the nurses so that there will be transparency in the treatment process. Giving false hopes and false reassurances are strictly discouraged.

The Code of Ethics is intended to serve as a guideline to the agency in the following areas:

A. Patient Rights and Responsibilities
B. Relationships to Other Provider Agencies
C. Fiscal Responsibilities
D. Marketing and Public Relations
E. Personnel

Patient Rights and Responsibilities

It is anticipated that observance of these rights and responsibilities will contribute to more effective patient care and greater satisfaction for the patient as well as the agency. The rights will be respected by all Agency personnel and integrated into all home care agency programs. A copy of these rights will be prominently displayed within the agency and made available to patients upon request.

- The patient is fully informed of all patient rights and responsibilities.
- The patient has the right to appropriate and professional care relating to physician orders.
- The patient has the right of choice of care providers.
- The patient has the right to receive information necessary to give informed consent prior to the start of any procedure or treatment.
- The patient has the right to refuse treatment within the confines of the law and to be informed of the consequences of his action.
- The patient has the right to privacy.
- The patient has the right to receive a timely response from the agency to his request for service.
- A patient will be admitted for service only if the agency has the ability to provide safe professional care at the level of intensity needed.
- The patient has the right to reasonable continuity of care.
- The patient has the right to be informed within reasonable time of anticipated termination of service or plans for transfer to another agency.
- The patient has the right to voice grievances and suggest changes in service or staff without fear of restraint or discrimination.
- The patient has the right to be fully informed of agency policies and charges for services, including eligibility for third-party reimbursements.
- The patient denied service solely on his inability to pay shall have the right of referral.

- The patient and the public have the right to honest, accurate, and forthright information regarding the home care industry in general and his chosen agency in particular, (e.g., cost per visit, employee qualifications, etc.).

Relationship to Other Provider Agencies

- The principle objective of home care and hospice agencies is to provide the best possible service to patients. Agencies shall honestly and conscientiously cooperate in providing information about referrals and shall work together to assure comprehensive services to patients and their families.
- Staff shall engage in ethical conduct of their affairs so that maximum fair trade occurs.

Fiscal Responsibilities

- The amount of service billed is consistent with amount and type of service provided.
- The cost per visit includes only legitimate expenses.
- The medical equipment sold or rented to a patient is provided at the lowest possible cost consistent with quality, quantity, and timeliness.
- The salaries and benefits of the provider and administrative staff shall be consistent with the size, responsibility, and geographical location of the agency.
- The provider shall not engage in "kick-backs" and "pay-offs."

Marketing and Public Relations

- Oral and written statements will fairly represent service, benefits, cost, and agency capability.
- Agencies that promote their service to the public through the media shall include information descriptive of home care and hospice in general, as well as agency specific information.

Personnel

- The agency shall be an equal opportunity employer and comply with all applicable laws, rules, and regulations.
- The agency shall have written personnel policies available to all employees and uniformly applied to all employees.
- The agency shall provide an ongoing evaluation process for all employees.
- The agency shall hire qualified employees and use them at the level of their competency.
- The agency shall provide supervision to all employees.
- The agency shall provide continuing education and in-service training for all employees to update knowledge and skills needed to give competent patient care.
- The agency shall hire adequate staffing to meet the needs of the patients to whom they render care.
- The agency shall have a pay scale that is consistent with the area and pay only for those expenses for travel and business that are within a reasonable norm.

ETHICAL ISSUES POLICY

1. The Agency recognizes that issues of an ethical nature related to the patient/client, Agency and the provision of services may develop. Such issues may include but are not limited to:

    a. Informed Consent

    b. Decision making

    c. High technology and medical experimentation

    d. Patient/client safety

    e. Accepting or refusing care

    f. Standards of care

    g. Advance Directives

    h. Confidentiality

    i. Care for persons with inadequate reimbursement for services

    j. Right to freedom of choice, dignity and movement

2. It is the policy of the Agency to:

    a. Provide care within an ethical framework established by the professional disciplines provided by the Agency, established in Agency policy and procedure, and as established by law and standards of care.

    b. Allow the patient/client or his/her representative the right to participate in any discussion concerning ethical issues and to document such involvement.

    c. Have Agency staff and the patient/client's physician participate in the consideration and resolution of ethical issues.

    d. Furnish staff with education regarding ethics and the mechanisms available to assist them with consideration and resolution of ethical issues.

3. Patient/Client Ethical Issues

    a. Ethical issues for patient/clients include but are not limited to the following:

        i. The patient/client has a Do Not Resuscitate or Do Not Intubate order but there is conflict among the family members.

        ii. The patient/client and/or family is participating in and/or conducting rituals, religious healing activities or other behaviors that are disturbing to the employee and/or causing the employee to be concerned for the patient/client's well-being.

        iii. The family and physician are concealing from the patient/client true information about his condition.

        iv. The physician does not respond to requests for care that the nurse believes is necessary, i.e. an increase or decrease in pain medication, testing for TB, to be seen by the physician, etc.

v. The patient/client refuses to accept assistance the employee feels are necessary, i.e. bathing, food stamps, companion, homemaker, ALF placement, etc.

vi. The patient/client refuses part of the ordered care (i.e., nursing) but chooses to accept another part of the ordered care (i.e., pharmacy).

vii. There is obvious drug use or other unusual or illegal activity in the patient/client's home which jeopardizes the employee's safety.

b. The Agency will convene an Ad Hoc Committee of the Professional Advisory Committee to discuss and attempt to resolve ethical issues that arise. This committee will meet for ethical issues arise.

The Agency's Medical Director/Advisor and the Agency employees involved in the patient/client's care will be included in the Ethics Committee.

c. The patient/client's physician (or if unavailable, the Agency's Medical Director/Advisor), and the Agency employees involved in the patient/client's care will be included in the Ethics Committee.

d. The Agency's Quality Improvement Committee or other designated individual(s) or group may serve as a resource to assist in the consideration of ethical issues.

e. The Governing Body will receive the minutes of the Ethics Committee meetings and may be called upon to take action on issues as required.

f. Anyone may initiate consideration by notifying the Administrator and/or Director of a potential or actual concern. The Administrator or Director shall present the issues at a meeting of the committee as soon as possible. Minutes shall be kept of the meeting, and as appropriate, staff, the patient/client and the patient/client's physician shall be advised of the results of the meeting in a manner appropriate to the individual situation.

