STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

CN #20-35

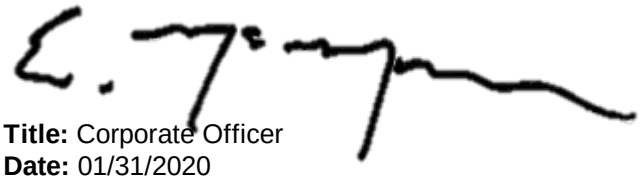
RECEIVED
JAN 28, 2020
CERTIFICATE OF NEED
DEPARTMENT OF HEALTH

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

APPLICATION FOR CERTIFICATE OF NEED
HOSPICE PROJECTS
(excludes amendments)

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

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

Signature and Title of Responsible Officer:  **Title:** Corporate Officer **Date:** 01/31/2020	**Person To Whom Questions Regarding This Application Should Be Directed:** Elliot McMillan **Telephone Number:** 208-401-1359
Legal Name of Applicant: Symbol Healthcare, Inc., d/b/a Puget Sound Hospice **Address of Applicant:** 4002 Tacoma Mall Blvd. Suite #204 Tacoma, WA 98409 **Telephone Number:** 208-401-1400	**Type of Project (check all that apply):** [**X**] New Agency [ ] Existing Medicare Certified/Medicaid Eligible Agency Expanding into Different County [ ] Existing Licensed-Only Hospice Agency to Become Medicare Certified/Medicaid Eligible
Project Summary: Establishment of a Medicare and Medicaid hospice agency in Pierce County. **Estimated capital expenditure: $**___$5,000_____	

INSTRUCTIONS FOR SUBMISSION:

1. Mail an original and a CD with a PDF of the completed application, with narrative portion to:

Mailing Address:	Physical Address:
Department of Health	Department of Health
Certificate of Need Program	Certificate of Need Program
Mail Stop 47852	111 Israel Road SE
Olympia, WA 98504-7852	Tumwater, WA 98501

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

2. COMPLETE THE FOLLOWING PRIOR TO SUBMISSION FOR REVIEW:

REVIEW FEE: $21,968

January 31, 2020

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

RE: Symbol Healthcare, Inc., d/b/a Puget Sound Hospice Public Comment (App #19-57)

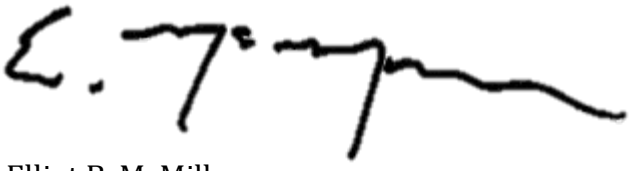
To Whom It May Concern:

Please accept the attached as Symbol Healthcare, Inc., d/b/a Puget Sound Hospice Certificate of Need application proposing to expand its hospice services to Medicare and Medicaid eligible patients in Pierce County.

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

Sincerely,

Symbol Healthcare, Inc.,
d/b/a Puget Sound Hospice
By:



Elliot B. McMillan
Secretary

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

January 2020

Contents

Introduction

With this application, Symbol Healthcare, Inc., d/b/a Puget Sound Hospice is seeking to expand its currently operational Medicare and Medicaid certified hospice services to Pierce County.[1] The Agency currently has a certificate of need for hospice services in Thurston County. In addition, Symbol operates a home health agency (Puget Sound Home Health) that services Pierce County. Because the proposal in this application will simply increase the service area of Symbol's existing hospice agency, there will be minimal capitol cost. Also, since Symbol will have an existing state licensed and Medicare certified hospice agency at the time this application is approved, it expects to able to provide hospice care to the residents of Pierce County within three months of CN approval.

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

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

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

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

Lastly, as a long-standing provider within Pierce County, Symbol has become a trusted community partner that has provided care for thousands of patients that has resulted in clinical outcomes that rank among the best in the country. Our locally led care team know the Home Health needs of Pierce County and continue to make uncompromising strides to provide not only comprehensive patient care, but exceptional clinical quality outcomes. With an agency rating of 4.5 stars, our patients receive some of the best hands on care in the state.[2]

With the addition of providing hospice care in Pierce County, Symbol will be able to provide more care along the spectrum of post-acute care. This will have a significant impact on our community in Pierce County, as we'll be better able to provide patients with the right care, in the right place, at the right time. Symbol's proposal set out in this application will demonstrate that Puget Sound Hospice is uniquely situated to provide

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

Section 1: Applicant Description

A. Legal name(s) of applicant(s).

Note: The term "applicant" for purposes of this certificate of need application is defined as any person (which includes a private corporation) proposing to engage in any undertaking subject to review under chapter 70.38 RCW. (See WAC § 246-310-010(6)(b)).

The legal name of the applicant is Symbol Healthcare, Inc. ("Symbol") d/b/a Puget Sound Hospice.

B. For existing facilities, provide the name and address of the facility.

Note: The term "existing facility" for this purpose is defined as a hospice agency that is currently providing licensed only hospice care services OR a hospice agency that is desiring to expand its Medicare certified service area.

Puget Sound Hospice is not an existing operating entity, though it has recently received a hospice CN for Thurston County and has begun the process to begin operating soon. Puget Sound Hospice is co-located with Symbol's home health operations, Puget Sound Home Health, at 4002 Tacoma Mall Blvd., Ste. 204, Tacoma, WA 98409.

[2] Washington state average is 3.5 stars.

Symbol notes that its ultimate parent, Pennant, owns and operates 129 health care provider entities across 13 states, including 33 hospice agencies, 28 home health agencies, 9 homecare/private duty agencies, and 54 senior care entities. This includes 8 CN-approved home health and hospice agencies in the State of Washington. The names and addresses of each of these entities are included in Exhibit 2.

C. Identify the type of ownership (public/private/corporation, etc.).

Symbol is a Nevada incorporated for-profit-corporation registered with and operating in the State of Washington (UBI 603-257-823).

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

The owning entity is the same as the applicant.

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

The operating entity is the same as the applicant.

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

The organizational chart included as Exhibit 1 depicts that Symbol is wholly owned by Cornerstone Healthcare, Inc. Cornerstone is wholly owned by the Pennant Group, Inc. The Pennant Group, Inc. is a publicly traded company and no individual shareholder has more than a 5% ownership interest.[3]

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

This question is not applicable to the applicant as it does not own or operate any facilities.

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

This question is not applicable to the applicant as it does not own or operate any facilities.

[3] To avoid confusion as to who that applicant is, Symbol notes that throughout this application we will reference Cornerstone and Pennant primarily because the close network of hospice and other health care entities under the larger Pennant umbrella provide each other with support, best practices, and more that have proven to help drive optimal patient outcomes as well as produce high employee satisfaction.

I. Identify the facility licensure/accreditation status.

Puget Sound Hospice's Medicare and Medicaid certification, state licensure, and accreditation by the Accreditation Commission for Health Care (ACHC) status is currently pending. We fully anticipate securing these prior to the Department's final decision on this application.

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

Puget Sound Hospice is not currently receiving reimbursement under Titles V, XVII, or XIX, but we are in the process of obtaining Medicare and Medicaid certification and anticipate securing that certification prior to the Department's final decision on this application.

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

Puget Sound Hospice is in the process of securing a medical director to support Pierce County. We are in discussions with several candidates and anticipate having an executed medical director contract prior to the conclusion of the screening period.

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

Puget Sound Hospice will contract for medical director services. A copy of Puget Sound Hospice's draft medical director agreement is included as Exhibit 3.

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

1. Total number of unduplicated hospice patients served per year for last three years.
2. Average length of stay (days) per patient for the last three years.
3. Median length of stay.
4. Average daily census per year for the last three years.

This question is not applicable as Symbol does not currently operate any hospice agencies in Washington State.

Section 2: Project Description

A. Provide the name and address of the proposed facility

Symbol's hospice agency will operate under the name Puget Sound Hospice, and will be co-located with Symbol's existing home health office located in Pierce County at the following address:

4002 Tacoma Mall Blvd. Suite #204
Tacoma, WA 98409

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

Puget Sound Hospice will be a state licensed and Medicare/Medicaid certified hospice agency in Pierce County servicing Pierce and Thurston Counties. Coupling our hospice services with our well-established home health services in Pierce County, we will be better able to help patients transition throughout the continuum of post-acute care.

As with all Pennant-affiliated hospice agencies, Puget Sound Hospice will provide exceptional patient-specific care, allowing the patient to choose where they reside, whether it be in a home setting, long term care facility or in a temporary location such as an acute care hospital. The provision of exceptional care will be provided by an interdisciplinary team of experienced and specially trained professionals providing medical, physical, emotional, social and spiritual support to the patient and their family.

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

As with all Pennant-affiliated hospice agencies, Puget Sound Hospice approaches hospice care with the foundational belief that health care that is tailored to the particular needs of its community will produce the best patient outcomes. All Pennant-affiliated agencies accomplish

this by adopting a model where local leaders are provided the opportunity and challenge to operate a community-centered agency. There is no corporate headquarters dictating mandatory practices that may not address specific community needs. Any operating model that allows for a considerable degree of adaptability may run the risk of making it challenging to meet an agency's rigorous (and sometimes extremely complex) clinical, administrative, and legal obligations.

To ensure Puget Sound Hospice will be both adaptable to the community's needs and able to meet its strict compliance obligations, it contracts with an affiliated service center called Pennant Services. Pennant Services provide Puget Sound Hospice with teams of experts in the field of hospice to provide world-class expertise and support in areas including quality integrity and improvement, human resources, legal, accounting, revenue cycle management, information technology, business data analytics, compliance auditing and assessment, and clinical education and training.

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

Table 1 summarizes the services that will be offered directly and via contract.

Table 1
Service Listing and Indication of Direct Provision or Contract

Service	Direct or Contract
Physician	Contract
Nursing	Direct
Certified Nursing Assistant	Direct
Physical, Occupational and Speech therapy	Contract
Alternative therapies	Contract
Dietary	Contract
Medical Social Services	Direct
Spiritual Care Coordinator	Direct
Pharmacy	Contract
Inpatient /Respite	Contract
Continuous Care	Direct
Bereavement Counseling (provided by Chaplain)	Direct
Volunteer Coordinator (provided by Social Worker)	Direct

Source: Applicant

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

Puget Sound Hospice will serve all patients who desire to be cared for by Puget Sound Hospice. In support of Pierce County's Commitment to meeting the needs of its diverse population, with an increasing number of adults 55 to 74 years old,[4] we anticipate that we will provide hospice care to patients across all demographic groups and traditionally underserved populations, including veterans, low-income person, racial and ethnic minorities, individuals with substance abuse history and mental health issues, and those with limited English speaking. Puget Sound Hospice shares the County's leadership vision of embracing the diversity of our communities and partnering with state and local government, community-based organizations, and others to improve the care of all patients.

E. List the equipment proposed for the project:
    1. Description of equipment proposed; and
    2. Description of equipment to be replaced, including cost of the equipment, disposal, or use of the equipment to be replaced.

Because Symbol has co-located Puget Sound Hospice and Puget Sound Home Health, equipment needs are limited to the addition of communication and computers/IT equipment. The specific equipment is included in Table 2.

Table 2
Equipment List[5]

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

Source: Applicant

F. Provide drawings of the proposed project:
    1. Single line drawings, approximately to scale, of current locations which identify current departments and services; and
    2. Single line drawings, approximately to scale, of proposed locations which identify current departments and services; and
    3. Total net and gross square feet of project.

A floor plan of the proposed Pierce County office location is included at Exhibit 4.

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

[4] Community Health Assessment Pierce County 2019, p. 6.
[5] All costs include sales tax.

Puget Sound Hospice anticipates serving patients within 60 days of receiving the CN for Pierce County. This short timeframe is due to our ability to provide services under an existing license and Medicare certification. In other words, we will be able to begin efforts to address Pierce County's need for hospice care so quickly because we're simply adding a county to an already existing license.[6]

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

Symbol's hospice philosophy is that compassionate, individualized hospice care should be available to any and all individuals with an illness for which there is no cure or for persons who elect not to attempt a cure, resulting in a limited life expectancy. Further, we are committed to partnering across the care continuum to focus on quality patient outcomes that improve the lives of patients. Because of our commitment to that philosophy, our long-range business plan involves expanding into communities across the State of Washington. The opportunity to be granted a CN to serve Pierce County—where we are confident that we can positively impact the lives of the terminally ill and their families—is consistent with our long-range business planning.

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 if a Certificate of Need is issued for the proposed project.

A copy of the signed terms and conditions sheet for the applicant's lease proposal is included in Exhibit 5. Please note that the lease agreement is between Symbol Healthcare, Inc., d/b/a Puget Sound Home Health and the landlord. The space will be shared between Puget Sound Home Health and Puget Sound Hospice. Since both the home health and hospice are operated by the same legal entity, an allocation of the existing leaser expense has been allocated to the hospice pro forma. There will be no addendum or change to the lease resulting from this allocation.

[6] Symbol notes again that Puget Sound Hospice's licensure and certification status is pending; however, based on Pennant's extensive experience with hospice licensing and certification, we fully anticipate Puget Sound Hospice will secure a state hospice licensure and Medicare certification and be operational prior to the Pierce County CN being issued.

Section 3: WAC 246-310-210 – Need

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

1. Identify the unmet hospice needs of the patient population in the proposed service area(s). The unmet patient need should not include physical plant deficiencies and/or increase facility operation deficiencies; and
2. Identify the negative impact and consequences of unmet hospice needs and deficiencies.

Our requested project seeks to address the unmet need for additional hospice services in Pierce County. The need for additional hospice agencies, as determined by the eight step methodology contained in WAC 246-310-290, indicates an unmet Average Daily Census (ADC) of 33 and 60 for 2020 and 2021, respectively. This unmet ADC translates into unmet patient days of 12,054 and 21,777 for 2020 and 2021. Please see Table 3 below for a breakout of unmet hospice needs.

The need for additional hospice agencies is determined by the same methodology referenced above. As applied to Pierce County, it identifies a need for 1.7 additional hospice providers by 2021. Please see Table 4 below.
Due to the length of explanation, the step by step description of the methodology is provided in Exhibit 11.

Table 3
Unmet Hospice Need

Indicator	2020	2021
Admissions (unmet)	200	362
Patient Days (Unmet)	12,054	21,777
ADC (Unmet)	33	60
Additional agencies needed (numeric need)	-	1.7

Source: DOH 260-028 November 2019 Hospice Need Methodology

Table 4
Numeric Need - Additional Agencies Needed

Indicator				Step 8 -Numeric Need	
Admissions (unmet)	2019 ADC (unmet)	2020 ADC (unmet)	2021 ADC (unmet)	Numeric Need?	Agencies Needed?
Patient Days (Unmet)	9.66	10.63	11.86	FALSE	FALSE
ADC (Unmet)	9	33	60	TRUE	1.7
Additional agencies needed (numeric need)	19.77	27.15	35.36	TRUE	1.01

Source: DOH 260-028 November 2019 Hospice Need Methodology

The Department directs applicants to provide certain financial projections for the first three years of the project. The timeframe in which the CN decisions are scheduled to be rendered for this cycle is mid-year of 2020, which means applicants are required to provide projections at least into the year 2023. However, official population forecasts that far into the future are not readily available although the methodology incorporates population trends in several steps.

To remain consistent with utilization of the methodology as the basis for this project rationale, population forecasts for 2022 and 2023 have been estimated. The historic population trends as well as the projected populations for 2019-2021 provided by the Office of Financial Management (OFM) were used to determine growth rates for 2022 and 2023. As seen in Table 4A the growth rate used for 2022 and 2023, for both age cohorts, is the same rate the OFM used to project 2021 population.

Table 4A
Pierce County Population Cohort Growth Rate

County	2016-2018 Average Population	2019 projected population	2020 projected population	2021 projected population	2022 projected population	2023 projected population
0-64 age cohort	738,738	756,339	765,139	769,198	773,813	778,456
Growth rate over prior year	NA	2.33%	1.15%	0.53%	0.60%	0.60%
65+ Age Cohort	119,836	130,688	136,114	142,422	146,695	151,095
Growth rate over prior year	NA	8.30%	3.99%	4.43%	3.00%	3.00%

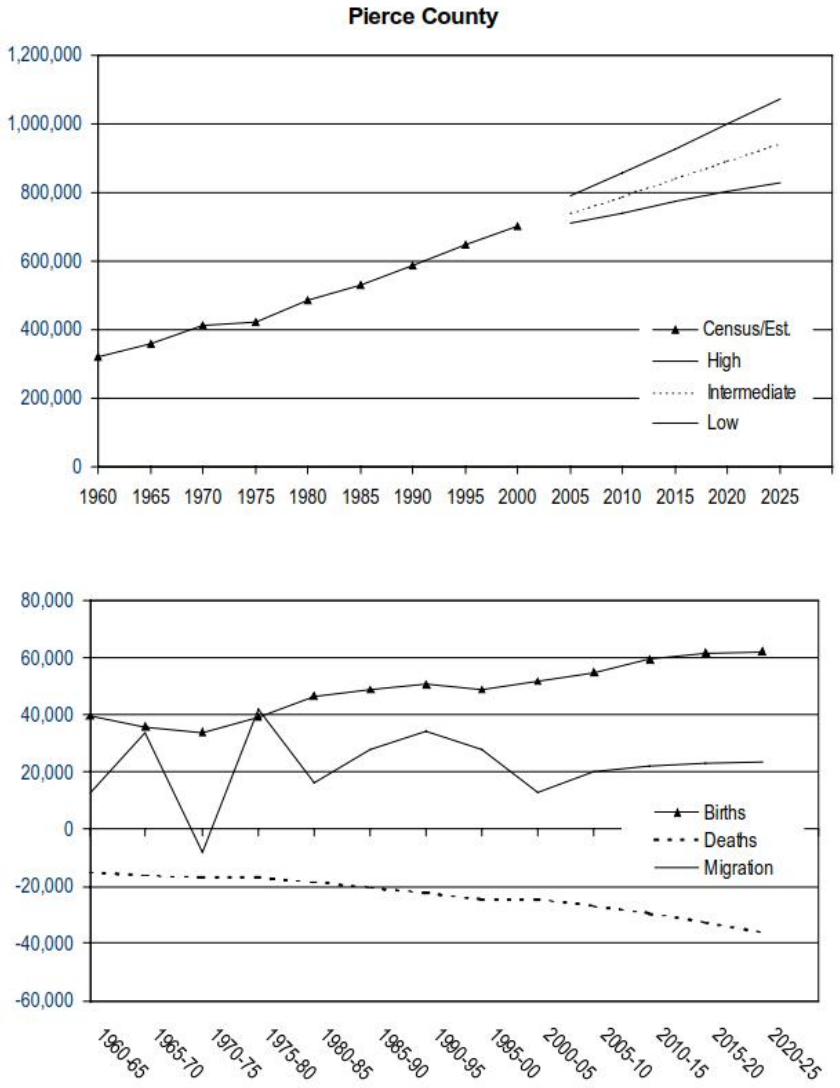
Source: DOH 260-028 November 2019 Hospice Need Methodology

This simplistic and conservative trending demonstrates that there exists a shortage of at least one agency to serve this growing community. Further, the soonest any agency could begin serving patients in Pierce County is September of 2020 which leaves hundreds of patients without timely access to their Medicare benefit for hospice in the current year. For this reason alone, the rationale for this project is to simply provide hospice care to those that are entitled to the service.

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

Based on the above, the negative impact of failing to meet the hospice needs of the residents of Pierce County would be considerable. Pierce County has experienced increased population growth over the past decade and this pattern is projected to continue. The graphs below show this growth trend continuing up through 2025.

Projected Population and Components of Change



The nature of hospice is to provide care, comfort and support to some of our most vulnerable residents as they experience perhaps the most fragile time of life, wherever they reside. Accessibility to a provider of the patient's choice is critical to providing the most appropriate type of care, individualized to best meet the patient's needs. The numeric need indicates that accessibility to providers is limited in 2020 which could leave those residents of Pierce County nearing the end of life with limited or no options. With limited access to hospice care hospice-appropriate patients will be unable to receive the individualized hospice care they need. Puget Sound Hospice is confident it can provide superior, life-changing care to those residents in need and meet the County's unmet need for hospice outlined above.

C. 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 the 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.

As stated in the 2019 Pierce County Community Health Assessment and shown in Exhibit 13, there is an increasing number of adults 55 to 74 years old in Pierce County. Those in the 55 to 64 and 65 to 74 age groups have increased 2.6% and 3.2% respectively since 2007. It is evident that healthcare systems need to prepare for these shifts in demographics to provide the workforce and services required.[7]

As is demonstrated in Table 5, the Pierce County population of persons 65+ is projected to grow by 8% from 2016 to 2021. This is a population increase of 22,586 for the 65+ population within the next three years.

This population growth trend projection is consistent with the actual growth that occurred from 2011 to 2018 among the 65+ population as shown in Table 6, a 27% increase. The 65+ age cohort accounts for an overwhelming majority of the growth in Pierce County. This growth in the elderly population has and will lead to growth in the need for hospice care. Our project will help ensure that all those who are nearing end of life in Pierce County have ample hospice care options.

Puget Sound Hospice also recognizes that Pierce County residents come from a wide range of ethnic, cultural, and socioeconomic backgrounds. We know and appreciate that each patient and family that we get the honor and care for are special and unique. Care planning for the patient and family is specific to their needs, beliefs and desires. This planning and rendering of care are always performed consistent with our thorough non-discrimination policies.

Relatedly, Puget Sound Hospice is eager to partner with the community to help drive Pierce County's goals to improve patient care. We feel that our philosophy, commitment, support structure, and operating model uniquely position us to address the issues outlined in the Pierce County Community Health Improvement Plan, including:

- addressing the gap between rich and poor,
- understanding the needs of those at greatest risk of isolation,
- addressing the needs of those at greatest risk of behavioral health issues,
- how resources can be allocated in a way that reduces health disparities,
- elevating the importance of diversity.[8]

Puget Sound Hospice committed to better understand the specific needs of those in Pierce County and working with community partners to meet those need. We are poised to help the

[7] Community Health Assessment Pierce County 2019, p. 6

[8] 2020 Community Health Improvement Plan Strategic Questions for Planning.

community address these issues, in part by our commitment to reach out and provide care to *all* Pierce County residents in need of hospice care.

Table 5

Pierce County Historical Population and Projected Population by Age Cohort

Age Cohorts	2016-2018 Average Population	2016-2018 % of population	2019 projected population	2020 projected population	2021 projected population	2021 % of population	% Change 2018 to 2021
0-64	738,738	86.04%	756,339	765,139	769,198	84.38%	2%
65+	119,836	14%	130,688	136,114	142,422	16%	8%
Total	858,574	100.00%	887,027	901,253	911,620	100.00%	3%

Source: DOH 260-028 November 2019 Hospice Need Methodology

Table 6

County Historical Population and Projected Population by Age Cohort

Age Cohorts	2011 Population	2011 % of population	2016-2018 Average Population	2016-2018 % of population	2021 projected population	2021 % of population	% Change 2011 to 2018	% Change 2011 to 2021
0-64	707,440	88.96%	738,738	86.04%	769,198	84.38%	4%	8%
65+	87,785	11%	119,836	14%	142,422	16%	27%	38%
Total	795,225	100.00%	858,574	100.00%	911,620	100.00%	7%	13%

Source: Washington State 2017 GMA Projections – Medium Series

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

Puget Sound Hospice is not an existing operational agency therefore, this question is not applicable.

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

1. Total unduplicated hospice patients served per year for the first three years;
2. Average length of stay (days) per patient per year for the first three years;
3. Median length of stay; and
4. Average daily census per year for the first three year.

If our proposed project is approved, we will be able to begin providing care as soon as we obtain the Pierce County hospice CN. A care team will already be in place via our recently approved Thurston County hospice CN that will be licensed, Medicare certified, and accredited by that time. Because we anticipate operating for part of 2020, the project commencement forecasts are provided for CY 2020, in which the first full year of operation will be 2021. Utilization forecasts for 2020-2023 are provided in Table 7.

Table 7 details the admissions, patient days, ALOS and ADC that Puget Sound Hospice projects in Pierce County for its first three full years of operation as well as a portion of its commencement year, 2020.[9]

Table 7
Puget Sound Hospice Projected Patient Census for Pierce County

	2020	2021	2022	2023
Projected Unduplicated Admissions	200	362	473	587
ALOS	60.86	60.86	60.86	60.86
Patient Days	193	14,155	23,625	35,040
ADC	9	33	60	85
Puget Sound Hospice Median LOS	17	17	17	17

Source: Applicant

F. Please provide a forecasted breakdown of patient diagnoses.

Table 8 identifies Puget Sound Hospice's estimated first full year of operation estimate of patients by diagnosis. The diagnoses were determined after reviewing Washington State Department of Health, Center for Health Statistics, death certificate data, 2017. They were also determined after considering that 80% of seniors over the age of 65 in Pierce County live with chronic disease as the graph below shows.[10]

[9] The methodology for arriving at these figures is set out in prior responses in this application.
[10] See https://www.doh.wa.gov/portals/1/Documents/Pubs/345-271-ChronicDiseaseProfilePierce.pdf.