4. Ethical Issues For Employees

a. The Agency recognizes that from time to time staff members' personal values and beliefs enter into their ability to provide care. Such issues include but are not limited to:

i. Working or traveling on certain religious holidays

ii. Right to life issues

iii. Administering blood transfusions

iv. Respecting an individual decision not to seek medical care because of their religious beliefs

v. Ethnic and sexual orientation issues for care

vi. Termination of life support systems and participation in certain advanced directive decisions

vii. Conflicting ethical, cultural or religious beliefs

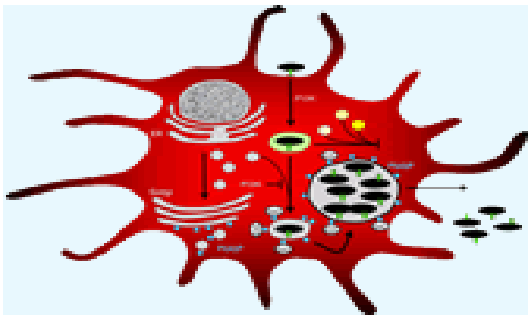
b. It is the Agency policy that:

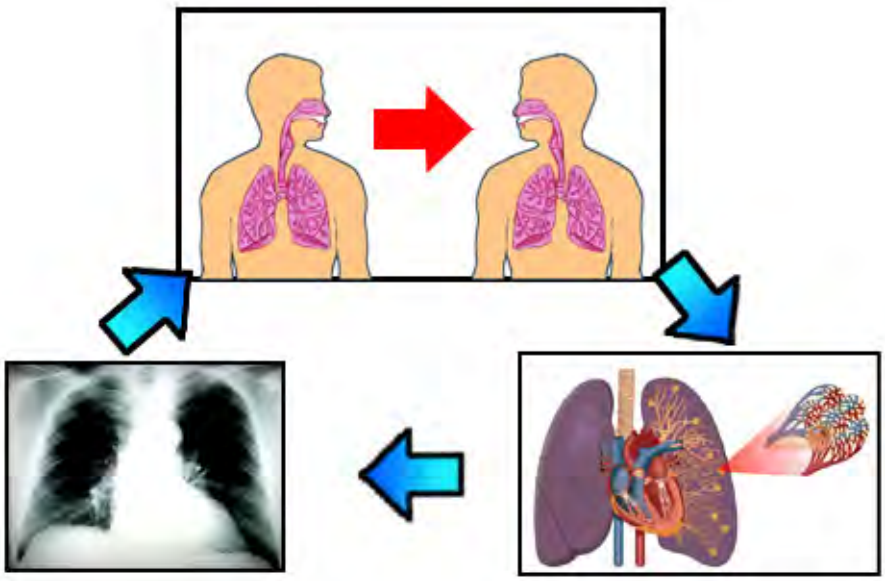
i. Refusal of an individual staff member to participate in certain aspects of care based upon personal values and beliefs will not disrupt the patient/client's care.

ii. When a situation arises for care that is in conflict with individual staff values and beliefs there is an alternative method of care.

iii. Individual performance evaluations will appropriately reflect the manager's consideration of motives related to refusal to participate based upon cultural values or religious beliefs.

TB/Blood borne Pathogens





What are blood borne pathogens?

Blood borne pathogens are infectious microorganisms in human blood that can cause disease in humans. These pathogens include, but are not limited to, hepatitis B (HBV), hepatitis C (HCV) and human immunodeficiency virus (HIV). Needlesticks and other sharps-related injuries may expose workers to blood borne pathogens. Workers in many occupations, including first responders, housekeeping personnel in some industries, nurses and other healthcare personnel, all may be at risk for exposure to blood borne pathogens.

What can be done to control exposure to blood borne pathogens?

In order to reduce or eliminate the hazards of occupational exposure to blood borne pathogens, an employer must implement an exposure control plan for the worksite with details on employee protection measures. The plan must also describe how an employer will use engineering and work practice controls, personal protective clothing and equipment, employee training, medical surveillance, hepatitis B vaccinations, and other provisions as required by OSHA's Blood borne Pathogens Standard (29 CFR 1910.1030). Engineering controls are the primary means of eliminating or minimizing employee exposure and include the use of safer medical devices, such as needleless devices, shielded needle devices, and plastic capillary tubes.

How do I find out about employer responsibilities and workers' rights?

Workers have a right to a safe workplace. The law requires employers to provide their employees with safe and healthful workplaces. The OSHA law also prohibits employers from retaliating against employees for exercising their rights under the law (including the right to raise a health and safety concern or report an injury). For more information see www.whistleblowers.gov or Workers' rights under the OSH Act.

OSHA can help answer questions or concerns from employers and workers. To reach your regional or area OSHA office, go to the OSHA Offices by State webpage or call 1-800-321-OSHA (6742).

Small businesses may contact OSHA's free On-site Consultation services funded by OSHA to help determine whether there are hazards at their worksites. To contact free consultation services, go to OSHA's On-site Consultation webpage or call 1-800-321-OSHA (6742) and press number 4.

Workers may file a complaint to have OSHA inspect their workplace if they believe that their employer is not following OSHA standards or that there are serious hazards. Workers can file a complaint with OSHA by calling 1-800-321-OSHA (6742), online via eComplaint Form, or by printing the complaint form and mailing or faxing it to the local OSHA area office. Complaints that are signed by a worker are more likely to result in an inspection.

If you think your job is unsafe or if you have questions, contact OSHA at 1-800-321-OSHA (6742). Your contact will be kept confidential. We can help. For other valuable worker protection information, such as Workers' Rights, Employer Responsibilities, and other services OSHA offers, visit OSHA's Workers' page.

Blood borne pathogens, such as bacteria and viruses, are present in blood and body fluids and can cause disease in humans. The blood borne pathogens of primary concern are hepatitis B, hepatitis C and HIV. These and other blood borne pathogens are spread primarily through:

Direct contact. ■ Infected blood or body fluid from one person enters another person’s body at a correct entry site, such as infected blood splashing in the eye. Indirect contact. ■ A person’s skin touches an object that contains the blood or body fluid of an infected person, such as picking up soiled dressings contaminated with an infected person’s blood or body fluid.

Respiratory droplet transmission. ■ A person inhales droplets from an infected person, such as through a cough or sneeze.

Vector-borne transmission. ■ A person's skin is penetrated by an infectious source, such as an insect bite.

Follow standard precautions to help prevent the spread of blood borne pathogens and other diseases whenever there is a risk of exposure to blood or other body fluids. These precautions require that all blood and other body fluids be treated as if they are infectious.

Standard precautions include maintaining personal hygiene and using personal protective equipment (PPE), engineering controls, work practice controls, and proper equipment cleaning and spill cleanup procedures.

TO PREVENT INFECTION, FOLLOW THESE GUIDELINES:

- Avoid contact with blood and other body fluids.
- Use CPR breathing barriers, such as resuscitation masks, when giving ventilations (rescue breaths). Wear disposable gloves whenever providing care, particularly if you may come into contact with blood or body fluids.
- Also wear protective coverings, such as a mask, eyewear and a gown, if blood or other body fluids can splash.
- Cover any cuts, scrapes or sores and remove jewelry, including rings, before wearing disposable gloves. Change gloves before providing care to a different patient.
- Remove disposable gloves without contacting the soiled part of the gloves and dispose of them in a proper container.
- Thoroughly wash your hands and other areas immediately after providing care. Use alcohol-based hand sanitizer where hand-washing facilities are not available if your hands are not visibly soiled.
- When practical, wash your hands before providing care.

TO REDUCE THE RISK 0F EXPOSURE, FOLLOW THESE ENGINEERING AND WORK PRACTICE CONTROLS:

- Use biohazard bags to dispose of contaminated materials, such as used gloves and bandages.
- Place all soiled clothing in marked plastic bags for disposal or cleaning.
- Biohazard warning labels are required on any container holding contaminated materials.
- Use sharps disposal containers to place sharps items, such as needles.

FACT SHEET

PREVENTING THE SPREAD OF BLOODBORNE PATHOGENS

- Clean and disinfect all equipment and work surfaces soiled by blood or body fluids.
- Use a fresh disinfectant solution of approximately 1½ cups of liquid chlorine bleach to 1 gallon of water (1-part bleach per 9 parts water, or about a 10% solution) and allow it to stand for at least 10 minutes.
- Scrub soiled boots, leather shoes and other leather goods, such as belts, with soap, a brush and hot water. If worn, wash and dry uniforms according to the manufacturer's instructions.

IF YOU ARE EXPOSED, TAKE THE FOLLOWING STEPS IMMEDIATELY:

- Wash needlestick injuries, cuts and exposed skin thoroughly with soap and water.
- If splashed with blood or potentially infectious material around the mouth or nose, flush the area with water.

- If splashed in or around the eyes, irrigate with clean water, saline or sterile irrigants for 20 minutes.
- Report the incident to the appropriate person identified in your employer's exposure control plan immediately.
- Additionally, report the incident to emergency medical services (EMS) personnel who take over care.
- Record the incident by writing down what happened.
- Include the date, time and circumstances of the exposure; any actions taken after the exposure; and any other information required by your employer.
- Seek immediate follow-up care as identified in your employer's exposure control plan.

Occupational Safety and Health Administration (OSHA) regulations require employers to have an exposure control plan, a written program outlining the protective measures the employer will take to eliminate or minimize employee exposure incidents.

The exposure control plan guidelines should be made available to employees and should specifically explain what they need to do to prevent the spread of infectious diseases.

Additionally, OSHA requires that a hepatitis B vaccination series be made available to all employees who have occupational exposure within 10 working days of initial assignment, after appropriate training has been completed. However, employees may decide not to have the vaccination. The employer must make the vaccination available if an employee later decides to accept the vaccination.

Post Exposure Evaluation and Follow-up Procedures will be as follows:

1. Following a report of an exposure incident, the Agency shall refer the employee for consultation, serologic testing, treatment and counseling, if necessary, and follow up.

2. The Agency will make immediately available to the exposed employee a confidential report of:

    a. Documentation of the route(s) of exposure and the circumstances under which the exposure incident occurred.

3. Identification and documentation of the source individual, unless the employer can establish identification is not feasible or prohibited by state or local law.

4. The Agency will assist in obtaining the source individual's consent for serologic testing to determine HBV and HIV infectivity. If consent cannot be obtained, it will be established that legally required consent cannot be obtained.

5. When the source individual is already known to be infected with HBV or HIV, testing for the source individual's known HBV or HIV status need not be repeated.

6. Results of the source individual's testing shall be made available to the exposed employee and the employee shall be informed of applicable laws and regulations concerning disclosure of the identity and infectious state of the source individual.

7. The exposed employee's blood shall be collected as soon as feasible and tested after consent is obtained. If the employee consents to baseline blood collection, but does not give consent at that time for HIV serologic testing, the sample must be preserved for 90 days. If, within 90 days of the exposure incident, the employee elects to have the baseline sample tested, such testing should be ordered as soon as possible.

8. When post-exposure prophylaxis is determined by the physician to be medically indicated as per the standards of the U.S. Public Health Service, counseling and evaluation of the reported illness will be given.

9. The Agency will ensure that the physician evaluating an employee after an exposure incident is provided with the following information:

    a. A copy of OSHA regulation 29 CFR.

    b. A description of the exposed employee's duties as they relate to the exposure incident.

    c. Documentation of the route(s) of exposure and circumstances under which exposure occurred.

    d. Results of the source individual's blood testing, if available.

    e. All medical records relevant to the appropriate treatment of the employee including vaccination status.

10. The Agency shall obtain and provide the employee with a copy of the written opinion for post-exposure and follow-up within 15 days of the completion of the evaluation. The physician's written opinion for post-exposure evaluation and follow-up will be limited to the following information:

    a. That the employee has been informed of the results of the evaluation.

    b. That the employee has been told about any medical conditions resulting from exposure to blood or other potentially infectious materials which require further evaluation or treatment.

    c. All other findings of diagnosis shall remain confidential and shall not be included in the written report.

TB INFECTIOUS CONTROL POLICY

Policy

It shall be the policy of this agency to adhere to the OSHA standards related to respiratory protection and the current CDC guidelines for tuberculosis infection control.

The agency does not admit TB patients to service and per CDC guidelines considers to be at low to medium risk. Yearly the agency as part of the annual evaluation and Infection control assessment will re-evaluate the risk based on current CDC guidelines, the risk definitions below and the local health department TB reported statistics. This evaluation will determine if the policy requirements for employee TB testing will be adjusted.

Purpose:

This plan is designed to prescribe practices relating to the management of Mycobacterium Tuberculosis in an effort to minimize the risk of exposure and transmission of this disease to home care staff, patients and others. It shall be available for review by all staff.

Definitions:

1. High Risk:
    a. The Agency PPD test conversion rate is significantly greater than previous conversion rates and epidemiological investigation suggests Agency acquired transmission or M. Tuberculosis, or
    b. A cluster of PPD conversions has occurred and epidemiological investigation suggests Agency acquired transmission of M. Tuberculosis, or
    c. Evidence of ongoing transmission of M. Tuberculosis.
2. Intermediate Risk:
    a. The Agency cares for three (3) or more TB patients per year,
    b. The PPD test conversion rate is the same as previous conversion rates for the Agency,
    c. No clusters of PPD test conversions have occurred, and
    d. No person-to-person transmission of M. Tuberculosis has been detected.
3. Low Risk:
    a. The Agency cares for less than three (3) TB patients per year,
    b. The PPD test conversion rate is the same as previous conversion rates for the Agency,
    c. No clusters of PPD test conversions have occurred, and
    d. No person-to-person transmission of M. Tuberculosis has been detected.
4. Very Low Risk:
    a. The Agency does not admit patients with active TB; patients who may have active TB are referred to a collaboratively agency, and
    b. The Agency provides services to communities of counties where TB cases have been reported during the previous year.

5. Minimal Risk:

a. The Agency does not admit TB patients; patients who may have active TB are referred to a collaborative agency and

b. The agency provides services to communities or counties where no TB cases have been reported during the previous year.

Procedures and Responsibilities:

1. The administration of this plan shall be the responsibility of the Agency Administrator and/or the most appropriate designee.