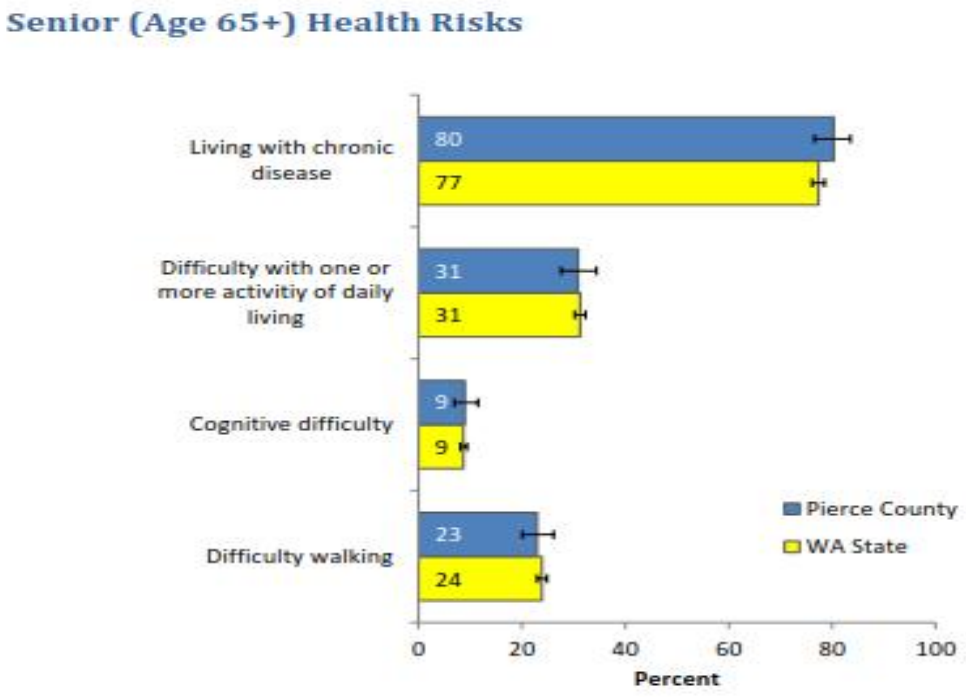


Table 8

Estimated Hospice Patients by Diagnosis and Percent

Diagnosis	Percent
Dementia	25%
Cancer	20%
Heart Disease	21%
Lung Disease	9%
Liver Disease	4%
COPD	9%
Stroke/CVA	7%
HIV	3%
Amyotrophic Lateral Sclerosis (ALS)	1%
Others (i.e. ESKD, neuro-degenerative dx)	1%
Total	100%

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

Puget Sound Hospice's assumptions related to use rate, market share and intensity of service used for planning and forecasting follow:

- The State's 2019-2020 Hospice Numeric Need Methodology determines *use rates* for hospice by age cohort (0-64 and 65+). The use rates are calculated by the State and, for this review cycle, are 27.89% for the 0-64 cohort group and 61.56% for the 65+ cohort group. These use rates are then used to project hospice patients by age cohort for 2019-2021.
- The numeric need methodology projects an unmet ADC of 33 in 2020 and 60 in 2021. The utilization related to this project in 2020 provided in Table 7, above, assumes a minimal ADC due to being late in the year. Utilization in 2021 (first full year) assumes a "ramp-up" to reach an ADC of 38.8. The third full year is projected to reach an ADC of 111 which is 85% of the forecasted unmet ADC for 2023.
- ALOS: Assumes the Washington State ALOS of 60.86-days. Gross Revenue by payer mix is broken out in Table 9. The provided payer mix is based on Pennant affiliated hospice trends for 2019.
- Patient Days: ALOS x admissions.
- ADC- Patient days divided by 365 days in a full year.
- Median LOS- Actual experience with Pennant's hospice agencies. Symbol refers to *Intensity of Service* as *Levels of Care* to reflect industry and regulatory verbiage. Table 10 lines out the percentage of each level of care in patient days. The percentages within the table reflect NHPCO historical usage levels for each level of care.
- Market share calculations use unmet patient days as a basis for estimation. Patient days provided by Symbol divided by total unmet patient days in a given year equals market share percent. Please see market share estimates in Table 11.

Table 9
Puget Sound Hospice, Gross Revenue by Payer
2021-2023

Payer	2021	2022	2023
Medicare (including VA)	94.6%	94.6%	94.6%
Medicaid	4.0%	4.0%	4.0%
Medicare Managed Care	1.2%	1.2%	1.2%
Private Pay	0.2%	0.2%	0.2%
Total	100.0%	100.0%	100.0%

Source: Applicant

Table 10

National Hospice and Palliative Care Organization (NHPCO)	
Level of Care by Percentage of Days of Care	Days of Care (%)
Routine Home Care (RHC)	98.0%
Inpatient Respite Care (IRC)	1.5%
Continuous Home Care (CHC)	0.2%
General Inpatient Care (GIP)	0.3%

Source: NHPCO 2017 Facts and Figures updated as of April 2018

Table 11

Market Share In UNMET Patient Days				
Year	2020	2021	2022	2023
Unmet Patient Days -Pierce County	12054	21777	28445	35307
Symbol Patient Days Served	193	14155	23625	35040
Market Share % of Unmet Patient Days	2%	65%	83%	99%

Source: Applicant

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

1. Identify all existing providers of services (licensed only and certified) similar to those proposed and provide utilization experience of those providers that demonstrates that existing services are not available to meet all or some portion of the forecasted utilization.
2. If existing services are available, demonstrate that such services are not accessible. Unusual time and distance factors, among other things, are to be analyzed in this section.
3. If existing services are available and accessible, justify why the proposed project does not constitute an unnecessary duplication of services.

Currently, six Medicare certified hospice agencies operate in Pierce County:

1. Franciscan Hospice
2. FHS Hospice
3. Kaiser Permanente Home Health and Hospice (Group Health)
4. MultiCare Home Health, Hospice and Palliative Care
5. Providence St. Peter Hospital Palliative CareKindred at Home
6. Kindred at Home

As shown in Exhibit 11, the 260-028 November 2019 Hospice Need Methodology provides the necessary analysis for us to determine that there is higher projected utilization than the current capacity can support. The numeric need indicates 1 (1.7) additional agency is needed to meet the unmet need by 2021. The forecasted total patient volume (admissions) for 2021 is 4,144 where the current admit capacity is 3,782. This capacity-to-demand comparison indicates there are potentially 362 unmet admissions in 2021. See Exhibit 11.

By definition, the presence of numeric need indicates that one additional provider would not be considered unnecessary duplication. As set out in this application, Puget Sound Hospice's proposed project will help meet the County's unmet need.

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

Puget Sound Hospice is committed to serving all patients regardless of race, color, religion (creed), gender, gender expression, age, national origin, disability, marital status, sexual orientation, English proficiency, or military status, and will ensure that all populations have access to services through its charity care policy. Furthermore, Puget Sound Hospice's admission, charity care, and non-discrimination policies reflect our commitment to caring for Medicare, Medicaid, and patients who have an inability to pay for care.[11]

Like many of its affiliate hospice agencies Puget Sound Hospice is poised to partner with a sister non-profit agency, the Finding Home Foundation. The Finding Home Foundation's sole purpose is to provide support to hospice patients and their families who are in need. Through this

[11] Puget Sound Hospice has included charity care in its financial projections to reflect our intent to provide hospice services to those who are indigent or cannot otherwise pay.

partnership, our affiliates have been able to facilitate life-changing experiences through the hospice experience.

Further, Cornerstone, Symbol's parent company, has established 33 hospice agencies across the west and mid-west. This has provided Cornerstone with extensive experience supporting hospice in a variety of diverse markets. This includes supporting agencies in large population markets like Dallas-Fort Worth, Los Angeles, Milwaukee, and Phoenix, as well as more rural areas like Big River, California, Cherokee, Iowa, and Clarkston, Washington. Each market presents unique populations with unique needs, as well as care-delivery challenges. Yet, the Puget Sound Hospice-affiliates in those markets have found great success in overcoming care-delivery challenges to meet the unique needs of those varying populations. Because Pennant's model creates strong ties among affiliates, we have the resources to enable us to, among other things, share specialized programs to address the needs of a given diverse or under-served population, implement successful approaches to improving quality patient outcomes, and partner with experts in the field of hospice to receive world-class support.

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

1. Admissions policy
2. Charity care policy; and
3. Patient referral policy, if not addressed in admissions policy.

Puget Sound Hospice's charity care policy, admissions policy, and patient referral policy are included as Exhibit 6.

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

1. 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 service areas.
2. 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.
3. The special needs and circumstances of osteopathic hospitals and non-allopathic services with which the proposed facility/service would be affiliated.

This project is not designed to serve any of the special needs referenced above. As such, this question is not applicable.

Section 4: WAC 246-310-220 – Financial Feasibility

A. If applicable, provide the proposed capital expenditure for the project.

Puget Sound Hospice projects an estimated capital expenditure of $5,000 for the expansion to support Pierce County. The costs incurred will be for the phone system, computer/IT equipment, and are detailed in Table 12.

Table 12
Proposed Capital Expenditure

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

Source: Applicant

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

Capital expenditures were estimated established vendor rates available to all Pennant affiliates, and Pennant's extensive experience establishing agencies and expanding existing ones.

C. Documentation of project impact on (a) capital costs, and (b) operating costs and charges for health services.

As documented in Exhibit 7, the pro forma forecast for this project, the $5,000 capital investment has no impact on costs. Hospice care has been shown to be cost-effective and is documented to reduce end-of-life costs. This project proposes to address the hospice agency shortage in the County and will improve access. Over time, this will reduce the costs of end-of-life care and benefit patients and their families.

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

Please see Exhibit 7 which contains the pro forma forecast for revenue and expense statements for part of 2020 and the three years of operation thereafter. The underlying assumptions incorporated into the pro forma are included in the same exhibit.

E. 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.

The small capital investment needed for this project will be funded by the Pennant Group, using reserves with no financing costs. This is the best, most efficient means of funding an expenditure of this size.

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

A letter of commitment of funds is provided in Exhibit 8 to demonstrate Pennant's intention to fully finance Puget Sound Hospice.

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

With a capital investment of this size, the use of reserves (which does not carry any financing costs) is preferred. Symbol considered no other financing methods.

H. Provide a pro forma balance sheet and expense and revenue statements for the first three years of operation.

Exhibit 7 contains the pro forma revenue and expense statements for part of 2020 and the three years of operation thereafter.

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

No capital beyond that identified in the CN capital expenditure budget is anticipated during the identified portion of 2020 or the three full years thereafter.

J. Identify the expected sources of revenues for the applicant's total operations (e.g., Medicaid, Medicare Managed Care, Healthy Options, Labor and Industries, etc.) for the first three years of operation, with anticipated percentage of revenue for each payer source.

Puget Sound Hospice anticipates the following payer mix based on actual Pennant affiliated hospices found in Table 13:

Table 13 Anticipated Payer Mix

Payer	% of Gross Revenue
Medicare	94.6%
Medicaid	4.0%
Commercial	1.2%
Self-Pay	0.2%
Total	100.0%

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

Symbol does not presently operate a hospice agency in Pierce County, so this question is inapplicable as to Puget Sound Hospice. Symbol does operate Puget Sound Home Health in Pierce County. Puget Sound Home Health's financials are provided in Exhibit 7.

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

Symbol does not presently operate a hospice agency in Pierce County, so this question is inapplicable as to Puget Sound Hospice. Symbol does operate Puget Sound Home Health in Pierce County. Puget Sound Home Health's financials are provided in Exhibit 7.

M. 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.

Symbol does not presently operate a hospice agency in Pierce County, so this question is inapplicable as to Puget Sound Hospice. Symbol does operate Puget Sound Home Health in Pierce County. Puget Sound Home Health's financials are provided in Exhibit 7.

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

This question is not applicable to hospice providers. Puget Sound Hospice, consistent with Medicare hospice reimbursement, will be paid a daily rate.

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

This question is not applicable to hospice providers. Puget Sound Hospice, consistent with Medicare hospice reimbursement, will be paid a daily rate.

P. 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.

Projected FTEs for a portion of 2020 and the full three years of operation thereafter are included in Table 14 below. Projected FTE's for the same period for field staff are also listed in Exhibit 7 (Pro Forma) to help provide clarity for financial projections.

Table 14
FTE, Wages, Benefits

Administrative Staff by FTE	2020	2021	2022	2023
Administrator	0.08	0.5	0.5	0.5
Assistant Director of Operations	-	0.5	1.0	1.0
Business Office Manager, Medical Records, Scheduling	0	1.3	2.2	3.2
Intake	0	1.0	1.0	1.0
Community Liaison	0	1.3	2.2	3.2
Total	1	4.6	6.8	8.9
Administrative Compensation and Benefits	**2020**	**2021**	**2022**	**2023**
Administrator	1,889	34,000	35,020	36,071
Assistant Director of Operations	-	42,500	85,000	87,550
Business Office Manager, Medical Records, Scheduling	3,591	64,635	107,877	159,998
Intake	2,889	52,000	52,000	52,000
Community Liaison	4,668	84,025	140,240	207,997
Payroll Taxes & Benefits	4,619	83,148	126,041	163,085
Total	17,656	360,308	546,177	706,701

Clinical Staff by FTE	2020	2021	2022	2023
Registered Nurse	1	5.8	9.7	14.4
Certified Nursing Assistant	0	3.9	6.5	9.6
Licensed Clinical Social Worker	0	1.3	2.2	3.2
Spiritual Care Coordinator	0	1.3	2.2	3.2
Director of Patient Services	0	1.0	1.6	2.4
Total	2	13.3	22.1	32.8
Clinical Compensation and Benefits	2020	2021	2022	2023
Compensation and Benefits				
Registered Nurse	12,500	436,286	728,168	1,079,986
Certified Nursing Assistant	1,671	120,997	201,945	299,516
Licensed Clinical Social Worker	1,268	91,782	153,185	227,197
Spiritual Care Coordinator	1,000	72,391	120,822	179,198
Director of Patient Services	1,205	87,257	145,634	215,997
Payroll Taxes & Benefits	5,293	242,614	404,926	600,568
Total	22,938	1,051,326	1,754,679	2,602,463

Source: Applicant

Puget Sound Hospice would like to address the key role of QAPI coordinator. From the commencement of this project through 2023, the QAPI role will be performed by the Director of Clinical Services. Therefore, only 1 FTE is required for the Director of Clinical Services and no FTEs are needed during that time for a QAPI coordinator. The administrator will continually review the hospice program with the assistance of the Director of Clinical Services to determine when additional FTEs are necessary to meet the needs of our QAPI program. It is not projected that a QAPI coordinator will be needed as a separate FTE until after the agency maintains an ADC of at least 35 consistently for 3 months.

Our Director of Clinical Services is perfectly positioned to perform QAPI coordinator roles when necessary. The Director of Clinical Services will be responsible for ensuring Puget Sound Hospice provides all necessary hospice services that support the plan of care. Acting in the QAPI coordinator role, the Director of Clinical Services establishes, implements and evaluates goals and objectives for hospice services that meet and promote the standards of quality and contribute to the total organization and philosophy. The objectives for these two roles go hand-in-hand.

Additional QAPI-related responsibilities the Director of Clinical Services will provide include:

- provide guidance and counseling to coordinators and Clinical Supervisors/staff to assist them in continually improving all aspects of hospice care services, provided through organization personnel.
- Plan and implement in-service and continuing education programs to meet education and training needs of organization personnel.
- Evaluation of organization performance via performance improvement program, productivity, quarterly and annual reviews. Assure for the quality and safe delivery of hospice services provided through the Organization.
- Responsible for the implementation and monitoring of the organization's quality assessment performance improvement (QAPI) program.
- Responsible for ensuring processes to monitor and evaluate safety, risk management and infection control programs.

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

As documented by the letter of financial commitment from Symbol and from the historical financials included in Exhibit 9, Symbol has sufficient cash reserves to assure that the costs of operations are covered until Medicare reimbursement is received for Puget Sound Hospice.

Section 5: WAC 246-310-230 – Structure and Process Quality of Care

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

Puget Sound Hospice is not an existing hospice agency, and thus does not currently have any employees. Projected employees are provided in Table 14, above.

B. Please provide your staff to patient ratio.

Our staff to patient ratio is provided below in Table 15.

Table 15

Proposed Staff to Patient ADC Ratio

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

Source: Applicant

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

Puget Sound Hospice is confident that our proposed staff to patient ratio is appropriate for several reasons. First, Pennant-affiliated hospice agencies have found that operating at these ratios are optimal to produce quality outcomes. Additionally, these ratios were in our 2018 hospice CN application for Thurston County, which the CN Department found to be appropriate. Further, we compared our proposed staff/patient ratios in this application with the approved 2018 hospice CN application for Snohomish County of our affiliated hospice agency, Glacier Peak Healthcare, Inc., d/b/a Alpha Hospice, which had these same ratios.

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

In addition to Symbol operating a home health agency in Pierce County, its ultimate parent company, Pennant, owns 129 healthcare organizations across 13 states in the United States, including a senior living home in Redmond, Washington, as well as home health agencies in Pierce and Snohomish counties. In the experience of Pennant's affiliate health care agencies, health care employees are drawn to the Pacific Northwest Region for its outdoor experiences, culture and vitality, and if Puget Sound Hospice has qualified and experienced staff in good standing that want to move to Pierce County, or to transition from long-term care or home health to hospice, we will be glad to support that relocation or transition.

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

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

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

Recruiting

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

- Identify any opportunity to recruit at local job fairs.
- Maintain a liaison with career/placement staff at regional colleges, universities, and clinical certification organizations to actively recruit its students, including offering clinical shadowing and volunteer opportunities.
- Join applicable healthcare professional associations.

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

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

- Email HR/Payroll Group with the standard subject line: Recruiting Need Discipline. The content of this email will set out the following information as to the open position:
- FTE
- Discipline
- Territory
- Rate Sets
- Urgency of fill: Immediate, moderate, low
- Potential Hire date
- Bonus – Sign on – automatic for urgent need, hard to fill.
- Post open position in Workday via human resource information system provided by Pennant Services.
- Post open position on job boards on LinkedIn, Indeed, Career Builder, Glassdoor.
- Share the job posting on agency social media.

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

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

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

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

Retention

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

- We offer competitive benefits, including health care, dental, vision, paid time off, and more.
- We perform an anonymous employee satisfaction survey annually to gauge employee satisfaction.
- We provide ongoing professional training based on needs identified in our QAPI program, annual compliance and profession-specific training, and regular in-service training.

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

The provider types on the interdisciplinary team are provided in Table 1. The interdisciplinary team composition will be consistent with CMS's hospice conditions of participation (see 42 CFR 418.56). Our interdisciplinary team will include, but not be limited to, (1) a doctor of medicine or osteopathy, (2) an RN, (3) a social worker, and (4) a pastoral or other counselor.

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

The in-service training plan is provided in Exhibit 10.

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

Puget Sound Hospice has the structure, resources, and support to enable it to frequently measure and monitor quality of care and customer satisfaction in multiple ways. For example, as an affiliate of Pennant, Puget Sound Hospice has established vendor rates and relationship with Strategic Health Programs (SHP), which is a third party platform that will allow us to effectively assess care delivery and analyze patient interactions. SHP has been found by our affiliate agencies to enhance their ability to identify opportunities for improvement, compare our performance to that of our national and state peers, monitor our quality of care delivery, and analyze patient satisfaction data in real-time using. SHP is also the Home Health CAHPS and CAHPS Hospice vendor. Patient satisfaction surveys are sent out via mail on a monthly basis and submitted as required by CMS quarterly by SHP. The data we receive allows us to track, monitor, and respond to outcomes that align with our goals and benchmarks.

Further, and as required by CMS, Symbol will participate in the Hospice Item Set which measures items such as treatment preferences, beliefs/values, pain screening and assessment and dyspnea screening and assessment.

A key component to Puget Sound Hospice's ability to address quality improvement is through its QAPI program. Pennant Services provides clinical and compliance resources who will help

train our staff how to develop an exceptional QAPI program, monitor the effectiveness of our QAPI program, and provide resource, tool, and templates to use to fully meet our QAPI obligations under the law.

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

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

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

I. 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.

Puget Sound Hospice anticipates leveraging Puget Sound Home Health staff to provide the ancillary services of physical therapy, occupational therapy, and speech-language pathology. Support services that will be provided via contract include: alternative therapies (pet, music, art, etc.), dietary, pharmacy and inpatient/respite. With our numerous preferred providers; Northwest Physician Network, Washington's Largest Specialist Network, and The Home Doctor, a locally owned and operated visiting physician group, we will continue to be a strong community partner delivering a high level of quality care, through a well-established clinical and administrative team. Symbol is also a member of the Rainier Health Network, an Accountable Care Organization solely owned by CHI Franciscan Health whose hospitals include St. Josephs, St. Anthony's, and St. Clare's within Pierce County.

Puget Sound Hospice is well aware of the fact that Medicare, Medicaid, and health care in general is a heavily regulated and complex. This demands that hospice providers have sophisticated processes, personnel, and expertise in order to meet the compliance, clinical, and operational standards required of it. To ensure Puget Sound Hospice has this level of sophistication, it contracts with its affiliate, Pennant Services. See attached Operational Support Agreement, Exhibit 12. Pennant Services will provide Puget Sound Hospice with teams of experts in the field of hospice to provide expertise in areas including quality integrity and improvement, human resources, legal, accounting, revenue cycle management, information technology, business data analytics, compliance auditing and assessment, and clinical education and training. With Pennant Service's support, Puget Sound Hospice already has the infrastructure, support, and platforms to provide a high degree of care. And while Pennant Services offer contracted services, the relationship between Pennant Services and Puget Sound

Hospice is truly viewed as a partnership. This piece of Puget Sound Hospice's model provides it with more than consultative service, it provides it with teams of partners at Pennant Services whose success will be measured by the success of Puget Sound Hospice.

J. Explain the specific means by which the proposed project will promote continuity in the provision of health care to the defined population and avoid unwarranted fragmentation of services. This section should include the identification of existing and proposed formal work 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 service agreements, and transfer agreements. Copies of relevant agreements and other documents should be included.

Much like the Hospitals for Healthier Community (HHC) Priorities have outlined (CHNA, 2019), Symbol commits to aligning with hospitals/health systems, and the post-acute care community to improve access to care for Pierce County residents.

Puget Sound Hospice is currently developing formal relationships with a medical director, local hospitals, nursing homes, including our sister facility, Olympia Transitional Care and Rehabilitation, and healthcare facilities and payers who will collaborate with Puget Sound Hospice to facilitate quick referral uptake (timely patient care), and coordinate care for our patients. Many of these relationships are already established due to our long term presence in the community with our home health service line. We intend to leverage these already existing relationships to help support the community by being able to offer the hospice service line.

K. Fully describe any history of the applicant entity and principals in Washington with respect to criminal convictions, denial or revocation of license to operate a health care facility, revocation of license to practice a health profession, or decertification as a provider of services in the Medicare or Medicaid program. if there is such history, provide clear, relevant, 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.

1. Have any of the applicants (see definition of applicants on page 4 of this application) been adjudged insolvent or bankrupt in any state or federal court?
2. Have any of the applicants been involved in a court proceeding to make judgment of insolvency or bankruptcy with respect to the applicants.

Neither Symbol, Cornerstone, nor Pennant have any history of criminal convictions, denial or revocation of license to operate a health care facility, revocation of license to practice a health profession, or decertification as a provider of services in the Medicare or Medicaid program. Further, they have never been adjudged insolvent or bankrupt in any state or federal court.

And, none have been involved in a court proceeding to make judgment of insolvency or bankruptcy with respect to the applicants.

L. 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.

The applicant, Symbol does not currently operate a hospice agency in Washington and does not hold any licenses and/or credentials in the State currently. However, Puget Sound Hospice's state hospice license is currently pending. Symbol operates Puget Sound Home Health, which operates under a valid in home services agency license to provide home health (credential number IHS.FS.60332035).

While not the applicant, we have provided a listing of all entities owned by Pennant for your reference. See Exhibit 2.

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

As stated earlier, Symbol is owned by Cornerstone Healthcare. For approximately 10 years, Cornerstone was a wholly owned subsidiary of the Ensign Group, owning and operating all of Ensign's home health and hospice agencies. Due in large part to Cornerstone's success in its home health and hospice operations, on October 1, 2019, Ensign spun Cornerstone and some of Ensign's senior living facilities into its own publicly traded company: the Pennant Group. Pennant now owns 129 healthcare facilities (33 of which are hospice agencies), and, because it includes Cornerstone, enjoys extensive experience owning and operating healthcare agencies and facilities. Pennant's history and expertise in healthcare operations will contribute to the success of Puget Sound Hospice in Pierce County.

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

Puget Sound Hospice is not an existing agency, and thus this question is not applicable.

Section 6: WAC 246-310-240 – Cost Containment

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

1. Decision criteria (cost limits, availability, quality of care, legal restrictions, etc.).

2. Advantages and disadvantages, and whether the sum of either the advantages or the disadvantages outweigh each other by application of the decision-making criteria.

3. Capital costs.

4. Staffing impact.

Symbol is choosing to establish a hospice agency in Pierce County at this time due to the need shown in the methodology, and the efficiencies to be achieved by co-locating with Symbol's current home health agency in Pierce County. These efficiencies will be achieved by initially sharing administrative overhead as well as clinical staff and potential vendors and services. This was our best course of action after considering all alternatives, which included leasing space and hiring and training staff. While this is a viable option, many initial costs will be avoided by co-locating. Symbol's parent company, Pennant, owns over 61 hospice and home health agencies, and has extensive experience in co-locating services, and achieving cost savings. Ultimately, these savings can be passed onto the patient and payers, thus further contributing to reducing hospice care costs.