2. Agency will follow current CDC guidelines for TB monitoring & testing.

    a. The 2 step Mantoux PPD test shall be required for all Agency field staff with patient contact upon hire (or a negative 2 step test completed within 12 months of hire) and a TB questionnaire every year, unless they have a positive result from the Mantoux test, in which case a chest x-ray is conducted. In accordance with CDC guideline, no follow up chest X-Ray is required, only an annual TB Verification/Attestation/ TB questionnaire

3. Agency staff and patients will be screened for exposure to TB.

    a. All Agency staff members who have not previously converted to a positive Mantoux PPD, will be screened for exposure to TB when being hired and as indicated by CDC guidelines, using the Mantoux 2 step PPD test administered and interpreted by a physician, ARNP or trained personnel.

    b. If the Agency staff being screened for exposure to TB when being hired does not have documentation of a PPD within the past six (12) months, a 2 step Mantoux test will be administered.

    c. Agency staff members who have converted to a positive Mantoux PPD will not be given a Mantoux PPD test on hire, but will be requested to submit a baseline negative chest x-ray report. The employee will complete a TB assessment and be assessed for symptoms of TB. If symptoms are noted or develop at any time, a chest x-ray will then be obtained. A TB questionnaire will be required every year.

    d. The patient's physician will be notified immediately when a patient exhibits signs and symptoms of TB on initial assessment to the Agency or at any time during the patient's admission.

    e. Patients with suspected or confirmed TB will be reported immediately to the local health department.

    f. Population considered at high risk includes the following (CDC definition):

        i. African Americans
        ii. Alcoholics
        iii. Asian and Pacific Islanders
        iv. Intravenous
        v. (IV) drug users
        vi. American Indians
        vii. Elderly persons
        viii. Alaskan Natives
        ix. People from areas of the world where TB is prevalent (Asia, Africa, Caribbean)
        x. Hispanics
        xi. Persons with pulmonary signs or symptoms
        xii. Persons with HIV infection or with risk factors for HIV infection
        xiii. People living in the same household as members of these groups
        xiv. Current or past inmates

Policies for Care of <u>Patients</u> with Suspected TB Infections

1. Home care for patients with suspected TB infections shall provide for early identification of active TB. Symptoms include, but are not limited to the following:

    a. productive cough
    b. coughing up blood
    c. weight loss
    d. loss of appetite
    e. lethargy
    f. weakness
    g. night sweats
    h. fever.

2. TB patients are not admitted to our Agency. In the event that a patient's TB infection is discovered while the patient is receiving services from the Agency, we will continue to care for the patient unless they prefer to be transferred to another Agency.

3. Care of patients with suspected or confirmed infections shall be available and shall include:

    a. Precautions to prevent exposure until communicability has been eliminated by chemotherapy

    b. Instructing patients to cover coughs and sneezes

    c. Instructing patients who are on TB medications about the importance of taking medications as prescribed unless adverse effects are seen.

4. Individuals with suspected or confirmed TB should, to the extent possible, be isolated from other residents in an area with the maximum possible ventilation, as follows:

    a. In a facility other than the home, regulations require isolation of patients in an acid fast bacilli (AFB) isolation room and, in areas where high hazard procedures are performed on such individuals, negative pressure and appropriate means to release exhaust must be maintained.

    b. Since this is not possible in the home, use of an approved particulate respirator is appropriate.

    c. A warning sign should be posted outside of the patient's room, e.g. "Special Respiratory Isolation" or "AFB Isolation" or a description of the necessary precautions.

5. The Agency shall make provisions for the performance of an instructions regarding cleaning, disinfecting or sterilizing as follows:

    a. Generally, critical items should be sterilized (needles, instruments or items introduced into the bloodstream or sterile areas of the body).

    b. Semi-critical items should be sterilized or cleaned with high-level disinfectants (non-invasive flexible items such as stethoscopes or BP cuffs).

    c. Non-critical items should be cleaned with detergents or low-level disinfectants (crutches, bed boards, nursing bags, etc.)

    d. Selection of chemical disinfectants depends on the intended use, level of disinfection required, and the structure and material of the item to be disinfected.

Policies for Care of <u>Staff</u> with Suspected TB Infections

1. The Agency shall manage staff with newly recognized conversions or a positive Mantoux PPD, and staff diagnosed with active TB.

    a. Agency staff who convert or who test positive on the Mantoux PPD test shall:

        i. Be requested to obtain a chest x-ray to determine if clinically active TB is present.

        ii. If symptomatic, the staff will be excluded from work until a physician's written statement of non-infectious status is obtained.

    b. When the Agency has staff with newly recognized conversions or a positive PPD:

        The positive Mantoux PPD, medical evaluation and treatment will be documented in the staff member's employee medical record.

    c. A chest x-ray will be conducted every five years on all employees having a positive Mantoux reading.

    d. When Agency staff members are diagnosed as having active TB the Agency shall:

        i. Exclude the staff member from work until a written statement of non-infectious status from the physician and the staff member has been shown to have three (3) consecutive daily AFB smears that are negative.

        ii. When the staff member returns to work, the Agency requires documentation from the staff member's health care provider that he/she is maintained on effective therapy and remains AFB sputum smear negative.

        iii. If the staff member discontinues therapy before the course has been completed, they must be excluded from work.

    e. Staff members with active TB sites other than the lung or larynx usually do not need to be excluded from work.

2. The Agency shall provide training and education of staff.

    a. Agency staff will receive training and education in TB infection control and the use of respiratory protection on hire and annually.

    b. Staff training and education will include:

        i. The basic concepts of TB transmission, pathogenesis, and diagnosis.

        ii. The potential for occupational exposure to persons with infectious TB.

        iii. The principles and practices of infection control that reduce the risk of TB transmission.

        iv. The purpose of Mantoux PPD testing and the importance of the skin test program.

        v. The principles of preventative therapy for latent TB infection.

        vi. The responsibility of the staff member to seek medical evaluation promptly.

        vii. The principles of drug therapy for active TB.

viii. The importance of notifying the Agency if diagnosed with active TB.

ix. The responsibilities of the Agency to maintain the confidentiality of the staff member who converts or develops active TB.

x. The higher risk posed by TB to the immune compromised individual or those with HIV.

xi. education specific to home care:

1. Cough producing procedures performed on patients with infectious TB should not be done in the home unless absolutely necessary.

2. Such procedures should be done in a health care facility in a room or booth with the recommended ventilation for such procedures.

3. If these procedures must be done in a patient's home, they should be performed in a well-ventilated area away from other household members.

4. If feasible, the home care staff should consider opening a window to improve ventilation or collecting the specimen while outside the dwelling.

5. The home care staff collecting these specimens should wear respiratory protection during the procedure.

6. The home care staff should instruct patients with suspected or confirmed TB to cover their mouths and noses with a tissue when coughing or sneezing.

7. The home care staff should instruct patients on TB medications and the importance of taking their medications as prescribed.

8. The home care staff should instruct patients at risk for developing TB in the importance of having pulmonary symptoms evaluated promptly for early detection of and treatment for TB.

Requirements for the Selection and Use of Respiratory Protective Devices

1. The Agency shall provide for employee use of a NIOSH-approved N95 or similar respirator equipped with high efficiency particulate air (HEPA) filters, the minimally acceptable level of respiratory protection.

2. If disposable respirators are used, their reuse is permitted as long as the respirator maintains its structural and functional integrity. The Agency must address the circumstances in which a disposable respirator will be considered to be contaminated and not reusable.