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

The current cap amount for the cap year ending 2020 is $29,964.78. We estimate average net reimbursement per admission of $11,685.96 by Year 3; which is more than 75% below the cap. This provides assurance that Puget Sound Hospice will not exceed the Medicare cost caps.

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

Improved access to hospice will support system efficiency. Data demonstrates that patients who die while in hospice care have lower health care expenditures, are hospitalized less often,

and undergo less intensive care than those who do not die in hospice care.[12] Hospice care is also proven to improve patient experience, reduce costs, and improving population health. Puget Sound Hospice's affiliations with health care providers throughout the entire acute and post-acute care spectrum will allow it to ensure that systems and healthcare providers in Pierce County have sufficient, timely access to hospice services—at the right place and right time, so that when patients choose to elect that benefit, care is available. The absence of timely, quality hospice care harms the patient and their family and increases use of the healthcare system, expressed in ED visits, clinic visits and hospitalizations.

Further, Puget Sound Hospice will share administrative support with Puget Sound Home Health in Tacoma, thus allowing for shared services, shared administrative support and shared overhead.

D. 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.

This question is not applicable.

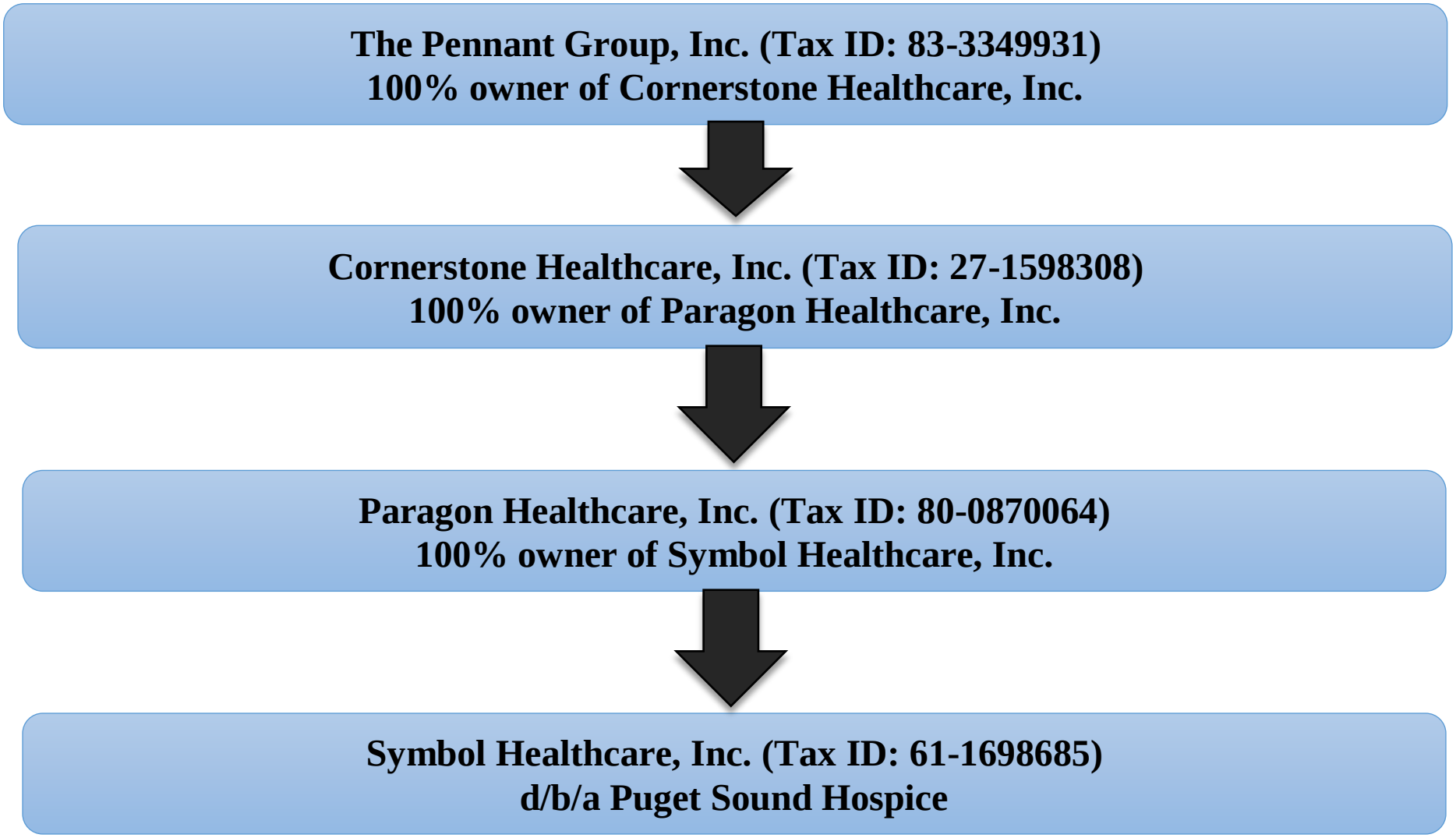
[12] https://jamanetwork.com/journals/jama/fullarticle/1930818

EXHIBITS LIST

Exhibit 1

Organizational Chart

Organizational Chart



ORGANIZATION CHART

The Pennant Group, Inc.

100% ownership interest in Cornerstone Healthcare, Inc.

The Pennant Group, Inc. is a publically traded company and no individual shareholder has more than 5% ownership interest.

Board of Directors:

Christopher R. Christensen	Director
Daniel H Walker	Director
John G. Nackel, Ph.D.	Director
Scott Lamb	Director
Roderic Lewis	Director
JoAnne Stringfield	Director
Steven M.R. Covey	Director

Officers:

Daniel H Walker	CEO & President
John J. Gochnour	Executive Vice President
Derek Bunker	Executive Vice President, Chief Investment Officer, & Secretary

Cornerstone Healthcare, Inc.

100% ownership interest in Paragon Healthcare, Inc.

Daniel H. Walker	Director/Sole Board Member
Brent Guerisoli	President
Elliot McMillan	Secretary
Lee Johnson	Treasurer

Paragon Healthcare, Inc.

100% ownership interest in Symbol Healthcare, Inc.

Daniel H. Walker	Director/Sole Board Member
Brent Guerisoli	President
Elliot McMillan	Secretary
Lee Johnson	Treasurer

Symbol Healthcare, Inc., d/b/a Puget Sound Hospice

Daniel Walker	Director/Sole Board Member
Brent Guerisoli	President
Elliot McMillan	Secretary
Lee Johnson	Treasurer

Exhibit 2

Pennant Owned Entities

Entities Owned By The Pennant Group, Inc.

Legal Name	DBA	Physical/Billing/Remittance Address	Physical City	Physica	Physical Zip
Virgin River Healthcare, Inc.	**A Gentle Touch Home Care**	1173 South 250 West, Suite 401B	St. George	UT	84770
Painted Sky Healthcare, Inc.	**Agape Hospice & Palliative Care**	2980 N Swan Rd., Ste 222	Tucson	AZ	85712
Monument Healthcare, Inc.	**All County Home Health**	37131 Interstate 10 West, #400	Boerne	TX	78006
Monument Healthcare, Inc.	**All County Hospice**	37131 Interstate 10 West, #400	Boerne	TX	78006
Glacier Peak Healthcare, Inc.	**Alpha Home Health**	10530 19th Ave SE, Ste 201	Everett	WA	98208
Glacier Peak Healthcare, Inc.	**Alpha Hospice**	10530 19th Ave SE, Ste 201	Everett	WA	98208
Vesper Healthcare, Inc.	**Buena Vista Hospice**	2545 West Hillcrest Drive, Ste 130	Thousand Oaks	CA	91320
Joshua Tree Healthcare, Inc.	**Buena Vista Palliative Care & Home Health**	2545 West Hillcrest Drive, Ste 130A	Thousand Oaks	CA	91320-22297
Vesper Healthcare, Inc.	**Buena Vista Valley Hospice**	16909 Parthenia Street, Ste. 102-B	Northridge	CA	91343
Joshua Tree Healthcare, Inc.	**Buena Vista Valley Palliative Care & Home Health**	16909 Parthenia Street, Ste. 302-A	Northridge	CA	91343
Great Plains Healthcare, Inc.	**Careage Home Care**	203 E. Bow Drive	Cherokee	IA	51012-1214
Iron Bridge Healthcare, Inc.	**Columbia River Home Health**	7105 W. Hood Place, Suite B-201	Everett	WA	99336-3807
Summerlin Healthcare, Inc.	**Comfort Hospice Care**	6655 West Sahara Ave, Ste B114	Las Vegas	NV	89146
Connected Healthcare, Inc.	**Connected Home Health**	7515 NE Ambassador Pl., Ste C	Portland	OR	97220-1379
Connected Healthcare, Inc.	**Connected Hospice**	7515 NE Ambassador Pl., Ste C	Portland	OR	97220-1379
Exemplar Healthcare, Inc.	**Symbii Home Health South**	1385 W. 2200 South, Suite 202	West Valley City	UT	84119
Exemplar Healthcare, Inc.	**Symbii Hospice South**	1385 W. 2200 South, Suite 202	West Valley City	UT	84119
Custom Care Healthcare, Inc.	**Custom Care Home Health**	4811 Merlot Avenue, Suite 110	Grapevine	TX	76051
Keystone Hospice Care, Inc.	**Custom Care Hospice**	4811 Merlot Avenue, Suite 110	Grapevine	TX	76051
Thousand Peaks Healthcare, Inc.	**Elevate Home Care (Longmont)**	310 Lashley St., Ste 109	Longmont	CO	80504
Thousand Peaks Healthcare, Inc.	**Elevate Home Care (Wheat Ridge)**	4891 Independence St., Suite 285	Wheat Ridge	CO	80033
Alpowa Healthcare, Inc.	**Elite Home Health**	1370 Bridge Street / PO Box 736	Clarkston	WA	99403
Alpowa Healthcare, Inc.	**Elite Hospice**	1370 Bridge Street /PO Box 736	Clarkston	WA	99403
Emblem Healthcare, Inc.	**Emblem Home Health**	3205 W. Ray Road, Ste 2B	Chandler	AZ	85226
Emblem Healthcare, Inc.	**Emblem Hospice**	3205 W. Ray Road, Ste 2A	Chandler	AZ	85226
Emblem Healthcare, Inc.	**Emblem Hospice Tucson**	7225 N. Oracle Rd., Ste 202	Tucson	AZ	85704
Prairie View Healthcare, Inc.	**Excell Home Care**	1200 SW 104th St., Ste D	Oklahoma City	OK	73139
Prairie View Healthcare, Inc.	**Excell Hospice**	1200 SW 104th St., Ste D	Oklahoma City	OK	73139
Sand Lily Healthcare, Inc.	**Excell Private Care Services**	4631 N. May Ave	Oklahoma City	OK	73112
Finding Home Healthcare, Inc.	**Finding Home Medical Services (ID)**	55 W. Willowbrook Dr., Suite 103	Meridian	ID	83646
Finding Home Healthcare, Inc.	**Finding Home Medical Services (UT)**	1385 West 2200 South, Suite 201	West Valley City	UT	84119
Heartland Healthcare, Inc.	**Gateway Hospice**	103 2nd Ave NE	Clarion	IA	50525
Teton Healthcare, Inc.	**Horizon Home Health**	63 W Willowbrook Drive	Meridian	ID	83646-1656
Teton Healthcare, Inc.	**Horizon Home Health East - Twin Falls**	1411 Falls Ave East, Suite 615	Twin Falls	ID	83301-3458
Teton Healthcare, Inc.	**Horizon Hospice**	63 W Willowbrook Drive	Meridian	ID	83646-1656
Teton Healthcare, Inc.	**Horizon Hospice East**	1411 Falls Ave East, Suite 615	Twin Falls	ID	83301-3458
Copper Basin Healthcare, Inc.	**Hospice of the Pines**	13207 E. State Route 169, Ste. A	Dewey	AZ	86327
South Plains Healthcare, Inc.	**Hospice of the South Plains**	4413 82nd Street, Ste 135	Lubbock	TX	79424
Eureka Healthcare, Inc.	**Kinder Hearts Home Health**	842 N. Mockingbird Lane	Abilene	TX	79603-5729
Eureka Healthcare, Inc.	**Kinder Hearts Hospice**	842 N. Mockingbird Lane	Abilene	TX	79603-5729
Red Rock Healthcare, Inc.	**Lake Powell Physical Therapy**	43rd Sixth Avenue / PO Box 3304	Page	AZ	86040-7500
Granite Healthcare, Inc.	**Namaste Home Health**	6000 E. Evans Ave., Suite 2-400	Denver	CO	80222-5411
Granite Healthcare, Inc.	**Namaste Hospice**	6000 E. Evans Ave., Suite 2-400	Denver	CO	80222-5411
Canyon Healthcare, Inc.	**Physician Home Care**	1385 W. 2200 South, Suite 202	West Valley City	UT	84119
Great Lakes Healthcare, Inc.	**Preceptor Home Health**	W175N11117 Stonewood Dr., Ste 100	Germantown	WI	53022
Great Lakes Healthcare, Inc.	**Preceptor Hospice**	W175N11117 Stonewood Dr., Ste 100	Germantown	WI	53022
Great Lakes Healthcare, Inc.	**Preceptor Therapy**	W175N11117 Stonewood Dr., Ste 100	Germantown	WI	53022
Symbol Healthcare, Inc.	**Puget Sound Home Health**	4002 Tacoma Mall Blvd Ste 204	Tacoma	WA	98409-7702
Symbol Healthcare, Inc.	**Puget Sound Hospice**	4002 Tacoma Mall Blvd Ste 204	Tacoma	WA	98409-7702

Entities Owned By The Pennant Group, Inc.

Legal Name	DBA	Physical/Billing/Remittance Address	Physical City	Physica	Physical Zip
Emerald Healthcare, Inc.	**Puget Sound Home Health of King County**	4002 Tacoma Mall Blvd Ste 204A	Tacoma	WA	98409
Rolling Hills Healthcare, Inc.	**Resolutions Hospice Austin**	1101 Arrow Point Drive Ste 301	Cedar Park	TX	78613
Clear Creek Healthcare, Inc.	**Resolutions Hospice Houston**	12600 N Featherwood Dr Ste 108	Houston	TX	77034
Mohave Healthcare, Inc.	**River Valley Home Health (Big River, CA)**	149350 Ukiah Trail, Ste 102 / PO Box 3200	Big River	CA	92242
Mohave Healthcare, Inc.	**River Valley Home Health (Lake Havasu, AZ)**	500 N Lake Havasu Ave., Ste D102	Lake Havasu	AZ	86403-3606
Mohave Healthcare, Inc.	**River Valley Home Health (Parker, AZ)**	1317 S. Joshua Ave, Ste Q	Parker	AZ	85344
Mohave Healthcare, Inc.	**River Valley Hospice (Big River, CA)**	149350 Ukiah Trail, Ste 103 /PO Box 3200	Big River	CA	92242
Mohave Healthcare, Inc.	**River Valley Hospice (Bullhead City, AZ)**	2649 Hwy 95, Unit H	Bullhead City	AZ	86442
Mohave Healthcare, Inc.	**River Valley Hospice (Parker, AZ)**	1317 S. Joshua Ave., Ste P	Parker	AZ	85344
iCare Private Duty, Inc.	**Safe Harbor Home Care**	5473 Kearny Villa Road, Suite 110B	San Diego	CA	92123-1160
Oceanside Healthcare, Inc.	**Seaport Home Health**	5473 Kearny Villa Road, Suite 100	San Diego	CA	92123
Oceanside Healthcare, Inc.	**Seaport Hospice**	5473 Kearny Villa Road, Suite 110A	San Diego	CA	92123
South Bay Healthcare, Inc.	**Sequoia Home Health**	830 Hillview Ct., Suite 225	Milpitas	CA	95035-4550
South Bay Healthcare, Inc.	**Sequoia Hospice**	830 Hillview Ct., Suite 245	Milpitas	CA	95035-4563
Arches Home Care, Inc.	**Stonebridge Home Care North (UT)**	1385 West 2200 South, Suite 203	West Valley City	UT	84119
Capitol Healthcare, Inc.	**Stonebridge Home Care Solutions (ID)**	55 W. Willowbrook Drive, Suite 101	Meridian	ID	83646
Virgin River Healthcare, Inc.	**Stonebridge Home Care Solutions (UT)**	1385 West 2200 South, Suite 201a	West Valley City	UT	84119
Mountain Peak Home Care, Inc.	**Stonebridge Home Care South (UT)**	363 N. University Ave., Ste 104	Provo	UT	84601
Silver Lake Healthcare, Inc.	**Symbii Home Health**	1385 West 2200 South, Suite 201	West Valley City	UT	84119
Star Valley Healthcare, Inc.	**Symbii Home Health (WY)**	625 S Washington St, Ste B / PO Box 607	Afton	WY	83110
Silver Lake Healthcare, Inc.	**Symbii Hospice**	1385 West 2200 South, Suite 201	West Valley City	UT	84119
Star Valley Healthcare, Inc.	**Symbii Hospice (WY)**	625 S Washington St, Ste B / PO Box 607	Afton	WY	83110
Red Rock Healthcare, Inc.	**Zion's Way Home Health (AZ)**	47 6th Avenue / PO Box 1015	Page	AZ	86040-1015
Red Rock Healthcare, Inc.	**Zion's Way Home Health (UT)**	1173 South 250 West, Suite 401A (as of Aug. 23, 2019)	St. George	UT	84770
Red Rock Healthcare, Inc.	**Zion's Way Hospice (AZ)**	47 6th Avenue	Page	AZ	86040-1015
Red Rock Healthcare, Inc.	**Zion's Way Hospice (UT)**	1173 South 250 West, Suite 401A (as of Aug. 23, 2019)	St George	UT	84770
Eagle Pass Senior Living LLC	**Amarsi Assisted Living**	5125 North 58th Avenue	Glendale	AZ	85301
Brenwood Park Senior Living, Inc.	**Brenwood Park Assisted Living**	9535 West Loomis Road	Franklin	WI	53132
Autumn Ridge Senior Living, Inc.	**Bridgewater Memory Care**	900 Autumn Ridge Drive	Grandbury	TX	76048
San Gabriel Senior Living, Inc.	**California Mission Inn**	8417 Mission Drive	Rosemead	CA	91770
San Gabriel Senior Living, Inc.	**California Mission Inn – Rose Manor**	4825 Earle Avenue	Rosemead	CA	91770
Rosenburg Senior Living, Inc.	**Cambridge Square Retirement Center**	2700 Avenue N	Rosenberg	TX	77471
Lowes Senior Living, Inc.	**Canyon Creek Memory Care**	4257 Lowes Drive, Temple, TX 76502	Temple	TX	76502
Cedar Senior Living, Inc.	**Cedar Hills Senior Living**	602 East Beltline Road, Cedar Hill, TX 75104	Cedar Hill	TX	75104
Prospect Senior Living, Inc.	**Citrus Hills Senior Living**	142 South Prospect Street	Orange	CA	92869-3842
Green Bay Senior Living, Inc.	**Cottonwood Manor Assisted Living**	1450 South Military Avenue, Green Bay, WI 54304	Green Bay	WI	54304
Wisconsin Rapids Senior Living, Inc.	**Cranberry Court Assisted Living I / Cranberry Court Assisted Living II**	2230 14th Street / 2230 James Court	SouthWisconsin Rap	WI	54494
DeSoto Senior Living, Inc.	**Deer Creek Senior Living**	747 West Pleasant Run Road, DeSoto, TX 75115	DeSoto	TX	75115
Spring Valley Assisted Living, Inc.	**Desert Springs Senior Living**	6650 W. Flamingo Road	Las Vegas	NV	89103
Orangewood Senior Living, Inc.	**Desert View Senior Living**	3890 N. Buffalo Drive, Las Vegas, NV 89129	Las Vegas	NV	89129
Brown Road Senior Housing LLC	**Grand Court of Mesa**	262 East Brown Road	Mesa	AZ	85201
Manitowoc Senior Living, Inc.	**Harbor View Assisted Living**	2115 Cappaert Road, Manitowoc, WI 54220	Manitowoc	WI	54220
Twin Falls Senior Living LLC	**Heritage Assisted Living**	622 Filer Avenue West	Twin Falls	ID	83301
Kenosha Senior Living, Inc.	**Kenosha Senior Living**	3109 30th Avenue, Kenosha, WI 53140	Kenosha	WI	53140
Lake Pointe Senior Living, Inc.	**Lakepoint Villa Assisted Living**	190 Lake Pointe Drive, Oshkosh, WI 54904	Oshkosh	WI	54904
Sandstone Senior Living, Inc.	**Lakeshore Assisted Living and Memory Care**	5250 Medical Drive	Rockwall	TX	75032
Willow Creek Senior Living, Inc.	**Las Fuentes Resort Village**	1035 Scott Drive	Prescott	AZ	86301
Lemon Senior Living LLC (management compa	**Lexington Assisted Living**	5440 Ralston Street, Ventura, California 93303	Ventura	CA	93303

Entities Owned By The Pennant Group, Inc.

Legal Name	DBA	Physical/Billing/Remittance Address	Physical City	Physica	Physical Zip
Granite Hills Senior Living, Inc.	**Lo-Har Senior Living**	768 Dorothy Street, El Cajon, CA 92019	El Cajon	CA	92019
Madison Senior Living, Inc.	**Madison Pointe Senior Living**	705 Ziegler Road, Madison, WI 53714	Madison	WI	53714
Orange Senior Living, Inc.	**Mainplace Senior Living**	1800 & 1832 W. Culver Avenue, Orange, CA 92868	Orange	CA	92868
Primrose Senior Living, Inc.	**Maple Meadows Assisted Living**	1001 Primrose Lane	Fond du Lac	WI	54935
McFarland Senior Living, Inc.	**McFarland Villa Assisted Living**	5206 Paulson Court, McFarland	McFarland	WI	53558
Two Rivers Senior Living, Inc.	**Meadow View Assisted Living**	4606 Mishicot Road	Two Rivers	WI	54241
Pleasant Run Senior Living, Inc.	**Meadowcreek Senior Living**	2400 West Pleasant Run Road	Lancaster	TX	75146
Mesa Springs Senior Living LLC	**Mesa Springs Independent Living**	7171 Buffalo Gap Road, Abilene, TX 79606	Abilene	TX	79606
Terrace Court Senior Living, Inc.	**Mountain Terrace Senior Living CBRF/ Mountain Terrace Senior Living RCAC**	3402 Terrace Court / 3312 Terrace Court	Wausau	WI	54401
Mountain Vista Senior Living, Inc.	**Mountain View Retirement Village**	7900 North La Canada Drive, Tucson, AZ 85704	Tucson	AZ	85704
Somers Kenosha Senior Living, Inc.	**North Point Senior Living**	3109 12th Street	Kenosha	WI	53144
2410 Stillhouse Senior Living, Inc.	**Paris Chalet Senior Living**	2410 Stillhouse Road	Paris	TX	75462
Go Assisted, Inc.	**Park Place Assisted Living**	2305 Ives Court, Reno, Nevada 89503	Reno	NV	89503
Bruce Neenah Senior Living, Inc.	**Parkside Senior Living**	2330 Bruce Street, Neenah, WI 54956	Neenah	WI	54956
Racine Senior Living, Inc.	**Racine Commons Assisted Living RCAC/CBRF**	8500(RCAC) / 8600(CBRF) Corporate Drive	Racine	WI	53406
Moss Bay Senior Living, Inc.	**Redmond Heights Senior Living**	7950 Willows Road NE, Redmond, Washington 98052-6813	Redmond	WA	98052-6813
Riverview Village Senior Living, Inc.	**Riverview Village Senior Living**	W176 N9430 Rivercrest	Menomonee Falls	WI	53051
Rockbrook Senior Living, Inc.	**Rockbrook Assisted Living and Memory Care / Rockbrook Memory Care**	2215 Rockbrook Drive	Lewisville	TX	75067
Thomas Road Senior Housing, Inc.	**Rose Court Senior Living**	2935 North 18th Place	Phoenix	AZ	85016
Oceano Senior Living, Inc.	**Santa Maria Terrace**	1405 E. Main St.,, Santa Maria, CA 93454	Santa Maria	CA	93454
Denmark Senior Living, Inc.	**Scandinavian Court Assisted Living**	346 Scandinavian Court, Denmark, WI 54208	Denmark	WI	54208
Beach City Senior Living LLC	**Sea Cliff Assisted Living**	18811 Florida Street	Huntington Beach	CA	92648
Saguaro Senior Living, Inc.	**Sherwood Village Assisted Living and Memory Care**	102 South Sherwood Village Drive	Tucson	AZ	85710
Stoughton Senior Living, Inc.	**Stoughton Meadows Assisted Living**	2321 Jackson St.	Stoughton	WI	53589
Mesa Grande Senior Living, Inc.	**The Citadel Assisted Living Facility**	520 South Higley Rd., Mesa (ALF) / 444 S. Higley Rd. (ILF)	Mesa	AZ	85206
Mission Inn Senior Living LLC	**The Grove Assisted Living**	3401 Lemon Street, Riverside, California 92501	Riverside	CA	92501
Sheboygan Senior Living, Inc.	**The Shores of Sheboygan Assisted Living I / The Shores of Sheboygan Assisted Living II**	3315 Superior Ave.	Sheboygan	WI	53081
Pearl Senior Living, Inc.	**Villa Court Assisted Living and Memory Care**	3985 & 4025 S. Pearl Street, Las Vegas, NV 89121	Las Vegas	NV	89121
Sycamore Senior Living, Inc.	**Whittier Glen Assisted Living**	10615 Jordan Road	Whittier	CA	90603
Stevens Point Senior Living, Inc.	**Willow Brooke Senior Living CBRF/ Willow Brooke Senior Living RCAC**	1800 Bluebell Lane / 1801 Lilac Lane	Stevens Point	WI	54481
Jameson Senior Living, Inc.	**Windsor Court Senior Living**	1101 Jameson Street, Weatherford, TX 76086	Weatherford	TX	76086
Brookhollow Senior Living LLC	**Wisteria Place Assisted Living**	3202 South Willis Street	Abilene	TX	79605

Exhibit 3

Puget Sound Hospice Medicare Director Services Agreement – Template

HOSPICE
MEDICAL DIRECTOR SERVICE AGREEMENT

AGREEMENT EFFECTIVE DATE:	
HOSPICE AGENCY:	SYMBOL HEALTHCARE, INC., D/B/A PUGET SOUND HOSPICE **Address**: 4002 Tacoma Mall Blvd., Ste. 204, Tacoma, WA 98409
MEDICAL DIRECTOR:	**Address:**

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

R E C I T A L S

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

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

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

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

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

Section 1. Medical Director's Duties

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

Section 2. Agency's Duties

Agency shall:

2.1 Organize, manage, and administer its resources to provide the hospice care and services to patients, caregivers and families necessary for the palliation and management of the terminal illness and related condition. Agency shall provide hospice care that (a) optimizes comfort and

dignity; and (b) is consistent with patient and family needs and goals, with patient needs and goals as priority.

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

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

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

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

Section 3. Compensation

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

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

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

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

Section 4. Insurance

4.1 Medical Director agrees to maintain general and professional liability and errors & omissions (malpractice) insurance during the term of this agreement in an amount not less than one million dollars ($1,000,000) per claim and three million dollars ($3,000,000) in the aggregate.

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

4.3 All insurance policies shall: (i) be issued by insurance companies with a policyholder rating of at least "B+" in the most recent version of Best's Key Rating Guide; and (ii) be written by companies authorized to do so in the state where the Agency Premises are located.

4.4 Medical Director's policies shall additionally: (i) name Agency as an "additional insured"; and (ii) provide that the policies will not be cancelled or modified as to limits on less than thirty (30) days' prior written notice to Agency. A current certificate or other acceptable evidence of Medical Director's insurance shall be provided upon written request and kept on file with Agency during the Term.

Section 5. Term and Termination

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

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

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

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

Section 6. Regulatory Changes

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

Section 7. Licensure, Eligibility and Compliance

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

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

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

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

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

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

Section 8. Medical Director's Schedule and Availability

8.1 Nothing in this Agreement shall be construed as limiting or restricting in any manner Medical Director's right to render the same or similar services to other individuals or entities, including

but not limited to, nursing homes and acute care facilities or home health and hospice agencies during or subsequent to the Term of this Agreement.

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

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

Section 9. Contractual Relationship

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

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

Section 10. Indemnification.

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

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

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

Section 11. Access to Books and Records

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

Section 12. Privacy

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

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

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

12.4 *Confidential Information*. Medical Director shall preserve the confidentiality of all private, confidential and/or proprietary information disclosed to or discovered by Medical Director in connection with this Agreement, including, without limitation, nonpublic financial information,

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

Section 13. Notices

All notices, demands, and communications called for in this Agreement will be given by registered or certified United States mail or available express mail carrier (Federal Express, UPS, Airbourne, etc.) return receipt requested, to the following address or to such other address as Agency or Medical Director may designate by written notice to the other pursuant to this Section. Such notice or other communication will be deemed given when received by the addressee, or on the date that the addressee refused delivery. For a notice from Medical Director to Agency to be effective, a true and complete copy of such notice shall be simultaneously delivered by Medical Director to Cornerstone Service Center, Inc., Attn: General Counsel, 27101 Puerta Real, Suite 450, Mission Viejo, CA 92691, as well as the respective addresses for the Parties, listed above.

Section 14. Dispute Resolution/Arbitration

14.1 The Parties agree to meet and confer in good faith to resolve any dispute(s) that may arise out of and/or relate to this Agreement. If such dispute(s) remain unresolved, the Parties mutually agree that such disputes shall be resolved exclusively by arbitration in accordance with the provisions of this Section. Notwithstanding anything contained in this Agreement to the contrary, any controversy, dispute or claim of whatsoever nature arising out of, in connection with, or in relation to the interpretation, performance or breach of this Agreement, including any claim based on contract, tort or statute, shall be determined by final and binding, confidential arbitration in accordance with the then current American Health Lawyers Association dispute resolution rules ("AHLA"), by a sole arbitrator selected from among the AHLA panel of certified arbitrators; provided, however, that if AHLA (or any successor organization thereto) no longer exists, then such arbitration shall be administered by the American Arbitration Association ("AAA") in accordance with its then-existing Commercial Arbitration Rules, and the sole arbitrator shall be selected in accordance with such AAA rules. Any arbitration hereunder shall be governed by the United States Arbitration Act, 9 U.S.C. 1-16 (or any successor legislation thereto), and judgment upon the award rendered by the arbitrator may be entered by any state or federal court having jurisdiction thereof. Neither Party nor the arbitrator shall disclose the existence, content or results of any arbitration hereunder without the prior written consent of all parties; provided, however, that either party may disclose the existence, content or results of any such arbitration to its partners, officers, directors, employees, agents, attorneys and accountants and to any other person or entity to whom disclosure is required by applicable law, including pursuant to an order of a court of competent jurisdiction. Unless otherwise agreed by the parties, any arbitration hereunder shall be held at a neutral location selected by the arbitrator in city where Agency's principal office is located. The cost of the arbitrator and the expenses relating to the arbitration (exclusive of legal fees) shall be borne equally by the Parties unless otherwise specified in the award of the arbitrator. Fees and costs paid or payable to the arbitrator shall be included in "costs and reasonable attorneys' fees" as used elsewhere in this Agreement and the arbitrator shall specifically have the power to award to the prevailing party such party's costs and expenses incurred in such arbitration, including fees and costs paid to the arbitrator.

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

14.3 In the event of any dispute between the parties arising under or in relation to this Agreement, the prevailing party in such dispute or litigation shall have the right to receive from the non-prevailing party all of the prevailing party's reasonable costs and attorneys' fees incurred in connection with any such dispute and/or litigation. As used herein, the term "prevailing party" shall refer to that party to this Agreement for whom the result ultimately obtained most closely approximates such party's position in such dispute or litigation.

14.4 This Agreement shall be governed by the laws of the state in which Agency's principal office is physically located.

Section 15. Miscellaneous

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

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

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

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

15.5 This Agreement shall binding upon the parties hereto, their heirs, successors and assigns. Notwithstanding the foregoing, Medical Director acknowledges that a material and substantial

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

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

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

[Signature Page to follow]

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

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

EXHIBIT A

MEDICAL DIRECTOR RESPONSIBILITIES:

ADMINISTRATIVE

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

PROFESSIONAL SERVICES

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

that the quality and appropriateness of services meets community and regulatory standards.

QUALITY ASSURANCE

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

EDUCATION

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

COMMUNITY

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

SOCIAL, REGULATORY, AND FINANCIAL

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

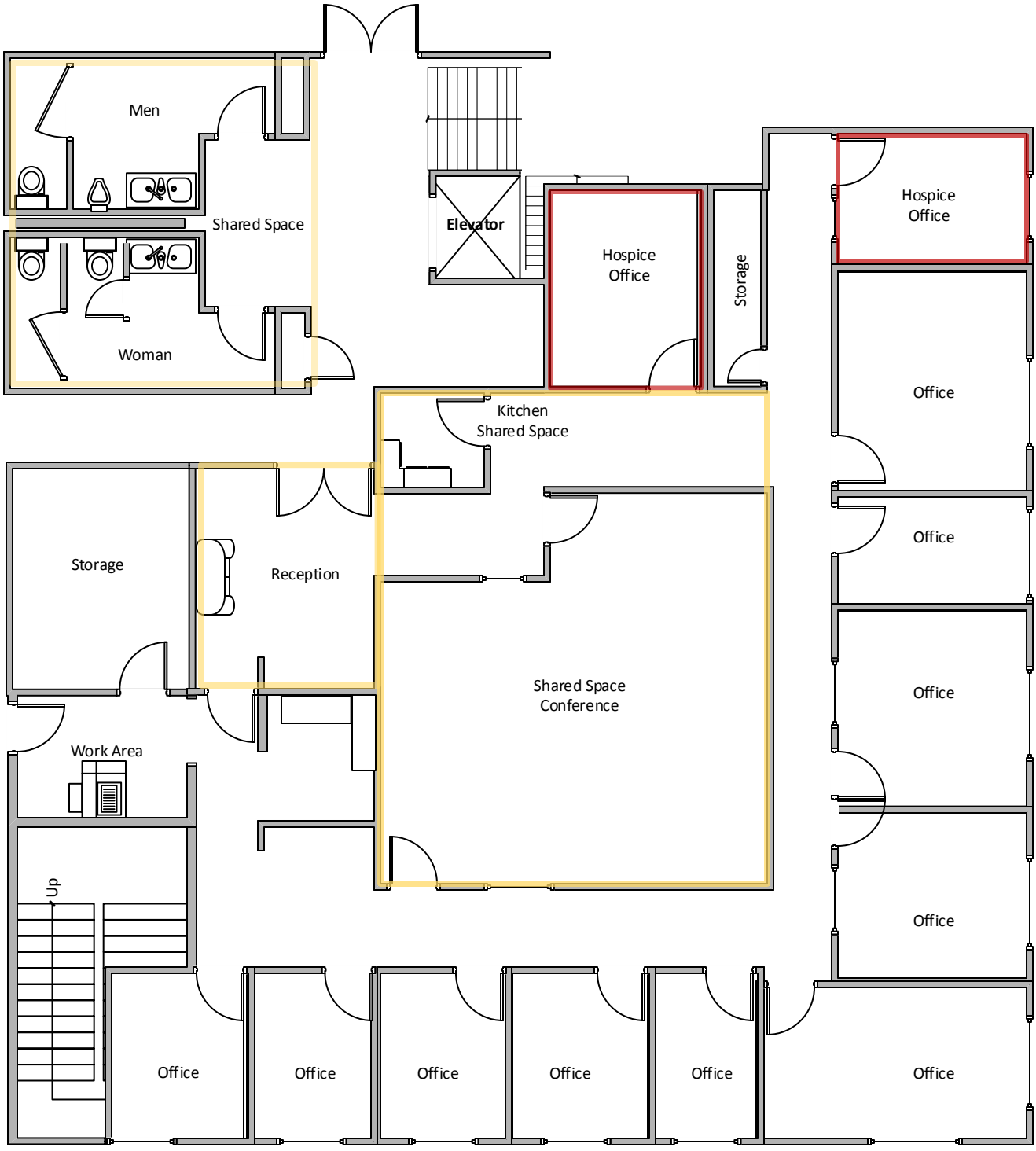
EXHIBIT B

[ATTACH PHYSICIAN SERVICES LOG/INVOICE]

Exhibit 4

Puget Sound Hospice Office Floor Plan

Office Space for
Symbol Healthcare, Inc., d/b/a
Puget Sound Home Health and Hospice



NOTE: Any space not delineated as hospice space or shared space is space occupied by Puget Sound Home Health.

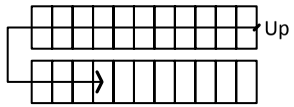

Up

Exhibit 5

Lease & Utility Costs Letter

LEASE -- COMMERCIAL / INDUSTRIAL PREMISES

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

WITNESSETH:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

LESSOR:
Jankelson Lacey Partnership, LP

by Kimberly Woods, Partner

DATE 10/27/2015

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

BY DEVIN A. CHRISTENSEN
ITS EXECUTIVE DIRECTOR

DATE 10/23/15

LANDLORD ACKNOWLEDGEMENT

STATE OF WASHINGTON)
) ss.
COUNTY OF PIERCE)

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

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

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

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

TENANT ACKNOWLEDGEMENT

STATE OF WASHINGTON)
) ss.
COUNTY OF PIERCE)

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

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

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

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

EXHIBIT "A"

4002 Tacoma Mall Blvd.
Tacoma, Washington 98409

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

EXHIBIT "B"

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

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

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

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

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

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

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

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

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

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

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

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

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

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

LESSOR:
Jankelson Lacey Partnership, LP

by Kimberly Woods, Partner

DATE 10/27/2015

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

BY DEVIN A. CHRISTENSEN
ITS EXECUTIVE DIRECTOR

DATE 10/26/15

EXHIBIT D

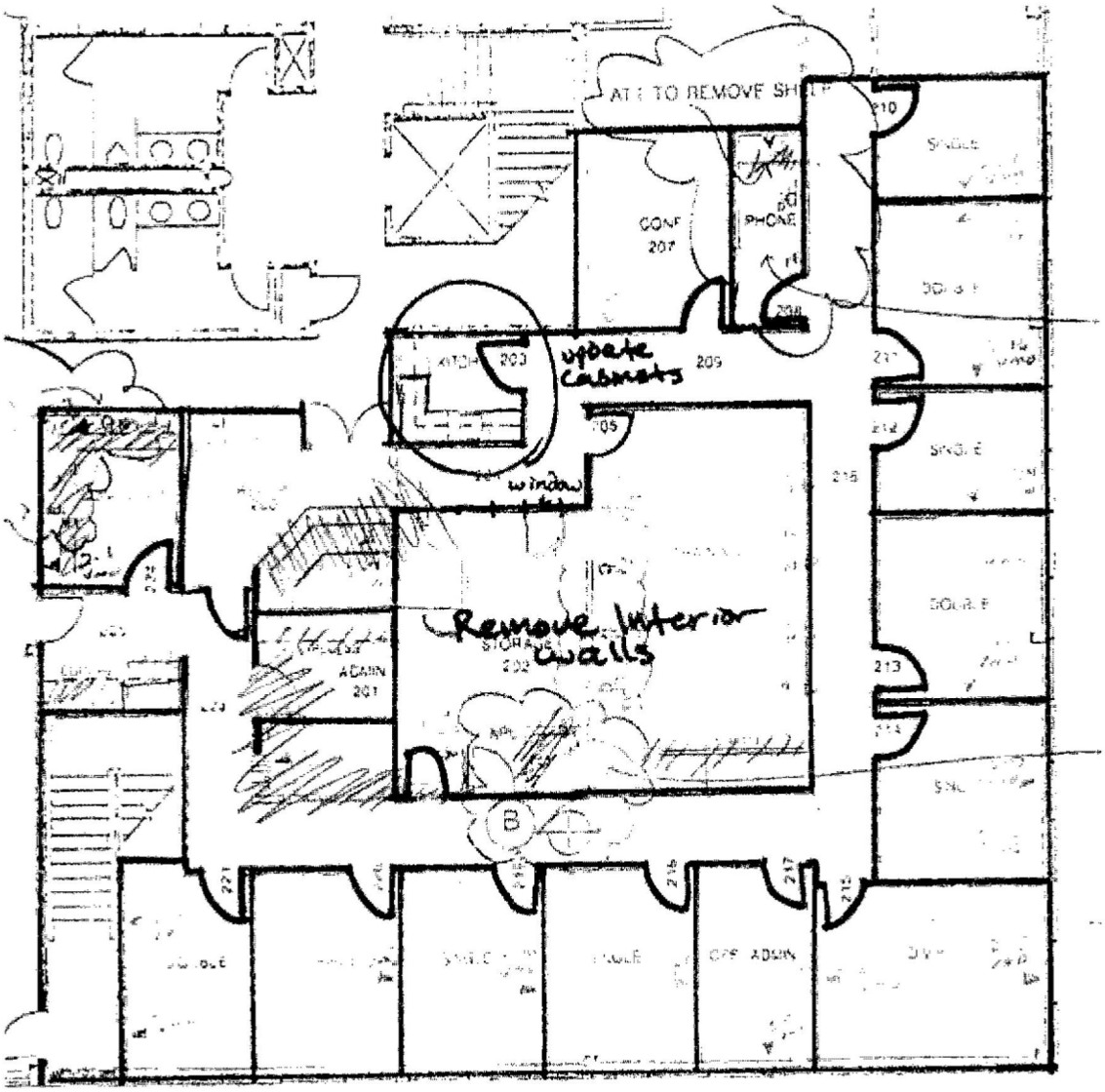

CONF
207
PHONE
update
cabinets
209
203
205
window
Remove interior
walls
ADMIN
201
B

EXHIBIT C

SIGNS

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

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

LESSOR:
Jankelson Lacey Partnership, LP

by Kimberly Woods, Partner

DATE 10/27/2015

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

BY DEVIN A. CHRISTENSEN
ITS EXECUTIVE DIRECTOR

DATE 10/23/15

FIRST ADDENDUM TO LEASE AGREEMENT

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

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

RECITALS

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

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

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

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

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

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

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

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

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

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

With Copy to:

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

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

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

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

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

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

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

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

TARGA REAL ESTATE SERVICES, INC.

July 1, 2019

Symbol Healthcare, Inc.
dba Puget Sound Home Health
4002 Tacoma Mall Blvd #204
Tacoma, WA 98409

To Whom It May Concern:

Targa Real Estate Services is the managing agency for Bank of America Building (Jankelson Lacey Partnership, LP) located at 4002 Tacoma Mall Blvd, Tacoma, WA 98409.

This letter serves as written confirmation that Puget Sound Home Health, located in suite 204 at Bank of America Building, pays monthly Common Area Maintenance charges in addition to monthly rent, accounting for utilities such as electricity, water and natural gas, as well as other common area expenses. These charges are paid on time and in full in accordance with their lease.

Please contact me should you have further questions or need any further confirmation of these common area payments made by Puget Sound Home Health.

Sincerely,

Jenny Korsmo

Jenny Korsmo
Bookkeeper
Targa Real Estate Services, Inc.
On behalf of Bank of America Building

Office
720 S 348th Street Ste A-2
Federal Way WA 98003

Mailing
PO Box 4508
Federal Way WA 98063

Seattle (253) 815-0393
Tacoma (253) 925-2242
Fax (253) 815-0191

Exhibit 6

Admission, Charity Care, & Referral Policies and Procedures

ADMISSION CRITERIA AND PROCESS
Policy No. 4-021.1

PURPOSE

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

POLICY

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

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

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

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

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

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

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

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

Admission Criteria

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

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

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

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

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

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

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

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

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

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

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

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

PROCEDURE

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

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

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

   A. Patient's geographical location

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

   C. Hospice personnel's education and experience

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

   E. Urgency of identified need for assessment

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

   A. Such notification and approval will be documented.

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

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

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

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

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

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

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

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

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

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

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

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

   A. Level of services required and frequency criteria

   B. Eligibility (according to organization admission criteria)

   C. Source of payment

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

   A. Nature and goals of care and/or service

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

   C. Access to care after hours

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

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

   F. Safety information

   G. Infection control information

   H. Emergency preparedness plans

   I. Available community resources

   J. Complaint/grievance process

K. Advance Directives

L. Availability of spiritual counseling in accordance with religious preference

M. Hospice personnel to be involved in care

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

    A. Patient

    B. Physician

    C. Referral source (if not physician)

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

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

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

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

REFERRAL DISCLOSURE AND CARE DECISIONS
Policy No. 1-004.1

PURPOSE

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

POLICY

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

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

PROCEDURE

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

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

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

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

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

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

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

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

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

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

CHARITY CARE
Policy No. 3-007.1

PURPOSE

To identify the criteria to be applied when accepting patients for charity care.

POLICY

Patients without third-party payer coverage and who are unable to pay for medically necessary care will be accepted for charity care admission, per established criteria.

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

The organization will consistently apply the charity care policy.

PROCEDURE

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

2. A social worker, as available, will meet with the patient to determine potential eligibility for financial assistance from other community resources.

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

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

5. When financial declarations reveal the patient is able to make partial payment for services, the Executive Director/Administrator, with the appropriate program director, will determine the sliding-fee schedule to be implemented.

6. The revised sliding-fee schedule will be presented to the patient for agreement and signature.

7. After acceptance for charity care, the patient's ability to pay will be reassessed every 60–90 days.

8. When the organization is unable to admit the patient or to continue charity care, every effort will be made to refer the patient for appropriate care/service with an alternate provider.

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

NONDISCRIMINATION POLICY AND GRIEVANCE PROCESS
Policy No. 2-037.1

PURPOSE

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

POLICY

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

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

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

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

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

PROCEDURE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 1557 Checklist

BASICS

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

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CHECKLIST

POLICY

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

NOTICE OF NONDISCRIMATION AND TAGLINES

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

TRANSLATED DOCUMENTS

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

VENDORS

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

PRE-ADMIT PROCESS

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

ADMISSION PROCESS

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

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

STAFF QUALIFICATION

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

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

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

A qualified staff member is one who has had;

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

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

CARE DELIVERY

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

DOCUMENTATION

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

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

GRIEVANCES

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

QUALITY IMPROVEMENT

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

RESOURCES

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

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

CONTACTS

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

PASSION FOR LEARNING

NONDISCRIMINATION STATION

Section 1557 of the Affordable Care Act

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

YES!

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

What should I know??

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

What could happen if we are not in compliance?

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

WATCH YOUR EMAIL FOR MORE INFORMATION AND RESOURCES

Where do I go for more information?

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

Who do I contact with questions?

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

Pennant Group Affiliate

LANGUAGE ACCESS PLAN AND POLICY

2019

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Summary of Nondiscrimination in Health Programs and Activities

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

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

The rule covers:

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

Protections under the rule

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

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

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

Enforcement

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

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

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

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

LANGUAGE ACCESS POLICY

Purpose

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

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

Scope

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

Policy Statement

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

Policy

Operation will;

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

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

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

GRIEVANCE POLICY AND PROCEDURE

Purpose

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

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

Scope

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

Policy Statement

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

Policy

Operation will;

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

Procedure

Operation shall;

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

Discrimination Grievance Form

Name	
Address	
City, State, ZIP	
Telephone Number	
Email address	

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

Name	
Address	
City, State, ZIP	
Telephone number	

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

Description of the action you would like to see taken

Signature	
Date of Complaint	

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

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

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

Notice of Non-discrimination

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

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

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

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

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

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

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

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

ELEMENTS AND PROCEDURES

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

ELEMENT 1: Assessment: Needs and Capacity

ELEMENT 2: Oral Language Assistance Services

ELEMENT 3: Written Translations

ELEMENT 4: Policies and Procedures

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

ELEMENT 6: Staff Training

ELEMENT 7: Assessment: Access and Quality

ELEMENT 8: Procurement of Language Assistance Services

ELEMENT 1: Assessment of Needs and Capacity

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

Description

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

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

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

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

PROCEDURE

Operation shall;

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

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

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

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

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

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

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

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

ELEMENT 2: Oral Language Assistance Services

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

Description

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

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

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

PROCEDURE

Operation shall;

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

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

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

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

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

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

ELEMENT 3: Written Translations

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

Description

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

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

PROCEDURE

Operation shall;

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

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

c. Use the services of qualified, professional translators.

ELEMENT 4: Policies and Procedures

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

Description

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

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

PROCEDURE

Operation shall;

a. Implement this Language Access Plan and policy.

b. Regularly monitor the efficacy of services provided.

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

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

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

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

Description

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

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

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

PROCEDURE

Operation shall;

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

b. Distribute and make available resources.

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

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

ELEMENT 6: Staff Training

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

Description

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

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

PROCEDURE

Operation shall;

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

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

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

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

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

f. Provide ongoing training as needed.