3. Whenever respirators are required to be used, the Agency must have a complete respiratory protection program in place, as follows:

    a. Respirators are recommended under the following circumstances:

        i. When employees enter the homes or rooms of individuals with suspected or confirmed infectious TB disease.

        ii. When employees perform high hazard procedures on individuals who have suspected or confirmed TB disease including, but not limited to:

            1. Aerosolized medication, e.g. Pentamidine.

            2. Bronchoscopy.

            3. Sputum induction.

            4. Endotracheal intubation.

            5. Suctioning procedures.

            6. When transporting an individual with suspected or confirmed TB disease in a closed vehicle.

            7. During performance of cough-inducing procedures in a well-ventilated area away from other household members.

    b. The Agency will use only respiratory protective devices certified by NIOSH such as N95 or similar for protection against TB.

    c. Respiratory protective devices used for TB shall meet the following criteria:

        i. They will have a NIOSH filter category rating of 95, 99, or 100.

        ii. They will be able to be qualitatively or quantitatively fit-tested to manufacturer's specifications for most health care workers.

    d. Agency staff will be medically screened for conditions which would prohibit wearing respiratory protection prior to being fit tested.

    e. Field employee will be fit tested prior to use.

    f. Agency staff will be required to wear respiratory protection when entering the homes of patients with suspected or confirmed TB.

    g. Respiratory precautions may be discontinued when the patient is no longer infectious.

    h. Agency staff unable to wear respiratory protection for medical reasons or because they are unable to obtain a proper fit in the fit test will not be assigned to care for patients with suspected or confirmed TB during the time they are infectious.

4. The Agency shall provide the wearer of the respirator mask with education and training in:

    a. The need for wearing their respective mask and the potential risks of not wearing it.

    b. How to properly use the respirator mask and the capabilities, and limitations of the mask.

    c. Inspecting, donning, fit checking, and correctly wearing the respirator masks, with the chance to handle it, learn how to don and wear it properly and check its important parts.

    d. The recognition of an inadequately functioning respirator mask.

    e. The manufacturer's instructions for storage, inspection, cleaning, and maintenance of the respirator masks.

5. The Agency will evaluate the effectiveness of the respiratory program.

    a. Both the written operating procedures and the administration of the program will be revised as necessary based on the results of the annual evaluation.

    b. The evaluation of the program will include work practices and employee acceptance of the respirator use by eliciting comments about such subjective areas as the comfort of the respirator and its interference with duties.

Medical Device Act

MDR Overview

Each year, the FDA receives several hundred thousand medical device reports of suspected device-associated deaths, serious injuries and malfunctions. Medical Device Reporting (MDR) is one of the post market surveillance tools the FDA uses to monitor device performance, detect potential device-related safety issues, and contribute to benefit-risk assessments of these products.
Mandatory reporters (i.e., manufacturers, device user facilities, and importers) are required to submit certain types of reports for adverse events and product problems to the FDA about medical devices. In addition, the FDA also encourages health care professionals, patients, caregivers and consumers to submit voluntary reports about serious adverse events that may be associated with a medical device, as well as use errors, product quality issues, and therapeutic failures. These reports, along with data from other sources, can provide critical information that helps improve patient safety.

Mandatory Medical Device Reporting Requirements:

The Medical Device Reporting (MDR) regulation (21 CFR 803) contains mandatory requirements for manufacturers, importers, and device user facilities to report certain device-related adverse events and product problems to the FDA.

Manufacturers: Manufacturers are required to report to the FDA when they learn that any of their devices may have caused or contributed to a death or serious injury. Manufacturers must also report to the FDA when they become aware that their device has malfunctioned and would be likely to cause or contribute to a death or serious injury if the malfunction were to recur.

Importers: Importers are required to report to the FDA and the manufacturer when they learn that one of their devices may have caused or contributed to a death or serious injury. The importer must report only to the manufacturer if their imported devices have malfunctioned and would be likely to cause or contribute to a death or serious injury if the malfunction were to recur.

Device User Facilities: A “device user facility” is a hospital, ambulatory surgical facility, nursing home, outpatient diagnostic facility, or outpatient treatment facility, which is not a physician’s office. User facilities must report a suspected medical device-related death to both the FDA and the manufacturer. User facilities must report a medical device-related serious injury to the manufacturer, or to the FDA if the medical device manufacturer is unknown.

A user facility is not required to report a device malfunction, but can voluntarily advise the FDA of such product problems using the voluntary MedWatch Form FDA 3500 under FDA’s Safety Information and Adverse Event Reporting Program. Healthcare professionals within a user facility should familiarize themselves with their institution's procedures for reporting adverse events to the FDA.

Voluntary Medical Device Reporting:

The FDA encourages healthcare professionals, patients, caregivers and consumers to submit voluntary reports of significant adverse events or product problems with medical products to MedWatch, the FDA’s Safety Information and Adverse Event Reporting Program or through the MedWatcher mobile app.

MEDICAL DEVICE/SAFETY HAZARDOUS DEVICE REPORTING

1. Definitions:

    a. Health hazard means a chemical for which there is statistically significant evidence based on at least one study conducted in accordance with established scientific principles that acute or chronic health effects may occur in exposed employees.

    b. Safety Data Sheet (SDS) means written or printed material concerning a hazardous chemical (OSHA 500:1131 CH 510 ATT 4 subpart Z). SDS is an OSHA approved method to make readily available to employees, current information and protective measures for chemical health hazards present in the work place.

    c. "MDR reportable events" are the adverse events or problems that the medical device regulation requires to be reported. For facilities, MDR reportable events include patient deaths and serious injuries that medical devices have or may have caused or contributed to, i.e., the devices may have directly caused the events or played a role in the events.

    d. Serious Injury*-There are three (3) possible types of serious injuries, and they are not mutually exclusive:

        i. Life threatening injuries;

        ii. Injuries that result in permanent damage or impairment; and

        iii. Injuries that require medical intervention to preclude permanent damage or impairment is defined as irreversible damage or impairment that is not trivial.

    e. Adverse events include:

        i. Death.

        ii. Life-threatening events.

        iii. Hospitalization-initial or prolonged.

        iv. Disability.

        v. Congenital Anomaly.

        vi. Required intervention to prevent permanent impairment/damage.

    f. Malfunction is the failure of a device to meet its performance specifications or to perform as intended. A malfunction is reportable when it is likely to cause or contribute to a death or serious injury if it were to recur. The regulation assumes that a malfunction will recur.

2. The Agency chooses to rely upon the evaluation of hazards provided by the chemical manufacturer or importer.

3. Procedures are implemented to document the reporting of medical device safety hazards and the subsequent corrective action taken, or to prevent the reoccurrence of an unsafe act.

4. The Agency understands the importance of communication of hazards for the protection of patients and staff.

5. The reporting of medical device and safety hazards is the specific responsibility of all employees of the Agency. The Administrator has the responsibility for ensuring compliance with reporting requirements.

6. A report is required when the agency has information that reason-ably suggest that a device has or “may have” caused or contributed to a death or serious injury of a patient. If the chance that a device may have caused or contributed to an event is very remote or very unlikely, the event should not be reported.