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

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

ELEMENT 7: Assessment of Access and Quality

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

Description

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

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

PROCEDURE

Operation shall;

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

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

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

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

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

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

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

ELEMENT 8: Procurement of Language Assistance Services

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

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

PROCEDURE

Operation shall;

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

Appendix A: Definitions

Auxiliary Aids and Services

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

Disability

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

Effective Communication

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

Qualified Bilingual/Multilingual Staff

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

Qualified Interpreter

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

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

Qualified Translator

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

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

Language Access

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

Language Assistance Services

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

Limited English Proficiency (LEP)

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

Meaningful Access

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

Plain Language

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

Preferred Language

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

Taglines

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

Translation

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

Translator

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

Vital Document

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

Appendix B: Language Access Related Resources

LEP.gov

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

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

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

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

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

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

YOUTUBE VIDEOS

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

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

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

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

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

Exhibit 7

Puget Sound Hospice Pro Forma & Other Financials

Symbol Healthcare, Inc
PIERCE CO. Hospice Pro Forma

REVENUE

Gross revenue by type of care **Pierce County**	**2020**	**2021**	**2022**	**2023**	
Routine Home Care	36,259	2,661,222	4,441,622	6,587,616	Days of Care x Per Diem Rates
Inpatient Respite	556	40,830	68,146	101,072	Days of Care x Per Diem Rates
Continuous Home Care	143	10,518	17,554	26,036	Days of Care x Per Diem Rates: Assumes one 8 hour shift per each unmet day
General InPatient	487	35,715	59,609	88,410	Days of Care x Per Diem Rates
Gross revenue subtotal	37,446	2,748,286	4,586,932	6,803,134	
Adjustments to revenue	**2020**	**2021**	**2022**	**2023**	
Contractual adjustments Medicare Managed Care, Medicaid Managed Care, Private Pay, Third Party Ins	(749)	(54,966)	(91,739)	(136,063)	Assumed 2%
Charity Care	(1,872)	(137,414)	(229,347)	(340,157)	Assumed 5%
Provisions for Bad Debt	(374)	(27,483)	(45,869)	(68,031)	Assumed 1%
Total Adjustments to Revenue	(2,996)	(219,863)	(366,955)	(544,251)	
Total Net Revenue	**34,450**	**2,528,423**	**4,219,977**	**6,258,883**	

EXPENSES

PATIENT CARE COSTS

Clinical Staffing	**2020**	**2021**	**2022**	**2023**	**Note**
Compensation and Benefits					
Registered Nurse	12,500	436,286	728,168	1,079,986	FTE x Annual Compensation

Certified Nursing Assistant	1,671	120,997	201,945	299,516	FTE x Annual Compensation	
Licensed Clinical Social Worker	1,268	91,782	153,185	227,197	FTE x Annual Compensation	
Spiritual Care Coordinator	1,000	72,391	120,822	179,198	FTE x Annual Compensation	
Director of Patient Services	1,205	87,257	145,634	215,997	FTE x Annual Compensation	
Payroll Taxes & Benefits	5,293	242,614	404,926	600,568	30% of Base Compensation	
Total	**22,938**	**1,051,326**	**1,754,679**	**2,602,463**		
Contracted Patient Care	**2020**	**2021**	**2022**	**2023**	**Note**	
Medical Director	1,061	76,786	128,158	190,078	MD rate of $200/hr. per contract. Assumption of .75hrs/ADC	
Physical Therapist	20	1,479	2,469	3,662	$42.38/hr	1.5 hours/20 ADC/Month
Occupational Therapist	19	1,370	2,287	3,392	$39.26/hr	1.5 hours/20 ADC/Month
Speech Therapist	17	1,241	2,071	3,071	$35.55/hr	1.5 hours/20 ADC/Month
Dietitian	16	1,162	1,939	2,876	$33.29/hr	1.5 hours/20 ADC/Month
Total	**1,133**	**82,038**	**136,924**	**203,079**		
Direct Patient Care Costs	**2020**	**2021**	**2022**	**2023**	**Note**	
DME	1,165	85,497	142,695	211,639	$6.04/PPD based on Pennant averages	
Pharmacy	1,367	100,359	167,501	248,430	$7.09/PPD based on Pennant averages	
General Inpatient Costs	487	35,715	59,609	88,410	$841.05 per General Inpatient DOC	
Medical Supplies	500	36,662	61,189	90,752	$2.59/PPD based on Pennant averages	
Inpatient Respite	556	40,830	68,146	101,072	$192.30 per Inpatient Respite DOC	
Room and Board	87	6,370	10,631	15,768	$.45/PPD based on Pennant averages	
Mileage	694	50,958	85,050	126,142	Estimate 8 miles/DOC reimbursed at $.45/mile based on existing local agency	

Subtotal	**4,856**	**356,391**	**594,822**	**882,214**
Total Direct Patient Care Costs		**1,489,755**	**2,486,425**	**3,687,755**

ADMINISTRATIVE COSTS

Administrative Compensation and Benefits	**2020**	**2021**	**2022**	**2023**	**Note**
Administrator	1,889	34,000	35,020	36,071	FTE x Annual Compensation, represents 50% of Puget Sound Administrator
Assistant Director of Operations	-	42,500	85,000	87,550	Full time Executive Director hired in Aug. 2021 based on growth
Business Office Manager, Medical Records, Scheduling	3,591	64,635	107,877	159,998	FTE x Annual Compensation
Intake	2,889	52,000	52,000	52,000	FTE x Annual Compensation
Community Liaison	4,668	84,025	140,240	207,997	FTE x Annual Compensation
Payroll Taxes & Benefits	4,619	83,148	126,041	163,085	30% of Base Compensation
Total	**17,656**	**360,308**	**546,177**	**706,701**	

Administration Costs	**2020**	**2021**	**2022**	**2023**	**Note**
Advertising	10,345	25,284	42,200	62,589	$10,000 launch plus 1% of revenue
Allocated Costs	1,872	137,414	229,347	340,157	5% Allocation to Pennant Service Center for supporting functions
B & O Taxes (Wa. gross reciepts tax)	562	41,224	68,804	102,047	1.5% of Gross Revenue
Dues & Subscriptions	750	4,500	4,500	4,500	$375/month, primarily Medbridge
Education and trainings	500	3,000	10,000	10,000	$10,000/year, Continuing education including Clinical education and compliance
Information Technology/Computer/Software Maintenance	2,500	15,000	15,000	15,000	$1250/month
Insurance	200	1,200	1,200	1,200	Liability and property content
Legal and professional	-	-	-	-	Included in Allocated Costs to Pennant Service Center

Licenses and Fees	-	13,600	3,000	3,000	First year Accredidation $3,100, Survey $7,500, Annual State License 3,000
Postage	1,000	6,000	6,000	6,000	$500/month
Purchased services	2,000	12,000	12,000	12,000	$1000/month; bank fees, system access: HCHB, SHP, Workday
Repairs and Maintenance	300	1,800	1,800	1,800	$150/month
Cleaning	420	2,520	2,520	2,520	$210/month
Office supplies	500	3,000	3,000	3,000	$250/month
Equipment lease & maintenance	1,000	6,000	6,000	6,000	$500/month, copier and postage machines
Building rent or lease	-	8,509	11,346	14,182	Effective 1/10/2021, Lease is 8% of space In 2021, 12% in 2022, and 15% of 2023
Lease NNN or Common Area Maintenance charges	62	370	554	693	Approximately $385/month and represents 8% in 2021, 12% in 2022, and 15% in 2023
Recruitment	7,750	7,750	3,000	3,000	$5,000 startup and $250/month following
Telephones	4,516	14,771	22,094	30,522	$55/FTE/month + $250/month for landlines
Travel	5,000	10,000	7,500	7,500	First year $15,000 support and launch, $7,500 thereafter
Subtotal	**39,276**	**313,943**	**449,864**	**625,709**	
Total Administrative Expense	**56,932**	**674,252**	**996,042**	**1,332,410**	
TOTAL COSTS	**56,932**	**2,164,007**	**3,482,466**	**5,020,165**	
EBITDA	(51,410)	364,416	737,511	1,238,718	
EBITDA Margin %	-149.23%	14.4%	17.5%	19.8%	
Depreciation	-	20,914	23,456	26,433	
Amortization	-	-	-	-	
EBIT	(51,410)	343,502	714,055	1,212,285	

Interest Expense	-	-	-	-
Earnings before Taxes	(51,410)	343,502	714,055	1,212,285

Symbol Healthcare, Inc

PIERCE CO. assumptions and calculations	2019	2020	2021	**Estimated** 2022	**Estimated** 2023	
Pierce County	9	33	60			WA DOH Numeric Need Methodology 10/15/18
Numeric need of 1	1	1	1			WA DOH Numeric Need Methodology 10/15/18
ADC	9	33	60	85.5	111.8	WA DOH Numeric Need Methodology 10/15/18
Patient Days						
Pierce County	3,427	12,054	21,777	28,445	35,307	WA DOH Numeric Need Methodology 10/15/18
Numeric need of 1	1	1	1			WA DOH Numeric Need Methodology 10/15/18
unmet patient days	3,427	12,054	21,777	31,500	41,223	WA DOH Numeric Need Methodology 10/15/18
ALOS in Washington	60.86	60.86	60.86	60.86	60.86	WA DOH Numeric Need Methodology 10/15/18
Pierce county unduplicated admissions calculation						
Unmet annual admits	56.31	198.06	357.82	517.58	677.34	
Monthly admits	4.69	16.51	29.82	43.13	56.45	*Unduplicated Admissions required to cover 100% of unmet need

Assumptions and Projections

Assumes 10/1/20 start date	**2020**	**2021**	**2022**	**2023**	
Patient Days	193	14,155	23,625	35,040	Projected service for 65% (2021), 75% (2022), and 85% (2023) of Unmet Patient Days
Annual admissions - Unduplicated Patients with ALOS of 60.86	3	232.58	388.19	575.74	
Monthly Unduplicated Patient admissions	2	19.4	32.3	48.0	
Average Daily Census (ADC)	3	38.8	64.7	96.0	

National Hospice and Palliative Care Organization (NHPCO)
2017 Facts and Figures updated as of April 2018

Table 10: Level of Care by Percentage of Days of Care	**DOC %**
Routine Home Care (RHC)	98.0%
Inpatient Respite Care (IRC)	1.5%
Continuous Home Care (CHC)	0.2%
General InPatient Care (GIP)	0.3%

CMS WA percentages of care Pierce - Days of Care (DOC)	**2020**	**2021**	**2022**	**2023**

Routine Home Care (RHC)	189	13,872	23,153	34,339	Level of Care Percentage x Projected service of unmet days
Inpatient Respite Care (IRC)	3	212	354	526	Level of Care Percentage x Projected service of unmet days
Continuous Home Care (CHC)	0	28	47	70	Level of Care Percentage x Projected service of unmet days
General InPatient Care (GIP)	1	42	71	105	Level of Care Percentage x Projected service of unmet days
Total Days of Care	193	14,155	23,625	35,040	

Referral resources based on Cornerstone averages			**# of Referrals by Source**		**Avg referral %**
Physician Referral	1	6.4	10.6	15.8	32.9%
Clinic Referral	1	7.1	11.8	17.5	36.5%
Transfer from Hospital	0	2.4	3.9	5.9	12.2%
Transfer from SNF	0	3.2	5.4	8.0	16.7%
All other	0	0.3	0.5	0.8	1.7%
Subtotal Referrals	2	19.4	32.3	48.0	

Per Diem Rates - 2020

Pierce	**Days 1-60**	**Days > 60**		
Routine Home Care	$ 224.84	$ 177.70	$ 191.84	Blended rate of 30% Tier 1 and 70% Tier 2 based on Cornerstone averages
Inpatient Respite	$ 192.30		Per Day	
			Per Hour, minimum 8 hours	
Continuous Home Care	$ 46.44		required	
General InPatient	$ 841.05		Per Day	

REVENUE

Gross revenue by type of care

Pierce County	**2020**	**2021**	**2022**	**2023**	
Routine Home Care	36,259	2,661,222	4,441,622	6,587,616	Days of Care x Per Diem Rates
Inpatient Respite	556	40,830	68,146	101,072	Days of Care x Per Diem Rates
Continuous Home Care	143	10,518	17,554	26,036	Days of Care x Per Diem Rates: Assumes one 8 hour shift per each unmet day
General InPatient	487	35,715	59,609	88,410	Days of Care x Per Diem Rates
Gross revenue subtotal	37,446	2,748,286	4,586,932	6,803,134	

Payor Mix

Medicare	1	94.6%	94.6%	94.6%	Based on total Cornerstone averages
Medicaid	0	4.0%	4.0%	4.0%	Based on total Cornerstone averages
Commercial	0	1.2%	1.2%	1.2%	Based on total Cornerstone averages
Other	0	0.2%	0.2%	0.2%	Based on total Cornerstone averages
Subtotal	1	100%	100%	100%	

Gross revenue by Payor Mix

Pierce County	**2020**	**2021**	**2022**	**2023**

Medicare	35,424	2,599,878	4,339,238	6,435,764	Gross revenue by Type of Care x Payor Mix
Medicaid	1,498	109,931	183,477	272,125	Gross revenue by Type of Care x Payor Mix
Commercial	449	32,979	55,043	81,638	Gross revenue by Type of Care x Payor Mix
Other	75	5,497	9,174	13,606	Gross revenue by Type of Care x Payor Mix
Gross revenue subtotal	**37,446**	**2,748,286**	**4,586,932**	**6,803,134**	
Adjustments to revenue	**2020**	**2021**	**2022**	**2023**	
Contractual adjustments					
Medicare Managed Care, Medicaid Managed Care, Private Pay, Third Party Ins	(749)	(54,966)	(91,739)	(136,063)	Assumed 2%
Charity Care	(1,872)	(137,414)	(229,347)	(340,157)	Assumed 5%
Provisions for Bad Debt	(374)	(27,483)	(45,869)	(68,031)	Assumed 1%
Total Adjustments to Revenue	(2,996)	(219,863)	(366,955)	(544,251)	
Total Net Revenue	**34,450**	**2,528,423**	**4,219,977**	**6,258,883**	

EXPENSES

PATIENT CARE COSTS

Clinical Staffing	**2020**	**2021**	**2022**	**2023**	**Annual Comp/FTE**	**Note**
Staffing by FTE's						
Registered Nurse	1	5.8	9.7	14.4	75,000	1 RN/12 ADC and .8 RN/12 ADC for weekend/night/call rotation
Certified Nursing Assistant	0	3.9	6.5	9.6	31,200	1 CNA/10 ADC
Licensed Clinical Social Worker	0	1.3	2.2	3.2	71,000	1 LCSW/30 ADC; Also covers Volunteer Coordinator until ADC of 60
Spiritual Care Coordinator	0	1.3	2.2	3.2	56,000	1 SCC/30 ADC; Also covers Bereavement Coordinator until ADC of 60
Director of Patient Services	0	1.0	1.6	2.4	90,000	1/DPS/40 ADC includes QAPI
Total	**2**	**13.3**	**22.1**	**32.8**		

Clinical Staffing	**2020**	**2021**	**2022**	**2023**	**Note**
Compensation and Benefits					
Registered Nurse	12,500	436,286	728,168	1,079,986	FTE x Annual Compensation
Certified Nursing Assistant	1,671	120,997	201,945	299,516	FTE x Annual Compensation
Licensed Clinical Social Worker	1,268	91,782	153,185	227,197	FTE x Annual Compensation
Spiritual Care Coordinator	1,000	72,391	120,822	179,198	FTE x Annual Compensation
Director of Patient Services	1,205	87,257	145,634	215,997	FTE x Annual Compensation

Payroll Taxes & Benefits	5,293	242,614	404,926	600,568	30% of Base Compensation
Total	**22,938**	**1,051,326**	**1,754,679**	**2,602,463**	

Contracted Patient Care	**2020**	**2021**	**2022**	**2023**	**Note**	
Medical Director	1,061	76,786	128,158	190,078	MD rate of $220/hr. per contract. Assumption of .75hrs/ADC	
Physical Therapist	20	1,479	2,469	3,662	$42.38/hr	1.5 hours/20 ADC/Month
Occupational Therapist	19	1,370	2,287	3,392	$39.26/hr	1.5 hours/20 ADC/Month
Speech Therapist	17	1,241	2,071	3,071	$35.55/hr	1.5 hours/20 ADC/Month
Dietitian	16	1,162	1,939	2,876	$33.29/hr	1.5 hours/20 ADC/Month
Total	**1,133**	**82,038**	**136,924**	**203,079**		

Direct Patient Care Costs	**2020**	**2021**	**2022**	**2023**	**Note**
DME	1,165	85,497	142,695	211,639	$6.04/PPD based on Cornerstone averages
Pharmacy	1,367	100,359	167,501	248,430	$7.09/PPD based on Cornerstone averages
General Inpatient Costs	487	35,715	59,609	88,410	$841.05 per General Inpatient DOC
Medical Supplies	500	36,662	61,189	90,752	$2.59/PPD based on Cornerstone averages
Inpatient Respite	556	40,830	68,146	101,072	$192.30 per Inpatient Respite DOC
Room and Board	87	6,370	10,631	15,768	$.45/PPD based on Cornerstone averages
Mileage	694	50,958	85,050	126,142	Estimate 8 miles/DOC reimbursed at $.45/mile based on existing local agency
Subtotal	**4,856**	**356,391**	**594,822**	**882,214**	

Total Direct Patient Care Costs	**28,927**	**1,489,755**	**2,486,425**	**3,687,755**

ADMINISTRATIVE COSTS

Administrative Staff by FTE	**2020**	**2021**	**2022**	**2023**	**Annual Comp/FTE**	**Note**
Administrator	.08	0.5	0.5	0.5	100,000	
Assistant DOO	-	0.5	1.0	1.0	85,000	
Business Office Manager, Medical Records, Scheduling	0	1.3	2.2	3.2	50,000	1 BOM/30 ADC
Intake	0	1.0	1.0	1.0	52,000	
Community Liaison	0	1.3	2.2	3.2	65,000	1 CL/30 ADC
Total	**1**	**4.6**	**6.8**	**8.9**		

Administrative Compensation and Benefits	**2020**	**2021**	**2022**	**2023**	**Note**
Administrator	1,889	34,000	35,020	36,071	FTE x Annual Compensation, represents 50% of Puget Sound Administrator
Assistant DOO	-	42,500	85,000	87,550	Full time Executive Director hired in Aug. 2021 based on growth
Business Office Manager, Medical Records, Scheduling	3,591	64,635	107,877	159,998	FTE x Annual Compensation
Intake	2,889	52,000	52,000	52,000	FTE x Annual Compensation
Community Liaison	4,668	84,025	140,240	207,997	FTE x Annual Compensation
Payroll Taxes & Benefits	4,619	83,148	126,041	163,085	30% of Base Compensation
Total	**17,656**	**360,308**	**546,177**	**706,701**	

Administration Costs	**2020**	**2021**	**2022**	**2023**	**Note**
Advertising	10,345	25,284.23	42,200	62,589	$10,000 launch plus 1% of revenue
Allocated Costs	1,872	137,414	229,347	340,157	5% Allocation to Cornerstone Service Center for supporting functions
B & O Taxes (Wa. gross reciepts tax)	562	41,224	68,804	102,047	1.5% of Gross Revenue
Dues & Subscriptions	750	4,500	4,500	4,500	$375/month, primarily Medbridge
Education and trainings	500	3,000	10,000	10,000	$10,000/year, Continuing education including Clinical education and compliance
Information Technology/Computer/Software Maintenance	2,500	15,000	15,000	15,000	$1250/month
Insurance	200	1,200	1,200	1,200	Liability and property content
Legal and professional	-	-	-	-	Included in Allocated Costs to Cornerstone Service Center
Licenses and Fees	-	13,600	3,000	3,000	First year Accreditation $3,100, Survey $7,500, Annual State License 3,000
Postage	1,000	6,000	6,000	6,000	$500/month
Purchased services	2,000	12,000	12,000	12,000	$1000/month; bank fees, system access: HCHB, SHP, Workday
Repairs and Maintenance	300	1,800	1,800	1,800	$150/month
Cleaning	420	2,520	2,520	2,520	$210/month
Office supplies	500	3,000	3,000	3,000	$250/month
Equipment lease & maintenance	1,000	6,000	6,000	6,000	$500/month, copier and postage machines

Building rent or lease		8,509	11,346	14,182	Effective 1/10/2021, Lease is 8% of space In 2021, 12% in 2022, and 15% of 2023
Lease NNN or Common Area Maintenance charges	62	370	554	693	Approximately $385/month and represents 8% in 2021, 12% in 2022, and 15% in 2023
Recruitment	7,750	7,750	3,000	3,000	$5,000 startup and $250/month following
Telephones	4,516	14,771	22,094	30,522	$55/FTE/month + $250/month for landlines
Travel	5,000	10,000	7,500	7,500	First year $15,000 support and launch, $7,500 thereafter
Subtotal	**39,276**	**313,943**	**449,864**	**625,709**	
Total Administrative Expense	**56,932**	**674,252**	**996,042**	**1,332,410**	
TOTAL COSTS	**85,860**	**2,164,007**	**3,482,466**	**5,020,165**	
EBITDA	(51,410)	364,416	737,511	1,238,718	
EBITDA Margin %	(1)	14.4%	17.5%	19.8%	
Depreciation	-	20,914	23,456	26,433	
Amortization	-	-	-	-	
EBIT	(51,410)	343,502	714,055	1,212,285	
Interest Expense		-	-	-	
Earnings before Taxes	(51,410)	343,502	714,055	1,212,285	

Symbol Healthcare, Inc (HH+THUR+PIER)

Cash Flow Statement	2021 **Year 1**	2022 **Year 2**	2023 **Year 3**
Operations			
Net Income	3,039,862	4,113,479	5,107,389
Add:			
Depreciation	75,674	78,650	81,218
Change In:			
Current Assets	(480,659)	(301,016)	(225,762)
Allowance for Bad Debt	76,779	14,945	22,619
Other Assets	(15,000)	7,500	-
Current Liabilities	428,659	131,741	56,702
Long Term Liabilities - Non Financing	-	-	-
Total Cash from Operations	3,125,315	4,045,299	5,042,165
Investing Activities			
Sale of Property and Equipment			
Purchase of Property and Equipment	(104,568)	(12,711)	(14,884)
Total Cash from Investing	(104,568)	(12,711)	(14,884)
Financing Activities			
Loan	-	-	-
Total Cash used for Financing	-	-	-
Net Cash	**3,020,747**	**4,032,588**	**5,027,281**
Beginning Cash	**150**	**150**	**150**
Cash From/(Used) Operations	3,125,315	4,045,299	5,042,165
Cash From/(Used) for Investing	(104,568)	(12,711)	(14,884)
Cash From/(Used) for Financing	-	-	-
Total Cash From/(Used)	3,020,747	4,032,588	5,027,281
Ending Cash	**3,020,897**	**4,032,738**	**5,027,431**

Symbol Healthcare, Inc.

Puget Sound Home Health and Hospice

Actual For the Twelve Months Ending December 31, 2019

	2016	2017	2018	2019	2020	2021	2022	2023
Total Net Home Health Revenue	6,825,857	7,824,557	8,177,854	8,392,198	8,811,808	8,988,044	9,167,805	9,351,161
Total Net Hospice Revenue (THURSTON CO. & PIERCE CO.)					1,956,632	5,144,795	7,636,797	9,675,703
TOTAL NET REVENUE	6,825,857	7,824,557	8,177,854	8,392,198	10,768,440	14,132,839	16,804,602	19,026,864
DIRECT COSTS								
HH- Therapy Wages	1,760,653	1,768,062	1,976,618	1,953,025	1,992,086	2,031,927	2,072,566	2,114,017
HH- Therapy Benefits	369,022	386,377	489,150	486,010	495,730	505,645	515,758	526,073
HH- Therapy Mileage	27,707	81,132	81,971	62,282	63,528	64,798	66,094	67,416
HH - Therapy Other	202,806	74,895	40,279	54,261	55,346	56,453	57,582	58,733
Total Home Health Therapy	2,360,188	2,310,465	2,588,018	2,555,577	2,606,689	2,658,823	2,711,999	2,766,239
HH- CNA Wages	49,470	24,152	40,479	42,644	43,497	44,367	45,254	46,159
HH- CNA Benefits	10,175	4,864	7,640	10,837	11,054	11,275	11,501	11,731
HH- CNA Mileage	848		7,563	3,195	3,259	3,324	3,390	3,458
HH - CNA Other		40	248	804	820	836	853	870
Total Home Health CNA	60,493	29,055	55,929	57,480	58,629	59,802	60,998	62,218
HH- Nursing Wages	801,721	986,460	980,297	1,181,378	1,205,005	1,229,106	1,253,688	1,278,761
HH- Nursing Benefits	136,444	171,888	282,710	318,022	324,382	330,870	337,487	344,237
HH- Nursing Mileage	81,539	111,785	110,370	113,801	116,077	118,399	120,767	123,182
HH - Nursing Other	77,673	13,396	89,388	58,743	59,918	61,116	62,338	63,585
Total Home Health Skilled Nursing	1,097,376	1,283,529	1,462,764	1,671,944	1,705,382	1,739,490	1,774,280	1,809,765
HH - SS Wages	50,934	54,341	61,580	68,885	70,262	71,667	73,101	74,563
HH - SS Benefits	10,118	12,154	16,921	18,378	18,746	19,121	19,503	19,893
HH - SS Mileage	138	1,586	498	159	163	166	169	173
HH - SS Other		1,088	584	419	427	436	444	453
Total Home Health Social Services	61,190	69,168	79,583	87,841	89,598	91,390	93,218	95,082
HH - Supplies	119,511	197,315	248,238	194,826	198,723	202,697	206,751	210,886
HH - Other Direct Costs	210	397	1,432	592	604	616	628	641

TOTAL DIRECT COSTS - HOME HEALTH	3,698,969	3,889,929	4,435,964	4,568,260	4,659,625	4,752,818	4,847,874	4,944,831
Hospice - CNA Wages					96,243	249,722	370,053	467,624
Hospice - CNA Benefits					28,873	74,917	111,016	140,287
Hospice - CNA Mileage					6,691	9,108	11,894	11,894
Total Hospice - CNA					131,807	333,747	492,963	619,805
Hospice - Nursing Wages					353,503	900,441	1,334,326	1,686,144
Hospice - Nursing Benefits					106,051	270,132	400,298	505,843
Hospice - Nursing Mileage					24,097	32,799	42,834	42,834
Total Hospice Skilled Nursing					483,650	1,203,372	1,777,457	2,234,821
Hospice - SS Wages					73,005	189,426	280,703	354,715
Hospice - SS Benefits					21,901	56,828	84,211	106,414
Hospice - SS Mileage					5,058	6,885	8,992	8,992
Total Hospice Social Services					99,965	253,139	373,905	470,121
Hospice - Spiritual Care Coordinator Wages					57,581	149,406	221,399	279,775
Hospice - Spiritual Care Coordinator Benefits					17,274	44,822	66,420	83,932
Hospice - Spiritual Care Coordinator Mileage					3,983	5,421	7,080	7,080
Total Hospice Spiritual Care Coordinator					78,839	199,650	294,899	370,787
Hospice Contracted Palliative Care					4,178	10,840	16,063	20,298
Hospice Pharmacy					79,809	207,129	306,936	387,866
Hospice Medical Supplies					29,154	75,665	112,125	141,689
Hospice DME					67,989	176,454	261,480	330,424
Hospice Room and Board					5,065	13,146	19,481	24,618
Hospice Respite and GIP					28,402	73,712	109,231	138,031
Total Hospice Other Direct Costs					210,420	546,107	809,254	1,022,627
TOTAL DIRECT COSTS - HOSPICE					1,008,858	2,546,855	3,764,540	4,738,460
Administration-Wages	768,139	1,005,951	1,151,723	1,151,723	1,388,118	1,454,711	1,531,498	1,531,498
Administration-Benefits	235,738	326,215	269,535	269,535	340,453	360,431	383,467	454,385
Administration-Purchased Services	75,753	174,102	231,496	231,496	286,056	305,761	328,481	328,481
Administration-Insurance	14,367	16,413	16,698	16,698	17,898	17,898	17,898	17,898
Administration-Other	360,629	440,010	487,579	487,579	660,200	648,560	673,017	673,017
Total Administration	1,454,625	1,962,691	2,157,031	2,157,031	2,692,725	2,787,361	2,934,361	3,005,279
TOTAL INDIRECT COSTS	1,454,625	1,962,691	2,157,031	2,157,031	2,692,725	2,787,361	2,934,361	3,005,279
TOTAL COSTS	5,153,594	5,852,620	6,592,995	6,725,291	8,361,208	10,087,033	11,546,775	12,688,570

Bad Debt	88,257	171,116	131,650	131,650	131,650	131,650	131,650	131,650
TOTAL OPERATING EXPENSES	5,241,851	6,023,736	6,724,646	6,856,941	8,492,858	10,218,683	11,678,425	12,820,221
Service Center Allocation	341,293	391,228	408,893	419,610	538,422	706,642	840,230	951,343
EBITDAR	1,242,713	1,409,593	1,044,316	1,115,647	1,737,160	3,207,514	4,285,947	5,255,300
EBITDAR Margin	18.19%	18.01%	0	0	0	0	0	0
Occupancy- Rent	89,318	88,898	87,638	87,638	89,390	91,178	93,002	94,862
Property Taxes	397	984	753	768	784	799	815	832
Total Property Expenses	89,716	89,883	88,391	88,391	90,174	91,977	93,817	95,693
EBITDA	1,152,998	1,319,710	955,925	1,027,256	1,646,986	3,115,536	4,192,130	5,159,607
EBITDA MARGIN	16.87%	16.87%	11.69%	0	15.29%	22.04%	24.95%	27.12%
Depreciation and Amortization	56,005	67,550	12,893	12,893	70,155	75,674	78,650	52,218
Gain or loss on disposal	886			0	0	0	0	0
Earnings Before Interest & Tax	1,096,106	1,252,161	943,033	943,033	1,576,831	3,039,862	4,113,479	5,107,389
Interest				0	0	0	0	0
Earnings Before Income Taxes	1,096,106	1,252,161	943,033	943,033	1,576,831	3,039,862	4,113,479	5,107,389
NET INCOME	1,096,106	1,252,161	943,033	943,033	1,576,831	3,039,862	4,113,479	5,107,389

Symbol Healthcare, Inc (HH+THUR+PIER)

Balance Sheet	2021 **Year 1**	2022 **Year 2**	2023 **Year 3**
Assets			
Current Assets			
Cash	150	150	150
Accounts Receivable	1,919,468	2,293,092	2,484,934
Allowance for Bad Debt	(394,028)	(408,973)	(416,647)
Prepaid Assets	5,351,724	5,458,759	5,567,934
Total Current Assets	6,877,314	7,343,028	7,636,371
Property and Equipment			
Leasehold Improvements	-	-	-
Furniture & Equipment	188,957	201,669	216,552
Accumulated Depreciation/Amortization	(139,899)	(145,419)	(145,419)
Total Property and Equipment	49,059	56,250	71,133
Other Assets			
Security Deposit	7,000	7,000	7,000
Start Up Costs	15,000	7,500	7,500
Other Assets	2,781,150	2,781,150	2,781,150
Total Other Assets	2,803,150	2,795,650	2,795,650
Total Assets	**9,729,523**	**10,194,928**	**10,503,154**
Liabilities			
Current Liabilities			
Accounts Payable/Credit Card Payable	105,253	159,321	184,374
Payroll Liabilities	640,544	718,217	749,866
Total Current Liabilities	745,797	877,538	934,240
Long Term Liabilities			
Other Liabilities Hospice CAP	63,538	63,538	63,538
Total Long Term Liabilities	63,538	63,538	63,538

Total Liabilities	**809,335**	**941,076**	**997,778**
Equity			
Additional Paid in Capital	1,258,505	1,258,505	1,258,505
Retained Earnings	7,217,958	10,257,820	14,371,300
Net Income	3,039,862	4,113,479	5,107,389
Total Equity	11,516,326	15,629,805	20,737,194
Total Liabilities and Equity	**12,325,661**	**16,570,881**	**21,734,972**

Exhibit 8

Pennant Commitment of Funds Letter

PENNANT
GROUP

January 15, 2020

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

Dear Ms. Sigman

As the Corporate Controller for The Pennant Group, Inc., the ultimate parent company of Symbol Healthcare, Inc., I am writing to affirm a commitment to fully finance the establishment of Puget Sound Hospice of Pierce County, in Pierce County, Washington. As the ultimate parent of Symbol Healthcare, Inc., we have provided a copy of Pennant's 10-Q in conjunction with this filing that demonstrates the necessary capital reserves to meet the funding requirements.

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

Sincerely,

Nate Schrandt
Corporate Controller
Pennant Group
1675 E. Riverside Dr., Ste 200
Eagle, ID 83616

Exhibit 9

Pennant Group, Inc.,

Securities and Exchange Commission

Form 10-Q Filing

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-Q

☒ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934.**

For the quarterly period ended September 30, 2019.

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934.**

For the transition period from _____ to _____.

Commission file number: 001-38900

THE PENNANT GROUP, INC.

(Exact Name of Registrant as Specified in Its Charter)

Delaware	**83-3349931**
(State or Other Jurisdiction of Incorporation or Organization)	(I.R.S. Employer Identification No.)

1675 E Riverside Drive, Suite 150
Eagle, ID 83616
(Address of Principal Executive Offices and Zip Code)
(208) 506-6100
(Registrant's Telephone Number, Including Area Code)

Title of each class	**Trading Symbol(s)**	**Name of each exchange on which registered**
Common Stock, par value $0.001 per share	PNTG	Nasdaq Global Select Market

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. ☒ Yes ☐ No

Indicate by check mark whether the registrant has submitted electronically, every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). ☒ Yes ☐ No

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act:

Large accelerated filer ☐	Accelerated filer ☐	Non-accelerated filer ☒	Smaller reporting company ☐	Emerging growth company ☒

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☒

Indicate by a check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). ☐ Yes ☒ No

As of November 12, 2019, 27,846,772 shares of the registrant's common stock were outstanding.

EXPLANATORY NOTE

The separation of The Pennant Group, Inc. from The Ensign Group, Inc. became effective at 12:01 a.m. Eastern Standard time on October 1, 2019. As a result of this separation, the home health and hospice agencies and substantially all of the senior living businesses separated from The Ensign Group, Inc. that were referred to as "New Ventures" in the registration statement of Form 10 are referred to as the The Pennant Group, Inc. within this report.

THE PENNANT GROUP, INC.
QUARTERLY REPORT ON FORM 10-Q
FOR THE THREE AND NINE MONTHS ENDED SEPTEMBER 30, 2019
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PART I. FINANCIAL INFORMATION

The financial statements and related footnotes as of September 30, 2019 should be read in conjunction with the New Ventures financial statements for the year ended December 31, 2018 contained in Exhibit 99.1 to Amendment No. 3 to the Company's Registration Statement on Form 10 as filed with the U.S. Securities and Exchange Commission on September 3, 2019, which became effective on September 9, 2019 (the "Information Statement" or "Form 10").

Item 1. ***Financial Statements***

THE PENNANT GROUP, INC.
CONDENSED COMBINED BALANCE SHEETS
(In thousands)
(Unaudited)

	September 30, 2019	December 31, 2018
Assets		
Current assets:		
Cash	$ 47	$ 41
Accounts receivable—less allowance for doubtful accounts of $1,045 and $616, respectively	30,249	24,469
Prepaid expenses and other current assets	3,605	4,613
Total current assets	33,901	29,123
Property and equipment, net	13,719	10,458
Right-of-use assets (Note 13)	239,101	—
Restricted and other assets	1,559	2,464
Intangible assets, net	53	78
Goodwill	41,233	30,892
Other indefinite-lived intangibles	33,462	25,136
Total assets	$ 363,028	$ 98,151
Liabilities and equity		
Current liabilities:		
Accounts payable	$ 4,744	$ 4,390
Accrued wages and related liabilities	14,579	12,786
Lease liabilities—current (Note 13)	13,611	—
Other accrued liabilities	17,659	12,371
Total current liabilities	50,593	29,547
Long-term lease liabilities—less current portion (Note 13)	227,388	—
Other long-term liabilities	691	3,316
Total liabilities	278,672	32,863
Commitments and contingencies		
Equity:		
Net parent investment	71,104	55,856
Noncontrolling interest	13,252	9,432
Total equity	84,356	65,288
Total liabilities and equity	$ 363,028	$ 98,151

See accompanying notes to condensed combined financial statements.

THE PENNANT GROUP, INC.
CONDENSED COMBINED STATEMENTS OF INCOME
(In thousands, except for per-share amounts)
(Unaudited)

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2019	2018	2019	2018
Revenue	$ 88,398	$ 72,953	$ 249,039	$ 210,721
Expense				
Cost of services	68,286	54,167	190,053	156,108
Rent—cost of services (Note 13)	8,538	7,776	25,368	23,065
General and administrative expense	8,577	4,465	23,710	13,456
Depreciation and amortization	1,071	742	2,843	2,177
Total expenses	86,472	67,150	241,974	194,806
Income from operations	1,926	5,803	7,065	15,915
Provision for income taxes	123	1,388	91	3,588
Net income	1,803	4,415	6,974	12,327
Less: net income attributable to noncontrolling interest	279	43	629	413
Net income attributable to The Pennant Group, Inc.	$ 1,524	$ 4,372	$ 6,345	$ 11,914
Earnings per share (Note 5):				
Basic and diluted	$ 0.06	$ 0.16	$ 0.25	$ 0.44
Weighted average common shares outstanding:				
Basic and diluted	27,834	27,834	27,834	27,834

See accompanying notes to condensed combined financial statements.

THE PENNANT GROUP, INC.
CONDENSED COMBINED STATEMENTS OF CHANGES IN EQUITY
(Unaudited)

	Net Parent Investment	Non-Controlling Interest	Total
		(In thousands)	
Total Equity as of December 31, 2018	$ 55,856	$ 9,432	$ 65,288
Noncontrolling interest attributable to subsidiary equity plan	(317)	658	341
Net income attributable to noncontrolling interest		150	150
Net transfer from parent	4,411		4,411
Net income attributable to The Pennant Group, Inc.	1,334		1,334
Total Equity as of March 31, 2019	61,284	10,240	71,524
Noncontrolling interest attributable to subsidiary equity plan	(2,497)	2,733	236
Net income attributable to noncontrolling interest		200	200
Net transfer from parent	11,041		11,041
Net income attributable to The Pennant Group, Inc.	3,487		3,487
Total Equity as of June 30, 2019	73,315	13,173	86,488
Noncontrolling interest attributable to subsidiary equity plan	(177)	194	17
Stock repurchase related to subsidiary equity plan		(394)	(394)
Net income attributable to noncontrolling interest		279	279
Net transfer from parent	(3,558)		(3,558)
Net income attributable to The Pennant Group, Inc.	1,524		1,524
Total Equity as of September 30, 2019	$ 71,104	$ 13,252	$ 84,356

	Net Parent Investment	Non-Controlling Interest	Total
		(In thousands)	
Total Equity as of December 31, 2017	$ 54,996	$ 4,920	$ 59,916
Noncontrolling interest attributable to subsidiary equity plan	(79)	417	338
Net income attributable to noncontrolling interest		89	89
Net transfer to parent	(941)		(941)
Net income attributable to The Pennant Group, Inc.	3,381		3,381
Total Equity as of March 31, 2018	$ 57,357	$ 5,426	$ 62,783
Noncontrolling interest attributable to subsidiary equity plan	(1,884)	2,228	344
Net income attributable to noncontrolling interest		281	281
Net transfer to parent	(5,065)		(5,065)
Net income attributable to The Pennant Group, Inc.	4,161		4,161
Total Equity as of June 30, 2018	$ 54,569	$ 7,935	$ 62,504
Noncontrolling interest attributable to subsidiary equity plan	(193)	541	348
Net income attributable to noncontrolling interest		43	43
Net transfer to parent	(3,576)		(3,576)
Net income attributable to The Pennant Group, Inc.	4,372		4,372
Total Equity as of September 30, 2018	$ 55,172	$ 8,519	$ 63,691

See accompanying notes to condensed combined financial statements.

THE PENNANT GROUP, INC.
CONDENSED COMBINED STATEMENTS OF CASH FLOWS
(Unaudited)

	Nine Months Ended September 30,	
	2019	**2018**
	(In thousands)	
Cash flows from operating activities:		
Net income	$ 6,974	$ 12,327
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	2,843	2,177
Provision for doubtful accounts	630	167
Share-based compensation	1,395	1,790
Non-cash leasing arrangement (Note 13)	175	—
Change in operating assets and liabilities		
Accounts receivable	(6,410)	(2,440)
Prepaid expenses and other assets	(254)	377
Operating lease obligations	(141)	—
Accounts payable	(97)	678
Accrued wages and related liabilities	1,793	(2)
Other accrued liabilities	5,288	201
Other long-term liabilities	—	927
Net cash provided by operating activities	12,196	16,202
Cash flows from investing activities:		
Purchase of property and equipment	(4,635)	(3,005)
Cash payments for business acquisitions, net of cash received	(18,760)	(1,625)
Cash payments for asset acquisitions	(20)	(398)
Escrow deposits	—	(13)
Restricted and other assets	909	(504)
Net cash used in investing activities	(22,506)	(5,545)
Cash flows from financing activities:		
Proceeds from sale of subsidiary shares	2,293	1,972
Repurchase of subsidiary shares	(2,687)	(1,972)
Net investment from/(to) parent	10,710	(10,652)
Net cash provided by/(used in) financing activities	10,316	(10,652)
Net increase in cash	6	5
Cash beginning of period	41	36
Cash end of period	$ 47	$ 41
Supplemental disclosures of cash flow information:		
Cash paid during the period for:		
Lease liabilities	$ 25,369	$ —
Non-cash financing and investing activity:		
Capital expenditures	$ 701	$ 801
Right-of-use assets obtained in exchange for new operating lease obligations	$ 8,665	$ —

See accompanying notes to condensed combined financial statements.

THE PENNANT GROUP, INC.
NOTES TO CONDENSED COMBINED FINANCIAL STATEMENTS
(Dollars and shares in thousands, except per share data)
(Unaudited)

1. DESCRIPTION OF BUSINESS

The Pennant Group, Inc. ("Pennant," the "Company," "it," or "its"), is comprised of the home health and hospice agencies and substantially all of the senior living businesses of The Ensign Group, Inc. (NASDAQ: ENSG) ("Ensign" or the "Parent"). As of September 30, 2019, the Company's subsidiaries operated 63 home health, hospice and home care agencies and 52 senior living communities located in Arizona, California, Colorado, Idaho, Iowa, Nevada, Oklahoma, Oregon, Texas, Utah, Washington, Wisconsin, and Wyoming.

On October 1, 2019, Ensign completed the separation of Pennant (the "Spin-Off"). To accomplish the Spin-Off, Ensign contributed the Company's assets and liabilities into Pennant and distributed to Ensign's stockholders all of the outstanding shares of Pennant common stock. Each Ensign stockholder received a distribution of one share of Pennant common stock for every two shares of Ensign's common stock plus cash in lieu of fractional shares. Additionally, the noncontrolling interest was converted into shares of Pennant at the established conversion ratio. As a result of the Spin-Off on October 1, 2019, Pennant began trading as an independent company on the NASDAQ under the symbol "PNTG."

Certain of the Company's subsidiaries, collectively referred to as the Service Center, provide accounting, payroll, human resources, information technology, legal, risk management, and other services to the operations through contractual relationships.

Each of the Company's affiliated operations are operated by separate, independent subsidiaries that have their own management, employees and assets. Each of Ensign's affiliated operations are operated by separate, independent subsidiaries that have their own management, employees, and assets. References herein to the consolidated "Company," "Parent" and "its" assets and activities is not meant to imply, nor should it be construed as meaning, that The Pennant Group, Inc. or The Ensign Group, Inc. has direct operating assets, employees or revenue, or that any of the subsidiaries, are operated by The Pennant Group, Inc. or The Ensign Group, Inc.

2. BASIS OF PRESENTATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation - The accompanying unaudited condensed combined financial statements of the Company (the "Interim Financial Statements") have been prepared on a stand-alone basis and are derived from the consolidated financial statements and accounting records of Ensign. The Interim Financial Statements reflect the Company's financial position, results of operations and cash flows as the business was operated as part of Ensign prior to the Spin-Off, and have been prepared in accordance with accounting principles generally accepted in the United States ("GAAP") and pursuant to the regulations of the SEC. Management believes that the Interim Financial Statements reflect, in all material respects, all adjustments which are of a normal and recurring nature necessary to present fairly the Company's financial position, results of operations, and cash flows for the periods presented in conformity with U.S. GAAP applicable to interim periods. The results of operations for the three and nine months ended September 30, 2019 and the cash flows for the nine months ended September 30, 2019 are not necessarily indicative of the results that may be expected for the fiscal year ending December 31, 2019.

The Condensed Combined Balance Sheet as of December 31, 2018 is derived from the Company's annual audited combined Financial Statements for the fiscal year ended December 31, 2018 which should be read in conjunction with these Condensed Combined Financial Statements and which are included in the Company's Registration Statement on Form 10, as amended and filed with the SEC on September 3, 2019. Certain information in the accompanying footnote disclosures normally included in annual financial statements was condensed or omitted for the interim periods presented in accordance with GAAP.

All intercompany transactions and balances between the various legal entities comprising the Company have been eliminated in the Interim Financial Statements. The condensed combined statements of income reflect income that is attributable to the Company and the noncontrolling interest.

The Company consists of various limited liability companies and corporations established to operate home health, hospice, home care, and senior living operations. The condensed combined balance sheets of the Company include assets and liabilities of Ensign that are specifically identifiable or otherwise attributable to the Company. Revenue was derived from transactional information specific to the Company's services provided. The costs in the condensed combined statements of income reflect direct and allocated costs.

The financial information included herein may not reflect the condensed combined financial position, results of operations, changes in equity, and cash flows of the Company in the future, and does not reflect what they would have been had the Company been operated as a separate, stand-alone entity during the periods presented.

Cost Allocation - The Interim Financial Statements include allocations of costs for certain shared services provided to the Company by Ensign subsidiaries. Such allocations include, but are not limited to, executive management, accounting, human resources, information technology, compliance, legal, payroll, insurance, tax, treasury, and other general and administrative items. These costs were allocated to the Company on a basis of revenue, location, employee count, or other measures. These cost allocations are reflected within general and administrative expense in the condensed combined statements of income, including for share-based compensation expenses disclosed in Note 12*, Options and Awards*. The amount of general and administrative costs allocated for the three and nine months ended September 30, 2019, inclusive of share-based compensation expense were $8,577 and $23,710, respectively, and for the three and nine months ended September 30, 2018 were $4,465 and $13,456, respectively. Management believes the basis on which the expenses have been allocated to be a reasonable reflection of the services provided to us during the periods presented.

Ensign is partially self-insured for healthcare, general and professional liability, and workers' compensation, and historically allocated premium expense to all subsidiaries of Ensign in its accounting records. To reflect all of the insurance costs, quarterly actuary determined adjustments were allocated to the Company based on the proportional historical premium expense. No self-insurance accruals have been allocated to the Company as these accruals represent the obligations of Ensign.

Ensign's external debt and related interest expense have not been allocated to the Company for any of the periods presented as no portion of the borrowings is being assumed by the Company as part of the Spin-Off.

Employees of the Company's subsidiaries participate in Ensign's equity-based incentive plans (the "Ensign Plans") and the Cornerstone Subsidiary Equity plan (the "Subsidiary Equity Plan"). Share-based compensation includes the expense attributable to employees of the Company's subsidiaries participating in the Ensign Plans, as well as the allocated cost related to Ensign subsidiaries' employees that participate in the Ensign Plans. Share-based compensation related to Ensign subsidiaries' employees that participate in the Ensign Plans were allocated on the basis of revenue. All share-based compensation related to the Subsidiary Equity Plan was recognized in the Interim Financial Statements and, therefore, no cost allocation was necessary.

The share-based compensation costs associated with the Subsidiary Equity Plan awards is initially measured at fair value at the grant date and is expensed as non-cash compensation over the vesting term. Historically, these awards have been granted once per year and the fair value has been determined by an independent valuation of the subsidiary shares. The valuation incorporated a discounted cash flow analysis combined with a market-based approach to determine the fair value of the subsidiary equity.

Cash presented in the condensed combined balance sheets represents cash located at our operations. The Company participates in the Parent's cash management program. Accordingly, no cash for this business was allocated to the Company in the Interim Financial Statements. The net activity of cash due to (from) Ensign is reflected in the net investment from Ensign.

Estimates and Assumptions - The preparation of Interim Financial Statements in conformity with GAAP requires management to make certain estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the Interim Financial Statements and the reported amounts of revenue and expenses during the reporting periods. The most significant estimates in the Company's Interim Financial Statements relate to revenue, cost allocations, intangible assets and goodwill, impairment of long-lived assets, right-of-use assets and lease liabilities for leases greater than 12 months, and income taxes. Actual results could differ from those estimates.

Fair Value of Financial Instruments - The Company's financial instruments consist principally of cash, accounts receivable, accounts payable and accrued liabilities. The Company believes all of the financial instruments' recorded values approximate fair values because of their nature or respective short durations. Fair value measurements are based on a three-tier hierarchy that prioritizes the inputs used to measure fair value. These tiers include: Level 1, defined as observable inputs such as quoted market prices in active markets; Level 2, defined as inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly; and Level 3, defined as unobservable inputs for which little or no market data exists, therefore requiring an entity to develop its own assumptions.

Revenue Recognition - On January 1, 2018, the Company adopted Accounting Standards Codification ("ASC") Topic 606, Revenue from Contracts with Customers ("Topic 606") applying the modified retrospective method. The adoption of Topic 606 did not have a material impact on the measurement nor on the recognition of revenue of contracts, for which all revenue had not been recognized, as of January 1, 2018, therefore no cumulative adjustment has been made to the opening balance of retained earnings at the beginning of 2018. See Note 4*, Revenue and Accounts Receivable*.

Accounts Receivable and Allowance for Doubtful Accounts - Accounts receivable consist primarily of amounts due from Medicare and Medicaid programs, other government programs, managed care health plans and private payor sources, net of estimates for variable consideration. The allowance for doubtful accounts reflects the Company's best estimate of probable losses inherent in the accounts receivable balance.

Property and Equipment - Property and equipment are initially recorded at their historical cost. Repairs and maintenance are expensed as incurred. Depreciation is computed using the straight-line method over the estimated useful lives of the depreciable assets (ranging from three to 15 years). Leasehold improvements are amortized on a straight-line basis over the shorter of their estimated useful lives or the remaining lease term.

Impairment of Long-Lived Assets - The Company reviews the carrying value of long-lived assets that are held and used in the operating subsidiaries for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable. Recoverability of these assets is determined based upon expected undiscounted future net cash flows from the operating subsidiary to which the assets relate, utilizing management's best estimate, appropriate assumptions, and projections at the time. If the carrying value is determined to be unrecoverable from future operating cash flows, the asset is deemed impaired and an impairment loss would be recognized to the extent the carrying value exceeded the estimated fair value of the asset. The Company estimates the fair value of assets based on the estimated future discounted cash flows of the asset. Management has evaluated its long-lived assets and the Company did not identify any asset impairment during the three and nine months ended September 30, 2019 and 2018.

Intangible Assets and Goodwill - Definite-lived intangible assets consist primarily of patient base and customer relationships. Patient base is amortized over a period of four to eight months, depending on the classification of the patients and the level of occupancy in a new acquisition when acquired. Customer relationships are amortized between one to seven years depending on the significance of the relationships.

The Company's indefinite-lived intangible assets consist of trade names and Medicare and Medicaid licenses. The Company tests indefinite-lived intangible assets for impairment on an annual basis or more frequently if events or changes in circumstances indicate that the carrying amount of the intangible asset may not be recoverable. The Company did not identify any asset impairment during the three and nine months ended September 30, 2019 and 2018.