7. A report is required when a reporting entity receives information that “reasonably suggest” that a device may have caused or contributed to an MDR reportable event. This includes any information such as professional, scientific or medical facts and observations or opinions that would reasonable suggest a device has caused or may have caused or contributed to a MDR reportable event.

8. All medical devices and safety hazards related to patients, personnel and visitors shall be reported immediately to assure that corrective action is taken.

9. An employee report of medical device /safety hazard occurrence should be submitted by an employee as soon as possible, listing the exact location and nature of the hazard. Upon completion, the report should be forwarded to the Administrator.

10. Upon receipt of the employee report of medical device/safety hazard, the Administrator shall conduct an investigation of the reported condition/act and document any action taken or suggested to eliminate the hazard. The manufacturer, if known, will be notified.

11. The Administrator will then forward the report to the Chairman of the QAPI Committee for further review and analysis. Summaries of all such reported hazards shall be documented in the minutes of the committee meeting.

12. All records will be retained for audit and reporting purposes. They will be retained for a minimum of five years.

13. The FDA will be notified by the Administrator when incidents result in serious injury, illness or death or manufacturer unknown. The manufacturer will be notified, if known. Reports must be submitted on FDA Form 3500A (mandatory MedWatch form) within 10 days from the time that any employee or person affiliated with the agency becomes aware that the device may have caused or contributed to a death or injury.

14. The report is to include the following:

    a. Information about the patient.

    b. Type of adverse event.

    c. Description of the event.

    d. Relevant laboratory/test data and patient history.

    e. Manufacturer and identification of the suspect device and certain other information about the device.

    f. Initial reporter of the event.

    g. User facility/distributor name, address and contact.

    h. Event problem codes for the device and patient.

    i. Where and when the report was sent.

15. The following are guidelines for reporting:

    a. Deaths to FDA and Manufacturer within 10 work days.

b. Serious Injuries* to the Manufacturer, and the FDA only if the manufacturer is unknown, within 10 work days.

c. Annual report of deaths and serious injuries to the FDA every January 1.

16. A mandatory in-service on Medical Device/Safety Hazard Reporting is provided on an annual basis with documentation of the date and time of the in-service, a list of attendees and an outline of the training content.

17. Employees will be provided with information and training on hazardous chemicals in the work area during initial orientation and yearly thereafter. The employee orientation will include:

    a. Hazard communication requirements of OSHA.

    b. The presence of hazardous chemicals in the work area.

    c. How to read and interpret labels and SDS.

    d. How to cope with emergency procedures (recognition, reporting, and evacuation).

What to Report to FDA MedWatch:

Use the MedWatch form to report adverse events that you observe or suspect for human medical products, including serious drug side effects, product use errors, product quality problems, and therapeutic failures for:

- Prescription or over-the-counter medicines, as well as medicines administered to hospital patients or at outpatient infusion centers
- Biologics (including blood components, blood and plasma derivatives, allergenic, human cells, tissues, and cellular and tissue-based products (HCT/Ps))
- Medical devices (including in vitro diagnostic products)
- Combination products
- Special nutritional products (dietary supplements, infant formulas, and medical foods)
- Cosmetics
- Foods/beverages (including reports of serious allergic reactions

Post Test

Employee Name: _____

Date: _____

Score: _____

1. Cultural differences are not limited to ethnicity and race relations; they extend to areas of religious views, sexuality and even differences in geographical differences pertaining to the location of one's upbringing.
   a. True
   b. False

2. Where an employee lives or has lived can contribute to cultural differences in the workplace.
   a. True
   b. False

3. What federal agency prohibits companies from discriminating against employees for any reason?
   a. OSHA
   b. CMS
   c. U.S. Equal Employment Opportunity Commission
   d. All of the above

4. The agency is not required to transport or physically evacuate a patient in the event of an emergency.
   a. True
   b. False

5. The patient is provided with the following:
   a. A copy of the Agency's policy on how to handle disaster related emergencies in the home.
   b. Patient responsibilities in the Agency's Emergency Preparedness and Response Plan.
   c. A list of community disaster resources that can assist during a disaster-related emergency.
   d. All of the above.

6. The agency reviews the Emergency Disaster Plan as:
    a. Needed.
    b. At least yearly.
    c. After each response.
    d. All of the above.

7. What are the types of emergencies?
    a. Man-Made.
    b. Natural.
    c. Technological.
    d. Any of the above.

8. All patients are informed of their right to voice a complaint/grievance against anyone furnishing services on behalf of the agency at:
    a. On admission.
    b. Before admission.
    c. A and B.
    d. None of the above.

9. What is the timeframe to provide the patient a response to the complaint?
    a. 10 days.
    b. 3 days.
    c. 30 days.
    d. As soon as possible.

10. How often are complaints reported to the Governing Body?
    a. Monthly
    b. Weekly
    c. Quarterly
    d. B and C

11. Who serves as the Agency's Privacy Officer?
    a. Director of Nursing
    b. Governing Body
    c. Administrator
    d. CFO

12. What does HIPAA stand for?
    a. Health Information Privacy Administrative Act
    b. Health Insurance Portability Accountability Act
    c. Health Information Protected and Accessed

13. What is the most important task performed to protect against infections?
    a. Using gloves.
    b. Good handwashing.
    c. Covering mouth when coughing.
    d. Staying home when you are sick.

14. Patient care bags may be put on the floor if a barrier is used?
    a. True
    b. False

15. Areas and equipment contaminated with blood should be cleaned immediately with:
    a. Lysol wipe.
    b. 1:10 bleach solution (10%).
    c. 100% bleach.
    d. Blood should not be touched.

16. Successful communication requires knowing what barriers to communication exist and how to navigate around those roadblocks. These may include:
    a. Physical barriers.
    b. Language barriers.
    c. Gender barriers.
    d. Any of the above.

17. Non-verbal communication components can include physical appearance.
    a. True
    b. False

18. SDS
    a. Is the new acronym for MSDS.
    b. Means “Service Date Same”.
    c. Will give symptoms for diseases.
    d. Stands for Safety Data Sheets.

19. OSHA was created to:
    a. Enforce local and state regulations.
    b. To require employers to assure a safe and healthful workplace.
    c. Provide a place to buy protective equipment.
    d. As a “catch all” for employee complaints, in general.

20. If a death of an employee occurs while working, how many hours does the agency have to notify OSHA?
    a. 10
    b. 8
    c. 24
    d. 48

21. Key items to remember about the Patient Bill of Rights are:
    a. The rights can be exercised at anytime.
    b. The patient always has the right to refuse care.
    c. The patient has the right to be treated with respect.
    d. All of the above.

22. A Corporate Compliance program is a system which is designed to detect and prevent violations of law by the agents, employees, officers and directors of a business.
    a. True
    b. False

23. What are the potential penalties the agency may face for non-compliance?
    a. prison
    b. fines
    c. sanctions
    d. possibly all of the above

24. The Code of Ethics is intended to serve as a guideline to the agency in the following areas:
    a. Patient Rights and Responsibilities
    b. Relationships to Other Provider Agencies
    c. Fiscal Responsibilities
    d. Marketing and Public Relations
    e. Personnel
    f. All of the above

25. Ethical issues for employees include:
    a. Working or traveling on certain religious holidays
    b. Right to life issues
    c. Administering blood transfusions
    d. Respecting an individual decision not to seek medical care because of their religious beliefs
    e. All of the above

26. Blood borne pathogens are infectious microorganisms in human blood that can cause disease in humans.
    a. True
    b. False

27. OSHA requires that a hepatitis B vaccination series to be made available to all employees who have occupational exposure within 10 working days of initial assignment.
    a. True
    b. False

28. How often does CDC recommend TB skin testing for direct care employees?
    a. On hire
    b. Yearly
    c. Exposure
    d. Every 3 years
    e. A, B and C

29. An equipment malfunction is reportable if the following occurs:
    a. Likely to cause a death.
    b. Likely to cause a serious injury.
    c. Contributes to a death or serious injury.
    d. All of the above.

30. Which of the following are considered reportable?
    a. Prescription or over-the-counter medicines
    b. Biologics
    c. Medical Devices
    d. All of the above

CERTIFICATE *of* COMPLETION

THIS ACKNOWLEDGES THAT ON THIS DATE: _____

[Recipient Name]

HAS SUCCESSFULLY COMPLETED THE YEARLY ACHC MANDATORY IN-SERVICES

CULTURAL AWARENESS; EMERGENCY/DISASTER; HOW TO HANDLE COMPLAINTS/GRIEVANCES; HIPAA; INFECTION CONTROL; COMMUNICATION BARRIERS; WORKPLACE/PATIENT SAFETY (OSHA); PATIENT RIGHTS/RESPONSIBILITIES;
CORPORATE COMPLIANCE; ETHICS; TB/BLOOD BORNE PATHOGENS; MEDICAL DEVICE ACT

x _____

SIGNATURE/TITLE

Relias Clinical Procedures: Skills Covered in the Library

For providers needing a clinical procedures solution delivered at the point of care, the Relias Clinical Procedures library provides over 400 topics appropriate for the entire interdisciplinary team. Using short PDF-based modules available via the Relias mobile app, clinicians can learn or refresh their skills to ensure quality care.

Procedures for the following skills are available in the library.

- 90-90-90 position
- Above knee stump bandaging
- Above knee amputation exercises
- Adding IV solution, priming tubing, changing tubing
- Adding sterile objects to a sterile field
- Administering oxygen in an emergency
- Administering oxygen through a mask
- Administering oxygen through a nasal cannula
- Administering tetanus toxoid for pressure ulcers and other wounds
- AED
- Air mattress
- Airborne precautions
- Airways obstruction conscious
- Alcohol based hand cleaner
- Alginate dressings
- Allergies
- Ambulating a resident using a gait belt
- Ambulating a resident with a cane
- Ambulating a resident with a walker
- Ambulating a resident with crutches
- Ambulation
- Anticipated discharge
- Anti-embolic hose
- Applying a bed cradle to the bed

Exhibit 15

QAPI Plan

Customer Service Plan

QUALITY ASSESSMENT/PERFORMANCE IMPROVEMENT PROGRAM

POLICY

Josephine At Home will develop, implement, evaluate, and maintain an effective, ongoing, agency-wide, date driven Quality Assessment/Performance Improvement (QAPI) Program under the direction of the Administrator and multidisciplinary QAPI Committee that evaluates and monitors the quality, safety and appropriateness of services provided by the agency. Josephine At Home's QAPI program will be ongoing, focused on client outcomes that are measurable, and have a written plan for the implementation in accordance with applicable state, federal and ACHC accreditation requirements. The committee will review and update or revise the plan of implementation at least quarterly or more often if needed. The QAPI program will provide key indicators of areas of risk management.

The Josephine At Home QAPI Program activities will be incorporated into the overall Josephine Caring Community Performance Improvement Program and reported to the designated QAPI Committee, Professional Advisory Committee and Governing Body.

Josephine At Home staff are involved in the agency QAPI Plan through carrying out QAPI activities, evaluating findings, recommending action plans, and/or receiving reports of findings.

Josephine At Home is required to maintain documentary evidence of its QAPI Program and be able to demonstrate its operation to state/federal/accreditation surveyors.

PURPOSE

To outline the structure, components and reporting requirements of the Josephine At Home Quality Assessment/Performance Improvement (QAPI) Program.

PROCEDURE

1. The Governing Body bears overall responsibility for the quality assessment performance improvement program. The Governing Body must ensure that the QAPI program reflects the complexity of the Agency and its services involves all Agency services (including those services provided under contract or arrangement); focuses on indicators related to improved outcomes, including the use of emergent care services, hospital admissions and readmissions, and takes actions that address the Agency's performance across the spectrum of care, including the prevention and reduction of medical errors. The Governing Body must ensure:

    a. That an ongoing program for quality improvement and client safety is defined, implemented and maintained;

    b. That the Agency-wide QAPI efforts address priorities for improved quality of care and client safety, and that all improvement actions are evaluated for effectiveness;

    c. That clear expectations for client safety are established, implemented and maintained;

d. That any findings of fraud or waste are appropriately addressed.

2. The Executive Director/designee is directly responsible for implementing the QAPI Plan. The duties and responsibilities relative to implementation of the QAPI Plan include:

    a. Assisting with the overall development and implementation of the QAPI plan;

    b. Assisting in the identification of goals and related client outcomes; and

    c. Coordinating, participating, and reporting of activities and outcomes.

3. At a minimum, the committee will consist of the following:

    a. Josephine At Home Executive Director

    b. Home Health Clinical Manager

    c. Josephine at Home HHA

    d. Josephine at Home staff RN

    e. Therapist (PT/OT/ST).

4. The Committee will meet at least quarterly or more often if needed. Written reports will be filed in the agency and be provided to the Governing Body following each meeting.

5. All Josephine At Home staff and contractors receive training related to QAPI activities and their involvement as part of the agency orientation and in-service training. Training includes, but is not limited to:

    a. The purpose of QAPI activities;

    b. Person(s) responsible for coordinating QAPI activities;

    c. Individual's role in QAPI;

    d. QAPI outcomes resulting from previous activities.

6. The QAPI Program must at least be capable of showing measurable improvement in indicators for which there is evidence that improvement in those indicators will improve health outcomes, client safety and quality of care.

7. Josephine At Home must measure, analyze and track quality indicators, including adverse client events, and other aspects of performance that enable Josephine At Home to assess processes of care, services and operations.

8. Josephine At Home identifies outcomes to benchmark by utilizing internal standards, processes and protocols; practice or service guidelines; industry research and/or best practices.