Goodwill represents the excess of the purchase price over the fair value of identifiable net assets acquired in business combinations. Given the time it takes to obtain pertinent information, the initial fair value might not be finalized at the time of the reported period. Accordingly, it is not uncommon for the initial estimates to be subsequently revised. The Company recorded goodwill and other intangible assets at the operation level when acquired, and as such, these assets are identifiable specifically to the subsidiaries of Pennant. Goodwill is subject to annual testing for impairment. In addition, goodwill is tested for impairment if events occur or circumstances change that would reduce the fair value of a reporting unit below its carrying amount. The Company performs its annual test for impairment during the fourth quarter of each year. The Company did not identify any impairment charge during the three and nine months ended September 30, 2019 and 2018. See further discussion at Note 9, *Goodwill and Intangible Assets, Net*.

Income Taxes - The Company's operations have been included in Ensign's U.S. federal and state income tax returns and all income taxes have been paid by subsidiaries of Ensign. Income tax expense and other income tax related information contained in these Interim Financial Statements are presented using a separate tax return approach. Under this approach, the provision for income taxes represents income tax paid or payable for the current year plus the change in deferred taxes during the year calculated as if the Company was a stand-alone taxpayer filing hypothetical income tax returns. Management believes that the assumptions and estimates used to determine these tax amounts are reasonable. However, the Company's Interim Financial Statements may not necessarily reflect its income tax expense or tax payments in the future, or what tax amounts would have been if the Company had been a stand-alone company during the periods presented.

Deferred tax assets and liabilities are established for temporary differences between the financial reporting basis and the tax basis of the Company's assets and liabilities at tax rates in effect when such temporary differences are expected to reverse. The Company generally expects to fully utilize its deferred tax assets; however, when necessary, the Company records a valuation allowance to reduce its net deferred tax assets to the amount that is more likely than not to be realized.

In determining the need for a valuation allowance or the need for and magnitude of liabilities for uncertain tax positions, the Company makes certain estimates and assumptions. These estimates and assumptions are based on, among other things, knowledge of operations, markets, historical trends and likely future changes and, when appropriate, the opinions of advisors with knowledge and expertise in certain fields. Due to certain risks associated with the Company's estimates and assumptions, actual results could differ.

Noncontrolling Interest - As grants related to the Subsidiary Equity Plan are vested and exercised, the Company's membership interest in its home health and hospice subsidiary is reduced based on the number of shares vested and exercised. The Company presents the noncontrolling interest and the amount of combined net income attributable to the Company in its Interim Financial Statements. The carrying amount of the noncontrolling interest is adjusted based on an allocation of subsidiary earnings based on ownership interest.

Share-Based Compensation -The Company measures and recognizes compensation expense for all share-based payment awards, including employee stock options, made to employees and Ensign's directors based on estimated fair values, ratably over the requisite service period of the award. Net income has been reduced as a result of the recognition of the fair value of all stock options and restricted stock awards issued, the amount of which is contingent upon the number of future grants and other variables. The total amount of share-based compensation was $268 and $1,395 for the three and nine months ended September 30, 2019, respectively, of which $155 and $1,058, respectively, was recorded in general and administrative expense. The total amount of share-based compensation was $613 and $1,790 for the three and nine months ended September 30, 2018, of which $492 and $1,424, respectively, was recorded in general and administrative expense.

Invested Capital - The net parent investment on the condensed combined balance sheets represents Ensign's historical investment in the Company, the net effect of transactions with, and allocations from, Ensign and the Company's accumulated earnings.

Earnings Per Share - For all periods presented, the earnings per share included on the accompanying Condensed Combined Statements of Income was calculated based on the 27,834 shares of Pennant common stock distributed on October 1, 2019 in conjunction with the Spin-Off, including shares related to the conversion of the noncontrolling interest. Prior to October 1, 2019, Pennant did not have any issued and outstanding common stock. The same number of shares was used to calculate basic and diluted earnings per share since no Pennant employee equity awards were outstanding prior to the Spin-Off. In connection with the Spin-Off, shares of existing equity awards were replaced with shares under the new Pennant awards. For further discussion see Note 5, *Computation of Net Income Per Common Share.*

Recent Accounting Pronouncements - Except for rules and interpretive releases of the SEC under authority of federal securities laws and a limited number of grandfathered standards, the Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) is the sole source of authoritative GAAP literature recognized by the FASB and applicable to the Company. For any new pronouncements, the Company considers whether the new pronouncements could alter previous generally accepted accounting principles and determines whether any new or modified principles will have a material impact on the Company's reported financial position or operations in the near term. The applicability of any standard is subject to the formal review of the Company's financial management and certain standards are under consideration.

Recent Accounting Standards Adopted by the Company

Leases and Leasehold Improvements - The Company leases senior living communities and commercial office space. In February 2016, the FASB established Topic 842, which requires lessees to recognize leases with terms longer than 12 months on the balance sheets and disclose key information about leasing arrangements. Leases will be classified as either finance or operating, with classification affecting the pattern of expense recognition in the income statement. The classification criteria for distinguishing between operating and finance (previously capital) leases are substantially similar to the previous lease guidance, but with no explicit bright lines.

On January 1, 2019, the Company adopted ASC Topic 842, *Leases* ("Topic 842"), using the modified retrospective transition method. Leases for reporting periods beginning after January 1, 2019 are presented under Topic 842, while prior period amounts are not adjusted and continue to be reported in accordance with our historic accounting under ASC Topic 840, *Leases* ("Topic 840"). The Company has elected the package of practical expedients permitted under the transition guidance which allows us to not reassess (1) initial direct costs, (2) lease classification for existing or expired leases, and (3) lease definition for existing or expired contracts as of the effective date of January 1, 2019. The new standard also provides practical expedients for an entity's ongoing accounting. The Company has made an accounting policy election to keep leases with an initial term of 12 months or less off of the balance sheets and recognize those lease payments in the condensed combined statements of income on a straight-line basis over the lease term. The lease agreements do not contain any material residual value guarantees or material restrictive covenants. The Company does not have material subleases.

At the inception of each lease, the Company performs an evaluation to determine whether the lease should be classified as an operating or finance lease. Operating leases are included in operating lease assets, current operating lease liabilities and noncurrent operating lease liabilities on the Company's condensed combined balance sheet. As the Company's leases do not provide an implicit rate, the Company uses its incremental borrowing rate based on the information available at lease commencement date in determining the present value of future lease payments. The Company records rent expense for operating leases on a straight-line basis over the term of the lease. The lease term used for straight-line rent expense is calculated from the date the Company is given control of the leased premises through the end of the lease term. The lease term excludes lease renewals because the renewal rents are not at a bargain, there are no economic penalties for the Company not to renew the lease, and it is not reasonably assured that the Company will exercise the extension options. The lease term used for this evaluation also provides the basis for establishing depreciable lives for buildings subject to lease and leasehold improvements.

The adoption of this standard resulted in recognition of right-of-use assets and lease liabilities of $238,573 and $241,453, respectively, on the Company's combined balance sheet as of January 1, 2019. Neither net deferred tax assets nor equity were impacted as a result of the adoption of this standard. The standard did not materially affect its combined net earnings or have a notable impact on liquidity or debt covenant compliance under Ensign's current agreements. See further discussion at Note 13, *Leases*.

Prior to the adoption of Topic 842, the Company recognized revenue related to its senior living residency agreements in accordance with the provisions of Topic 840. Subsequent to the adoption of Topic 842, lessors are required to separately recognize and measure the lease component of a contract with a customer utilizing the provisions of Topic 842 and the non-lease components utilizing the provisions of Topic 606, Revenue from Contracts with Customers. To separately account for the components, the transaction price is allocated among the components based upon the estimated stand alone selling prices of the components. Additionally, certain components of a contract which were previously included within the lease element recognized in accordance with Topic 842 prior to the adoption of Topic 842 (such as common area maintenance services, other basic services, and executory costs) are recognized as non-lease components subject to the provisions of Topic 606 subsequent to the adoption of Topic 842. Entities are required to recognize a cumulative effect adjustment to beginning retained earnings as of the initial application date of Topic 842 for changes to amounts recognized for these certain components for the transition from Topic 840 to Topic 606. However, entities are permitted to elect the practical expedient under ASU 2018-11, *Leases* ("ASU 2018-11"), allowing lessors to not separate non-lease components from the associated lease components when certain criteria are met. Entities that elect to utilize the lease/non-lease component combination practical expedient under ASU 2018-11 upon initial application of Topic 842 are required to apply the practical expedient to all new and existing transactions within a class of underlying assets that qualify for the expedient as of the initial application date with a cumulative effect adjustment to beginning retained earnings as of the initial application date for any changes recognized related to existing transactions.

Upon adoption of Topic 842, the Company elected the lessor practical expedient within ASU 2018-11. The Company recognizes revenue under resident agreements based upon the predominant component, either the lease or non-lease component, of the contracts rather than allocating the consideration and separately accounting for it under Topic 842 and Topic 606. The Company has concluded that the non-lease components of the agreements governing its senior living communities are the predominant component of the contract; therefore, the Company recognizes revenue for these agreements under Topic 606. The timing and pattern of revenue recognition is substantially the same as that in effect prior to the adoption of Topics 606 and 842.

Stock Compensation - In June 2018, the FASB issued ASU 2018-07, *Compensation-Stock Compensation* ("ASU 2018-07"), which simplifies several aspects of the accounting for nonemployee share-based payment transactions resulting from expanding the scope of ASC Topic 718, *Compensation-Stock Compensation* ("Topic 718"), to include share-based payment transactions for acquiring goods and services from nonemployees. ASU 2018-07 specifies that Topic 718 applies to all share-based payment transactions in which a grantor acquires goods or services to be used or consumed in a grantor's own operations by issuing share-based payment awards. ASU 2018-07 also clarifies that Topic 718 does not apply to share-based payments used to effectively provide (1) financing to the issuer or (2) awards granted in conjunction with selling goods or services to customers as part of a contract accounted for under Topic 606. The Company adopted ASU 2018-07 effective January 1, 2019. The adoption of ASU 2018-07 did not have a material impact on Interim Financial Statements and related disclosures.

Accounting Standards Recently Issued but Not Yet Adopted by the Company

Financial Accounting Standards Board, or FASB, Accounting Standards Update, or ASU, 2018-13 "Fair Value Measurement (Topic 820): Disclosure Framework – Changes to the Disclosure Requirements for Fair Value Measurement" or ASU 2018-13 - In August 2018, the FASB issued amended guidance to simplify fair value measurement disclosure requirements. The new provisions eliminate the requirements to disclose (1) transfers between Level 1 and Level 2 of the fair value hierarchy, (2) policies related to valuation processes and the timing of transfers between levels of the fair value hierarchy, and (3) net asset value disclosure of estimates of timing of future liquidity events. The FASB also modified disclosure requirements of Level 3 fair

value measurements. This guidance is effective for annual periods beginning after December 15, 2019, which will be the Company's fiscal year 2020, with early adoption permitted. The adoption of this standard is not expected to have a material impact on our condensed combined financial statements.

FASB ASU, 2017-04 "Intangibles - Goodwill and Other (Topic 350): Simplifying the Test for Goodwill Impairment" or ASU 2017-04 - In January 2017, the FASB issued amended authoritative guidance to simplify and reduce the cost and complexity of the goodwill impairment test. The new guidance eliminates "Step 2" from the traditional two-step goodwill impairment test and redefines the concept of impairment from a measure of loss when comparing the implied fair value of goodwill to its carrying amount, to a measure comparing the fair value of a reporting unit with its carrying amount. The FASB also eliminated the requirements for any reporting unit with a zero or negative carrying amount to perform a qualitative assessment or "Step 2" of the goodwill impairment test. The new guidance does not amend the optional qualitative assessment of goodwill impairment. This guidance is effective for annual periods beginning after December 15, 2019, which will be the Company's fiscal year 2020, with early adoption permitted. The adoption of this standard is not expected to have a material impact on our condensed combined financial statements.

FASB ASU 2016-13 "Financial Instruments - Credit Losses (Topic 326): Measurement of Credit Losses on Financial Instruments" or ASU 2016-13 - In June 2016, the FASB issued ASU 2016-13, *Financial Instruments—Credit Losses (Topic 326): Measurement of Credit Losses on Financial Instruments (*"Topic 326"), which replaces the existing incurred loss impairment model with an expected credit loss model and requires a financial asset measured at amortized cost to be presented at the net amount expected to be collected. Topic 326 will be effective for fiscal years beginning after December 15, 2019, which will be the Company's fiscal year 2020, and early adoption is permitted. The Company has not yet determined the effect the Topic 326 will have on its results of operations, financial condition or cash flows.

3. RELATED PARTY TRANSACTIONS AND NET PARENT INVESTMENT

The Interim Financial Statements include a combination of stand-alone and combined business functions between Ensign and the Company's subsidiaries. The Company leases 29 of its senior living communities from subsidiaries of Ensign, each of the leases have a term of 15 years from the lease commencement date. The total amount of rent expense included in rent - cost of services paid to related parties was $2,942 and $8,409 and for the three and nine months ended September 30, 2019, respectively, and $2,568 and $7,670 for the three and nine months ended September 30, 2018, respectively. For further discussion on the modification of these leases subsequent the the Spin-Off on October 1, 2019, see Note 13, *Leases*.

Certain related party activity occurs as the Company's subsidiaries receive services from Ensign's subsidiaries. Services included in cost of services were $998 and $2,493 for the three and nine months ended September 30, 2019, respectively, and $857 and $2,191 for the three and nine months ended September 30, 2018.

The condensed combined balance sheets of the Company include Ensign assets and liabilities that are specifically identifiable or otherwise attributable to the Company and were transferred to the Company in connection with the Spin-Off. Transactions that have occurred between subsidiaries of the Company and subsidiaries of Ensign are considered to be effectively settled at the time the transaction is recorded. The net effect of these transactions, including the cash management, is included in the condensed combined statements of cash flows as "Net investment from/(to) Parent".

For further discussion on the agreements governing the relationship between Pennant and Ensign in connection with the Spin-Off, please refer to Note 15, *Subsequent Events*.

4. REVENUE AND ACCOUNTS RECEIVABLE

Revenues are recognized when services are provided to the patients at the amount that reflects the consideration to which the Company expects to be entitled from patients and third-party payors, including Medicaid, Medicare and insurers (private and Medicare replacement plans), in exchange for providing patient care. The healthcare services in home health and hospice patient contracts include routine services in exchange for a contractual agreed-upon amount or rate. Routine services are treated as a single performance obligation satisfied over time as services are rendered. As such, patient care services represent a bundle of services that are not capable of being distinct within the context of the contract. Additionally, there may be ancillary services which are not included in the rates for routine services, but instead are treated as separate performance obligations satisfied at a point in time, if and when those services are rendered.

Revenue recognized from healthcare services are adjusted for estimates of variable consideration to arrive at the transaction price. The Company determines the transaction price based on contractually agreed-upon amounts or rate, adjusted for estimates

of variable consideration. The Company uses the expected value method in determining the variable component that should be used to arrive at the transaction price, using contractual agreements and historical reimbursement experience within each payor type. The amount of variable consideration which is included in the transaction price may be constrained, and is included in the net revenue only to the extent that it is probable that a significant reversal in the amount of the cumulative revenue recognized will not occur in a future period. If actual amounts of consideration ultimately received differ from the Company's estimates, the Company adjusts these estimates, which would affect net service revenue in the period such variances become known.

Revenue from the Medicare and Medicaid programs accounted for 56.8% and 55.1% of the Company's revenue for the three and nine months ended September 30, 2019, respectively, and 54.0% and 53.2% of the Company's revenue for the three and nine months ended September 30, 2018, respectively. The Company records revenue from these governmental and managed care programs as services are performed at their expected net realizable amounts under these programs. The Company's revenue from governmental and managed care programs is subject to audit and retroactive adjustment by governmental and third-party agencies. Consistent with healthcare industry accounting practices, any changes to these governmental revenue estimates are recorded in the period the change or adjustment becomes known based on final settlement.

Disaggregation of Revenue

The Company disaggregates revenue from contracts with its patients by reportable operating segments and payors. The Company has determined that disaggregating revenue into these categories achieves the disclosure objectives to depict how the nature, amount, timing and uncertainty of revenue and cash flows are affected by economic factors. A reconciliation of disaggregated revenue to segment revenue as well as revenue by payor is provided in Note 6, *Business Segments*.

The Company's service specific revenue recognition policies are as follows:

Home Health Revenue

Medicare Revenue

Net service revenue is recorded under the Medicare prospective payment system based on a 60-day episode payment rate that is subject to adjustment based on certain variables including, but not limited to: (a) an outlier payment if the patient's care was unusually costly; (b) a low utilization adjustment if the number of visits was fewer than five; (c) a partial payment if the patient transferred to another provider or transferred from another provider before completing the episode; (d) a payment adjustment based upon the level of covered therapy services; (e) the number of episodes of care provided to a patient, regardless of whether the same home health provider provided care for the entire series of episodes; (f) changes in the base episode payments established by the Medicare program; (g) adjustments to the base episode payments for case mix and geographic wages; and (h) recoveries of overpayments.

The Company makes adjustments to Medicare revenue on completed episodes to reflect differences between estimated and actual payment amounts, an inability to obtain appropriate billing documentation and other reasons unrelated to credit risk. Therefore, the Company believes that its reported net service revenue and patient accounts receivable will be the net amounts to be realized from Medicare for services rendered.

In addition to revenue recognized on completed episodes, the Company also recognizes a portion of revenue associated with episodes in progress. Episodes in progress are 60-day episodes of care that begin during the reporting period, but were not completed as of the end of the period. As such, the Company estimates revenue and recognizes it on a daily basis. The primary factors underlying this estimate are the number of episodes in progress at the end of the reporting period, expected Medicare revenue per episode and the Company's estimate of the average percentage complete based on visits performed.

Non-Medicare Revenue

Episodic Based Revenue - The Company recognizes revenue in a similar manner as it recognizes Medicare revenue for episodic-based rates that are paid by other insurance carriers, including Medicare Advantage programs; however, these rates can vary based upon the negotiated terms.

Non-episodic Based Revenue - Revenue is recognized on an accrual basis based upon the date of service at amounts equal to its established or estimated per visit rates, as applicable.

Hospice Revenue

Revenue is recognized on an accrual basis based upon the date of service at amounts equal to the estimated payment rates. The estimated payment rates are daily rates for each of the levels of care the Company delivers. Revenue is adjusted for an inability to obtain appropriate billing documentation or authorizations acceptable to the payor and other reasons unrelated to credit risk. Additionally, as Medicare hospice revenue is subject to an inpatient cap and an overall payment cap, the Company monitors its provider numbers and estimates amounts due back to Medicare if a cap has been exceeded. The Company records these adjustments as a reduction to revenue and an increase to other accrued liabilities.

Senior Living Revenue

The Company has elected the lessor practical expedient within Topic 842 and recognizes, measures, presents, and discloses the revenue for services rendered under the Company's senior living residency agreements based upon the predominant component, either the lease or non-lease component, of the contracts. The Company has determined that the services included under the Company's senior living residency agreements each have the same timing and pattern of transfer. The Company recognizes revenue under Topic 606 for its senior residency agreements, for which it has determined that the non-lease components of such residency agreements are the predominant component of each such contract.

The Company's senior living revenue consists of fees for basic housing and assisted living care. Accordingly, we record revenue when services are rendered on the date services are provided at amounts billable to individual residents. Residency agreements are generally for a term of 30 days, with resident fees billed monthly in advance. For residents under reimbursement arrangements with Medicaid, revenue is recorded based on contractually agreed-upon amounts or rates on a per resident, daily basis or as services are rendered.

Revenue for the three months ended September 30, 2019 and 2018, is summarized in the following tables:

	Three Months Ended September 30,			
	2019		2018	
	Revenue	% of Revenue	Revenue	% of Revenue
Medicare	$ 37,413	42.3%	$ 30,048	41.2%
Medicaid	12,780	14.5	9,371	12.8
Total Medicaid and Medicare	50,193	56.8	39,419	54.0
Managed care	7,553	8.5	6,299	8.6
Private and other[(a)]	30,652	34.7	27,235	37.4
Revenue	$ 88,398	100.0%	$ 72,953	100.0%

(a) Private and other payors also includes revenue from all payors generated in home care operations for the three months ended September 30, 2019 and 2018.

Revenue for the nine months ended September 30, 2019 and 2018, is summarized in the following tables:

	Nine Months Ended September 30,			
	2019		2018	
	Revenue	% of Revenue	Revenue	% of Revenue
Medicare	$ 102,812	41.3%	$ 85,985	40.8%
Medicaid	34,317	13.8	26,062	12.4
Total Medicaid and Medicare	137,129	55.1	112,047	53.2
Managed care	21,428	8.6	18,197	8.6
Private and other[(a)]	90,482	36.3	80,477	38.2
Revenue	$ 249,039	100.0%	$ 210,721	100.0%

(a) Private and other payors also includes revenue from all payors generated in home care operations for the nine months ended September 30, 2019 and 2018.

Balance Sheet Impact

Included in the Company's condensed combined balance sheets are contract assets, comprised of billed accounts receivable and unbilled receivables, which are the result of the timing of revenue recognition, billings and cash collections, as well as, contract liabilities, which primarily represent payments the Company receives in advance of services provided. The Company had no

material contract liabilities as of September 30, 2019 and December 31, 2018, or activity during three and nine months ended September 30, 2019 and 2018.

Accounts receivable as of September 30, 2019 and December 31, 2018 is summarized in the following table:

	September 30, 2019	December 31, 2018
Medicare	$ 16,526	$ 11,457
Medicaid	7,172	6,692
Managed care	3,551	3,079
Private and other	4,045	3,857
Accounts receivable, gross	31,294	25,085
Less: allowance for doubtful accounts	(1,045)	(616)
Accounts receivable, net	$ 30,249	$ 24,469

Practical Expedients and Exemptions

As the Company's contracts with its patients have an original duration of one year or less, the Company uses the practical expedient applicable to its contracts and does not consider the time value of money. Further, because of the short duration of these contracts, the Company has not disclosed the transaction price for the remaining performance obligations as of the end of each reporting period or when the Company expects to recognize this revenue. In addition, the Company has applied the practical expedient provided by ASC 340, *Other Assets and Deferred Costs* ("Topic 340"), and all incremental customer contract acquisition costs are expensed as they are incurred because the amortization period would have been one year or less.

5. COMPUTATION OF NET INCOME PER COMMON SHARE

Basic and diluted net income per share are computed by dividing net income by the weighted average number of outstanding common shares during the period. Net income is equal to net income attributable to The Pennant Group, Inc. adjusted to include net income attributable to noncontrolling interest. Net income attributable to the noncontrolling interest has been included in the numerator for the historical periods prior to the spin-off as the non-controlling subsidiary interest included in the condensed combined financial statements was converted into common shares of Pennant concurrent with the distribution to Ensign stockholders at the date of the spin-off.

The weighted average common shares outstanding for basic and diluted net income per share for the periods presented is based on the number of shares of Pennant common stock outstanding on the distribution date. On October 1, 2019, the distribution date, Ensign stockholders received one share of Pennant common stock for every two shares of Ensign's common stock held as of the record date. The total shares distributed to the Ensign Group shareholders was 26,674. Additionally, concurrent with the Spin-Off the noncontrolling subsidiary interest converted into 1,160 shares of Pennant. The total number of common shares distributed on October 1, 2019 of 27,834 is being utilized for the calculation of basic and diluted earnings per share for all periods presented, as no common stock was outstanding prior to the date of the Spin-Off.

In conjunction with the spin-off, outstanding options and unvested restricted stock awards held by employees of the Company under the Ensign stock plans ("2007 Omnibus Incentive Plan" and "2017 Omnibus Incentive Plan" or collectively the "Ensign Plans") and the Company Subsidiary Equity Plan (together with the Ensign Plans the "Plans") were modified and replaced with Pennant awards. Additionally, the Company issued new options and restricted stock awards to Pennant and Ensign employees under the 2019 Omnibus Incentive Plan (the "OIP") and Long-Term Incentive Plan (the "LTIP") which were not included in the computation of basic and diluted earnings per share for any periods presented. Beginning in the fourth quarter, the dilutive impact of the outstanding options and equity incentive awards will be reflected in diluted net income per share using the treasury stock method. See further discussion at Note 15, *Subsequent Events*.

The following table sets forth the computation of basic and diluted net income per share for the periods presented:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2019	2018	2019	2018
Numerator:				
Net income attributable to The Pennant Group, Inc.	$ 1,524	$ 4,372	$ 6,345	$ 11,914
Add: net income attributable to noncontrolling interests	279	43	629	413
Net Income	$ 1,803	$ 4,415	$ 6,974	$ 12,327
Denominator:				
Adjusted weighted average common shares	27,834	27,834	27,834	27,834
Earnings Per Share:				
Basic and diluted net income per common share	$ 0.06	$ 0.16	$ 0.25	$ 0.44

6. BUSINESS SEGMENTS

The Company classifies its operations into the following reportable operating segments: (1) home health and hospice services, which includes the Company's home health, hospice and home care businesses; and (2) senior living services, which includes the operation of assisted living, independent living and memory care communities. The reporting segments are business units that offer different services and are managed separately to provide greater visibility into those operations.

As of September 30, 2019, the Company provided services through 63 affiliated home health, hospice and home care agencies, and 52 affiliated senior living operations.

The Company evaluates performance and allocates capital resources to each segment based on an operating model that is designed to maximize the quality of care provided and profitability. The Company's Service Center provides various services to all lines of business. The accounting policies of the reporting segments are the same as those described in Note 2*, Summary of Significant Accounting Policies.* The Company does not review assets by segment and therefore assets by segment are not disclosed below.

Beginning in the third quarter of 2019, in anticipation of the Spin-Off, the GAAP segment measure of profit and loss was changed from segment income (loss) before provision for income taxes to Adjusted Segment EBITDAR from Operations. Prior period presentation has been revised to reflect the new measurement.

Adjusted EBITDAR from Operations is Net Income attributable to the Company's reportable segments excluding the interest expense; provision for income taxes; depreciation and amortization expense; rent; start-up costs; acquisitions costs; and stock-based compensation expense. General and administrative expenses are not allocated to the reportable segments, accordingly the segment earnings measure reported is before allocation of corporate general and administrative expenses. The Company's CODM uses Adjusted EBITDAR from Operations as the primary measure of profit and loss for the Company's reportable segments and to compare the performance of its operations with those of its competitors. In order to view the operations performance on a comparable basis, the Company excludes from the EBITDAR calculations for the reportable segments the following: 1) costs at start-up operations, 2) share-based compensation, 3) acquisition related costs, and 4) transaction costs. Also, the Company's segment measures may be different from the calculation methods used by other companies and, therefore, comparability may be limited.

For the three and nine months ended September 30, 2019 and 2018, segment revenues by major payor source were as follows:

	Three Months Ended September 30, 2019			
	Home Health and Hospice Services	Senior Living Services	Total Revenue	Revenue %
Medicare	$ 37,413	$ —	$ 37,413	42.3%
Medicaid	5,156	7,624	12,780	14.5
Subtotal	42,569	7,624	50,193	56.8
Managed care	7,553	—	7,553	8.5
Private and other[(a)]	5,049	25,603	30,652	34.7
Total revenue	$ 55,171	$ 33,227	$ 88,398	100.0%

(a) Private and other payors in our home health and hospice services segment includes revenue from all payors generated in home care operations.

	Three Months Ended September 30, 2018			
	Home Health and Hospice Services	Senior Living Services	Total Revenue	Revenue %
Medicare	$ 30,048	$ —	$ 30,048	41.2%
Medicaid	3,193	6,178	9,371	12.8
Subtotal	33,241	6,178	39,419	54.0
Managed care	6,299	—	6,299	8.6
Private and other[(a)]	4,297	22,938	27,235	37.4
Total revenue	$ 43,837	$ 29,116	$ 72,953	100.0%

(a) Private and other payors in our home health and hospice services segment includes revenue from all payors generated in home care operations.

	Nine Months Ended September 30, 2019			
	Home Health and Hospice Services	Senior Living Services	Total Revenue	Revenue %
Medicare	$ 102,812	$ —	$ 102,812	41.3%
Medicaid	12,996	21,321	34,317	13.8
Subtotal	115,808	21,321	137,129	55.1
Managed care	21,428	—	21,428	8.6
Private and other[(a)]	14,260	76,222	90,482	36.3
Total revenue	$ 151,496	$ 97,543	$ 249,039	100.0%

(a) Private and other payors in our home health and hospice services segment includes revenue from all payors generated in home care operations.

	Nine Months Ended September 30, 2018			
	Home Health and Hospice Services	Senior Living Services	Total Revenue	Revenue %
Medicare	$ 85,985	$ —	$ 85,985	40.8%
Medicaid	8,951	17,111	26,062	12.4
Subtotal	94,936	17,111	112,047	53.2
Managed care	18,197	—	18,197	8.6
Private and other[(a)]	11,711	68,766	80,477	38.2
Total revenue	$ 124,844	$ 85,877	$ 210,721	100.0%

(a) Private and other payors in our home health and hospice services segment includes revenue from all payors generated in home care operations.

The following table presents certain financial information regarding our reportable segments, general and administrative expenses are not allocated to the reportable segments and are included in "All Other" for the three and nine months ended September 30, 2019 and 2018:

	Home Health and Hospice Services	Senior Living Services	All Other	Total
Three Months Ended September 30, 2019				
Revenue	$ 55,171	$ 33,227	$ —	$ 88,398
Segment Adjusted EBITDAR from Operations	$ 8,499	$ 11,574	$ (5,045)	$ 15,028
Three Months Ended September 30, 2018				
Revenue	$ 43,837	$ 29,116	$ —	$ 72,953
Segment Adjusted EBITDAR from Operations	$ 7,423	$ 11,499	$ (3,975)	$ 14,947

	Home Health and Hospice Services	Senior Living Services	All Other	Total
Nine Months Ended September 30, 2019				
Revenue	$ 151,496	$ 97,543	$ —	$ 249,039
Segment Adjusted EBITDAR from Operations	$ 23,873	$ 35,703	$ (14,524)	$ 45,052
Nine Months Ended September 30, 2018				
Revenue	$ 124,844	$ 85,877	$ —	$ 210,721
Segment Adjusted EBITDAR from Operations	$ 19,886	$ 34,774	$ (12,034)	$ 42,626

The following table reconciles the total Combined Adjusted EBITDAR from Operations for our reportable segments to Combined Income from Operations:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2019	2018	2019	2018
Total Combined Adjusted EBITDAR from Operations	$ 15,028	$ 14,947	$ 45,052	$ 42,626
Less: Depreciation and amortization	1,071	742	2,843	2,177
Rent—cost of services	8,538	7,776	25,368	23,065
Adjustments to Combined EBITDAR from Operations:				
Less: Costs at start-up operations [(a)]	60	56	377	92
Share-based compensation expense [(b)]	268	613	1,395	1,790
Acquisition related costs [(c)]	72	—	613	—
Spin-off related transaction costs [(d)]	3,372	—	8,020	—
Add: Net income attributable to noncontrolling interest	279	43	629	413
Combined Income from Operations	$ 1,926	$ 5,803	$ 7,065	$ 15,915

(a) Represents results related to start-up operations. This amount excludes rent, depreciation and amortization expense.
(b) Share-based compensation expense incurred.
(c) Acquisition related costs that are not capitalizable.
(d) Costs incurred related to the Spin-Off are included in general and administrative expense.

7. ACQUISITIONS

The Company's acquisition focus is to purchase or lease operations that are complementary to the Company's current businesses, accretive to the Company's business or otherwise advance the Company's strategy. The results of all the Company's operating subsidiaries are included in the Interim Financial Statements subsequent to the date of acquisition. Acquisitions are accounted for using the acquisition method of accounting.

During the nine months ended September 30, 2019, the Company expanded its operations with the addition of two home health agencies, five hospice agencies, two home care agencies and two stand-alone senior living operations. In connection with the acquisitions of one of the senior living communities, the Company entered into a new long-term "triple-net" lease with a subsidiary of Ensign. The Company did not acquire any material assets or assume any liabilities. A subsidiary of the Company

entered into a separate operations transfer agreement with the prior operator of each acquired operation as part of each transaction. The addition of these operations added a total of 143 operational senior living units to be operated by the Company's operating subsidiaries. The aggregate purchase price for these acquisitions was $18,780.

The fair value of assets for all home health, hospice and home care acquisitions was concentrated in goodwill and as such, these transactions were classified as business combinations in accordance with ASC Topic 805, *Business Combinations* ("Topic 805"). The purchase price for the business combinations was $18,760, which mostly consisted of goodwill of $10,341 and indefinite-lived intangible assets of $8,326. The fair value of assets for the senior living acquisitions were concentrated in intangible assets and as such, these transactions were classified as an asset acquisition. The purchase price for the asset acquisitions was $20. The Company anticipates that the majority of total goodwill recognized will be fully deductible for tax purposes as of September 30, 2019.

During the nine months ended September 30, 2018, the Company expanded its operations with the addition of two home health agencies, one hospice agency, one home care agency and two stand-alone senior living operations. In connection with the acquisition of these senior living communities, the Company entered into new long-term "triple-net" leases with subsidiaries of Ensign. The Company did not acquire any material assets or assume any liabilities. A subsidiary of the Company entered into a separate operations transfer agreement with the prior operator of each acquired operation as part of each transaction. The addition of these operations added a total of 74 operational senior living units to be operated by the Company's operating subsidiaries.The aggregate purchase price for these acquisitions was $2,023.

The fair value of assets for most home health, hospice and home care acquisitions was concentrated in goodwill and as such, these transactions were classified as business combinations in accordance with Topic 805. The purchase price for the business combinations was $1,625, which mostly consisted of goodwill of $1,007 and indefinite-lived intangible assets of $602. The fair value of assets for the remaining home health, hospice, home care, and all senior living acquisitions were concentrated in intangible assets and as such, these transactions were classified as an asset acquisition. The purchase price for the asset acquisitions was $398.

The Company's acquisition strategy has been focused on identifying both opportunistic and strategic acquisitions within its target markets that offer strong opportunities for return. The operating subsidiaries acquired by the Company are frequently underperforming financially and can have regulatory and clinical challenges to overcome. From time to time, these acquisitions are more strategic in nature that may or may not have positive operational results. Financial information, especially with underperforming operating subsidiaries, is often inadequate, inaccurate or unavailable. Consequently, the Company believes that prior operating results are not a meaningful representation of the Company's current operating results or indicative of the integration potential of its newly acquired operating subsidiaries. Revenue and income before tax included in the condensed combined statement of income relating to the business combinations was $6,489 and $1,023 during the three months ended September 30, 2019, respectively, and $9,930 and $1,573 during the nine months ended September 30, 2019, respectively. Acquisition costs related to the business combinations were $72 and $560 during the three and nine months ended September 30, 2019, respectively.

Pro forma financial information has been included for the businesses combinations during the nine months ended September 30, 2019. Business combinations during the nine months ended September 30, 2018 were deemed immaterial and as such, no pro forma financial information has been included. The acquisitions during the nine months ended September 30, 2019 have been included in the September 30, 2019 condensed combined balance sheets of the Company, and the operating results have been included in the condensed combined statements of income of the Company since the dates the Company gained effective control.

Revenues and operating costs were based on actual results from the prior operator or from regulatory filings where available. If actual results were not available, revenues and operating costs were estimated based on available partial operating results of the prior operator of the operation, or if no information was available, estimates were derived from the Company's post-acquisition operating results for that particular operation.

The unaudited pro forma information is not indicative of what the results of operations would have been if the business combinations had actually occurred at the beginning of the periods presented, and is not intended as a projection of future results or trends.

The following tables represent unaudited pro forma results of condensed combined operations as if the business combinations to date in fiscal year 2019 had occurred at the beginning of 2018, after giving effect to certain adjustments. The unaudited pro forma information is not indicative of what the results of operations would have been if the acquisitions had actually occurred at the beginning of the periods presented, and is not intended as a projection of future results or trends.

	Three Months Ended September 30,	
	2019	2018
Revenue	$ 88,800	$ 80,220
Net income attributable to The Pennant Group, Inc.[(a)]	$ 1,535	$ 4,930

(a) Net income attributable to The Pennant Group, Inc. for each of the three months ended September 30, 2019 and 2018 includes a tax impact of 25.2% and 25.0%, which are the respective statutory tax rates.

	Nine Months Ended September 30,	
	2019	2018
Revenue	$ 260,389	$ 232,523
Net income attributable to The Pennant Group, Inc.[(a)]	$ 6,949	$ 13,586

(a) Net income attributable to The Pennant Group, Inc. for each of the nine months ended September 30, 2019 and 2018 includes a tax impact of 25.2% and 25.0%, which are the respective statutory tax rates.

8. PROPERTY AND EQUIPMENT—NET

Property and equipment, net consist of the following:

	September 30, 2019	December 31, 2018
Leasehold improvements	$ 5,859	$ 4,299
Equipment	18,041	14,436
Furniture and fixtures	919	583
	24,819	19,318
Less: accumulated depreciation	(11,100)	(8,860)
Property and equipment, net	$ 13,719	$ 10,458

See also Note 7, *Acquisitions* for information on acquisitions during the nine months ended September 30, 2019.

9. GOODWILL AND INTANGIBLE ASSETS—NET

The Company tests goodwill during the fourth quarter of each year or more often if events or circumstances indicate there may be impairment. The Company performs its goodwill impairment analysis for each reporting unit that constitutes a business for which (1) discrete financial information is produced and reviewed by operating segment management and (2) provides services that are distinct from the other components of the operating segment, in accordance with the provisions of ASC Topic 350, *Intangibles-Goodwill and Other* ("Topic 350"). Topic 350 provides the option to first assess qualitative factors to determine whether it is more likely than not that the fair value of a reporting unit is less than its carrying value, a "Step 0" analysis. If, based on a review of qualitative factors, it is more likely than not that the fair value of a reporting unit is less than its carrying value, the Company performs "Step 1" of the traditional two-step goodwill impairment test by comparing the net assets of each reporting unit to their respective fair values. The Company determines the estimated fair value of each reporting unit using a discounted cash flow analysis. In the event a unit's net assets exceed its fair value, an implied fair value of goodwill must be determined by assigning the unit's fair value to each asset and liability of the unit. The excess of the fair value of the reporting unit over the amounts assigned to its assets and liabilities is the implied fair value of goodwill. An impairment loss is measured by the difference between the goodwill carrying value and the implied fair value.

The following table represents activity in goodwill by segment as of and for the nine months ended September 30, 2019:

	Home Health and Hospice Services	Senior Living Services	Total
December 31, 2018	$ 27,250	$ 3,642	$ 30,892
Additions	10,341	—	10,341
September 30, 2019	$ 37,591	$ 3,642	$ 41,233

Other indefinite-lived intangible assets consist of the following:

	September 30, 2019	December 31, 2018
Trade name	$ 355	$ 328
Medicare and Medicaid licenses	33,107	24,808
Total	$ 33,462	$ 25,136

Definite-lived intangible assets consist of the following:

		September 30, 2019			December 31, 2018		
Intangible Assets	Weighted Average Life (Years)	Gross Carrying	Accumulated Amortization	Net	Gross Carrying	Accumulated Amortization	Net
Patient base	0.7	$ 611	$ (607)	$ 4	$ 591	$ (573)	$ 18
Customer relationships	2.6	470	(421)	49	470	(410)	60
Total		$ 1,081	$ (1,028)	$ 53	$ 1,061	$ (983)	$ 78

Amortization expense was $45 and $86 for the nine months ended September 30, 2019 and 2018, respectively.

Estimated amortization expense for each of the periods ending December 31 is as follows:

Year	Amount
2019 (remainder)	$ 8
2020	14
2021	14
2022	14
2023	3
	$ 53

10. OTHER ACCRUED LIABILITIES

Other accrued liabilities consist of the following:

	September 30, 2019	December 31, 2018
Refunds payable	$ 2,109	$ 1,905
Deferred revenue	1,892	1,542
Resident deposits	6,317	6,310
Property taxes	1,200	932
Transaction costs	3,861	—
Other	2,280	1,682
Other accrued liabilities	$ 17,659	$ 12,371

Refunds payable includes payables related to overpayments, duplicate payments and credit balances from various payor sources. Deferred revenue occurs when the Company receives payments in advance of services provided. Resident deposits include refundable deposits to residents and a small portion consists of non-refundable deposits recognized into revenue over a period of time. Property taxes include amounts owed on our various properties. Transaction costs consist of costs incurred related to the Spin-Off.

11. INCOME TAXES

The Company recorded income tax expense of $123 and $91 during the three and nine months ended September 30, 2019, respectively, or 6.4% and 1.3% of earnings before income taxes. The Company recorded income tax expense of $1,388 and

$3,588 during the three and nine months ended September 30, 2018, respectively, or 23.9% and 22.5% of earnings before income taxes. The effective tax rate includes excess tax benefits from stock-based compensation which is offset by non-deductible expenses including non-deductible compensation. The rate is further impacted by transaction costs related to the Spin-Off that were deductible prior to completing the transaction on October 1, 2019.

The Company is not currently under examination by any material income tax jurisdiction. During 2019, the statutes of limitations will lapse on the Company's 2015 federal tax year and certain 2014 and 2015 state tax years. The Company does not believe the federal or state statute lapses or any other event will significantly impact the balance of unrecognized tax benefits in the next 12 months. The net balance of unrecognized tax benefits was not material to the Interim Financial Statements for the three and nine months ended September 30, 2019 and 2018.

12. OPTIONS AND AWARDS

Stockholders have approved the the Ensign and Subsidiary Equity Plans, which provide for the granting of equity-based compensation. Under the Plans, stock-based payment awards, including employee stock options and restricted stock awards, are issued based on estimated fair value. The following disclosures represent share-based compensation expense relating to the Plans, including awards to employees of the Company's subsidiaries and an allocation of costs from employees in the Service Center. Total share-based compensation expense for all of the Plans for the three and nine months ended September 30, 2019 and 2018:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2019	2018	2019	2018
Ensign Plans direct expense	$ 113	$ 121	$ 337	$ 366
Ensign Plans allocated expense	138	144	464	394
Subsidiary Equity Plan	17	348	594	1,030
Total share-based compensation	$ 268	$ 613	$ 1,395	$ 1,790

As share-based compensation expense recognized in the Company's condensed combined statements of income for the three and nine months ended September 30, 2019 and 2018 was based on awards ultimately expected to vest, it has been reduced for estimated forfeitures. The Company estimates forfeitures at the time of grant and, if necessary, revises the estimate in subsequent periods if actual forfeitures differ.

The Company uses the Black-Scholes option-pricing model to recognize the value of stock-based compensation expense for share-based payment awards under the Plans. Determining the appropriate fair-value model and calculating the fair value of stock-based awards at the grant date requires considerable judgment, including estimating stock price volatility, expected option life and forfeiture rates. The Company develops estimates based on historical data and market information, which can change significantly over time.

The Ensign Plans

Stock Options

Under the Ensign Plans, options granted to employees of the subsidiaries of Pennant generally vest over five years at 20% per year on the anniversary of the grant date. Options expire ten years after the date of grant. The fair value of each option is estimated on the grant date using a Black-Scholes option-pricing model with the following weighted average assumptions for stock options granted:

Grant Year	Options Granted	Weighted Average Risk-Free Rate	Expected Life	Weighted Average Volatility	Weighted Average Dividend Yield
2019	5	1.5%	6.2	34.0%	0.4%
2018	11	2.8%	6.3	32.0%	0.5%

The expected volatility is based on the historical market volatility of Ensign's stock price over the expected life of the stock options granted. The expected life represents the period of time that the awards are expected to be outstanding and is based on the contractual terms of each instrument, taking into account employees' historical exercise and termination behavior.

For the nine months ended September 30, 2019 and 2018, the following represents the exercise price and fair value displayed at grant date for stock option grants:

Grant Year	Granted	Weighted Average Exercise Price	Weighted Average Fair Value of Options
2019	5	$ 53.50	$ 19.16
2018	11	$ 36.61	$ 12.73

The weighted average exercise price equaled the weighted average fair value of common stock on the grant date for all options granted during the nine months ended September 30, 2019 and 2018 and therefore, the intrinsic value was $0 at date of grant.

The following table represents the employee stock option activity during the nine months ended September 30, 2019:

	Number of Options Outstanding	Weighted Average Exercise Price	Number of Options Vested	Weighted Average Exercise Price of Options Vested
December 31, 2018	297	$ 15.94	182	$ 13.28
Employees transferred[(a)]	30	17.43		
Granted	5	53.50		
Forfeited	(9)	21.13		
Exercised	(100)	12.66		
September 30, 2019	223	$ 18.67	150	$ 15.12

(a) Represents awards to employees who have transferred between the Company and Ensign during the nine months ended September 30, 2019.

The following summary information reflects stock options outstanding, vested and related details as of September 30, 2019:

	Stock Options Outstanding				Stock Options
Year of Grant	Exercise Price	Number Outstanding	Black-Scholes Fair Value	Remaining Contractual Life (Years)	Vested and Exercisable
2009	$ 4.06 - $ 4.56	—	$ —	0	—
2010	4.77 - 4.96	2	6	1	2
2011	5.90 - 7.99	8	26	2	8
2012	6.56 - 7.96	12	46	3	13
2013	7.98 - 11.49	11	51	4	11
2014	10.55 - 18.94	67	406	5	64
2015	21.47 - 25.24	36	325	6	25
2016	18.79 - 19.89	40	269	7	17
2017	18.64 - 22.90	24	164	8	8
2018	26.53 38.59	18	223	9	2
2019	$53.50 $53.99	5	96	10	—
Total		223	$ 1,612		150

Restricted Stock Awards

All awards were granted at an issued price of $0 and generally vest over five years. A summary of the status of Ensign's non-vested restricted stock awards as of September 30, 2019, and changes during the period ended September 30, 2019, is presented

below:

	Non-Vested Restricted Awards	Weighted Average Grant Date Fair Value
December 31, 2018	21	$ 22.59
Employees transferred[(a)]	6	24.88
Vested	(7)	23.55
Forfeited	(1)	19.61
September 30, 2019	19	$ 24.23

(a) Represents non-vested awards related to employees who have transferred between the Company and Ensign during the nine months ended September 30, 2019.

In future periods, the Company expects to recognize approximately $570 and $471 in share-based compensation expense for unvested options and unvested restricted stock awards, respectively, which were outstanding as of September 30, 2019. Future share-based compensation expense will be recognized over 2.9 and 2.8 weighted average years for unvested options and restricted stock awards, respectively. There were 73 unvested and outstanding options at September 30, 2019, of which 68 are expected to vest. The weighted average contractual life for options outstanding, vested and expected to vest at September 30, 2019 was 5.7 years.

The aggregate intrinsic value of options outstanding, vested, expected to vest and exercisable as of and for the period ended September 30, 2019 is as follows:

Options	September 30, 2019	December 31, 2018
Outstanding	$ 6,433	$ 6,545
Vested	4,848	4,604
Expected to vest	1,586	1,941
Exercisable	4,123	2,263

The intrinsic value is calculated as the difference between the market value of the underlying common stock and the exercise price of the options.

Subsidiary Equity Plan

On May 26, 2016, Ensign implemented a management equity plan and granted stock options and restricted stock awards of a subsidiary of Ensign. These awards generally vest over a period of three to five years or upon the occurrence of certain prescribed events. The value of the stock options and restricted stock awards is tied to the value of the common stock of the subsidiary. The awards can be put to the Company at various prescribed dates, which in no event may be earlier than six months after vesting of the restricted stock or exercise of the stock options. The Company can also call the awards at any time. The Company did not grant any additional options or restricted stock awards during the nine months ended September 30, 2019 and granted 221 options during the nine months ended September 30, 2018. During both the nine months ended September 30, 2019 and 2018, there were 976 restricted stock awards that vested.

The grant date fair value of the awards is recognized as compensation expense over the relevant vesting periods, with a corresponding adjustment to noncontrolling interest. The grant value was determined based on independent valuation of the subsidiary shares close to the grant date. The valuation incorporated a discounted cash flow analysis combined with a market-based approach to determine the fair value of the subsidiary equity.

The following table represents stock options and restricted stock awards activity during the period ended September 30, 2019:

	Number of Options Outstanding	Weighted Average Exercise Price	Non-Vested Restricted Awards	Weighted Average Grant Date Fair Value
December 31, 2018	483	$ 1.83	996	$ 1.37
Vested	—	—	(976)	1.37
Forfeited	(32)	1.91	—	—
September 30, 2019	451	$ 1.83	20	$ 1.37

In future periods, the Company expects to recognize approximately $179 and $23 in share-based compensation expense for unvested options and unvested restricted stock awards, respectively, which were outstanding as of September 30, 2019. Future share-based compensation expense will be recognized over 3.1 and 1.6 weighted average years for unvested options and restricted stock awards, respectively. There were 163 vested and exercisable options at September 30, 2019. There were 288 unvested and outstanding options at September 30, 2019, all of which are expected to vest. The weighted average contractual life for options outstanding, vested and expected to vest at September 30, 2019 was 7.5 years.

During the nine months ended September 30, 2019 and 2018, the Company repurchased 534 and 865 shares of common stock, respectively, under the Subsidiary Equity Plan for $2,687 and $1,972, respectively. The Company subsequently sold the shares and received net proceeds of $2,293 and $1,972, respectively. The Company repurchased 65 and 865 shares of common stock under the Subsidiary Equity Plan for a total of $394 and $1,972 during the three months ended September 30, 2019 and 2018, respectively.

13. LEASES

The Company's operating subsidiaries lease 52 senior living communities and its administrative offices under non-cancelable operating leases, most of which have initial lease terms ranging from five to 20 years. Most of these leases contain renewal options, most involve rent increases and none contain purchase options. The lease term excludes lease renewals because the renewal rents are not at a bargain, there are no economic penalties for the Company to renew the lease, and it is not reasonably assured that the Company will exercise the extension options. As of September 30, 2019, the Company's operating subsidiaries leased 29 communities from subsidiaries of Ensign ("Ensign Leases"). The existing leases with subsidiaries of Ensign are for initial terms of 15 years. In addition to rent, each of the operating companies are required to pay the following: (1) all impositions and taxes levied on or with respect to the leased properties (other than taxes on the income of the lessor); (2) all utilities and other services necessary or appropriate for the leased properties and the business conducted on the leased properties; (3) all insurance required in connection with the leased properties and the business conducted on the leased properties; (4) all community maintenance and repair costs; and (5) all fees in connection with any licenses or authorizations necessary or appropriate for the leased properties and the business conducted on the leased properties.

Fifteen of the Company's affiliated senior living communities, excluding the communities that are operated under the Ensign Leases (as defined herein), are operated under two separate master lease arrangements. Under these master leases, a breach at a single community could subject one or more of the other communities covered by the same master lease to the same default risk. Failure to comply with Medicare and Medicaid provider requirements is a