9. The QAPI Plan and program will include at least the following:

    a. Program objectives;

    b. A description of how the QAPI program will be administered and coordinated.

    c. A description of oversight and responsibility for reports to the Governing Body/owner.

    d. A system for identifying, analyzing and correcting adverse events.

    e. A method to select, prioritize and track quality indicators by high risk, high volume, problem prone areas and by the effect on client safety and quality of care. At least one (1) important aspect of care/service and one (1) important administrative/operational aspect of function or service will be monitored at any given time. The program focuses on indicators or measures related to improved outcomes including, at a minimum:

        - Use of emergent care services;
        - Hospital admissions and readmissions; and
        - Performance across the spectrum of care, including the prevention and reduction of medical errors.

    f. A system that measures significant outcomes for optimal care for all client care disciplines. The QAPI Committee will use the measures in the care planning and coordination of services and events.

    g. A process to monitor and address measures needing improvement based on analysis of agency outcome data, including, but not limited to data derived from OASIS assessments, Home Health Compare, and Home Health Consumer Assessment of Healthcare Providers and Systems (HH-CAHPS).

    h. Development of a plan to ensure compliance with state statutes and administrative codes.

    i. Josephine At Home shall conduct QAPI projects. The number and scope of projects conducted annually must reflect the scope, complexity and past performance of the Agency's services and operations.

    j. Josephine At Home shall document QAPI projects undertaken, the reasons for conducting these projects and the measurable progress achieved on these projects. QAPI projects are prioritized using criteria specified by the agency.

    k. Josephine At Home continually evaluates progress toward outcomes and identifies new areas to improve or replicate as indicated by results of data analysis.

10. Josephine At Home shall use the data collected to:

    a. Monitor the effectiveness and safety of services and care; and quality of care; and

    b. Identify opportunities for improvement.

    c. The Governing Body must approve the frequency and detail of data collection.

11. A system to collect and ensure submission of applicable Home Health Agency Statistical Reports to the Washington State DOH and ACHC.

12. Each QAPI activity/study includes the following items:

    a. A description of indicator(s) to be monitored/activities to be conducted; This includes, but is not limited to the identification of high risk, problem prone processes related to care, treatment or services.

    b. Frequency of activities.

    c. Designation of who is responsible for conducting the activities.

    d. Methods of data collection.

    e. Acceptable limits for findings.

    f. Plans to re-evaluate if findings fail to meet acceptable limits.

    g. Any other activities required under state or federal laws or regulations.

    h. A system for monitoring to determine the effectiveness of QAPI actions.

13. In addition, the QAPI Committee will conduct a quarterly review of the following to detect trends and create an action plan to decrease occurrences:

    a. Clinical record review results. Refer to Professional Advisory Committee Policy for information related to clinical record review processes.

    b. Negative client care outcomes.

    c. Complaints and incidents of unprofessional conduct by licensed staff and misconduct by unlicensed staff.

    d. Infection prevention and control activities.

    e. Occurrence Reports.

    f. Adverse Events/Potentially Avoidable Events (Casper Reports).

        - Tracking of adverse events includes analysis of their causes, and implement preventive actions.

g. Publicly reported outcome measures (Home Health Compare).

h. Sentinel events and/or near misses if applicable.

i. Medication administration and errors.

j. Effectiveness and safety of all services provided including the following:

- The competency of clinical staff.
- The promptness of service delivery.
- The appropriateness of the responses to client complaints and incidents.

k. A determination that services have been performed as outlined in the individualized service plan, care plan or plan of care.

l. An analysis of client complaint data.

m. An analysis of client, employee, Physician or other qualified licensed practitioner and referral source satisfaction survey data (as applicable).

n. Worker's compensation claims.

o. Review and oversight of contracted services.

14. The methods used by the Josephine At Home staff for reviewing data include, but are not limited to:
    a. Current documentation (e.g., review of clinical records, QAPI activity reports, occurrence reports, complaints, satisfaction surveys, etc.).

    b. Client care.

    c. Direct observation of clinical performance.

    d. Operating systems.

    e. Interviews with clients and/or Josephine At Home personnel.

15. The Agency must take actions aimed at Performance Improvement, and, after implementing those actions, the Agency must measure its success and track performance to ensure improvements are sustained.

16. Identified problems that directly or potentially threaten client care and safety will be corrected immediately.

17. A written plan of correction is developed in response to any PI activity that does not meet an acceptable threshold (which is established for each QAPI activity by the QAPI Committee). The plan of correction identifies changes in policies and procedures that will

improve agency performance.

18. QAPI documents will be kept confidential but will be made available to surveyors upon request.

19. The QAPI Plan will be summarized, evaluated and updated at least annually in conjunction with the Annual Agency Program Evaluation and the recommendations forwarded to the Professional Advisory Committee and Governing Body for approval.

20. The QAPI Annual Report Summary includes, but is not limited to:

    a. The effectiveness of the QAPI program;

    b. Summary of all QAPI activities, findings and corrective actions;

    c. The effectiveness, quality and appropriateness of care/service provided to the clients, service areas and community served;

    d. Effectiveness of all programs including care/service provided under contractual arrangements;

    e. Review and revision of policies and procedures, and forms used by Josephine at Home ;

    f. Is incorporated into the Annual Agency Program Evaluation.

Date Approved:

CUSTOMER SATISFACTION

POLICY

Josephine At Home considers the clients, their caregivers/family, Josephine At Home employees and volunteers, vendors and contracted staff, and health care facilities as clients of the organization.

Josephine At Home regards as a principal factor in its assessing organizational performance the quality of care/service delivered to its clients and the ability to meet client expectations. Josephine at Home's commitment to its clients, their caregivers, and the staff of the organization will be reflective of its philosophy and will be reviewed in light of Josephine at Home 's own explicit and implicit commitment to provide excellent care/service to its clients.

In accordance with Medicare requirements, Josephine at Home will monitor client satisfaction through the administration and monitoring of Home Health Consumer Assessment of Healthcare Providers and Systems (HH-CAHPS) as part of the agency's Quality Assessment/Performance Improvement Program.

PURPOSE

To focus the efforts of Josephine At Home on the enhancement of client satisfaction to those individuals serviced and employed by the home care organization and to meet Medicare regulations pertaining to collection of client satisfaction data through the HH-CAHPS survey process.

PROCEDURE

1. Written client satisfaction surveys will be distributed to Josephine At Home clients at client discharge through the HH-CAHPS approved vendor.
2. Written client satisfaction surveys will be sent to Home Care (non-medical) clients and will also be utilized prior to HH-CAHPS participation eligibility for skilled home health clients.
3. The Executive Director or designee will contact a sample of active patients on a monthly basis to evaluate client satisfaction with services provided following admission and identify opportunities for improvement.
4. On at least an annual basis, Josephine At Home will conduct focused satisfaction surveys focusing on referral sources and employees.
5. All response data will be collected and analyzed on an ongoing basis. Staff will follow up all signed dissatisfied client satisfaction questionnaires and a response provided to the client.
6. Based on client responses, trends will be identified.
7. Outcomes/variances will be examined and followed up by the appropriate management staff. Corrective actions will be planned and initiated.

8. A summary of findings and corrective actions taken will be made and reported quarterly as part of the QAPI Program.
9. All unsolicited correspondence will be examined for positive feedback and negative variances.
10. Response data will be collected and analyzed by the QAPI Committee and the results will be sent to the Executive Director and Governing Body.

Date Approved: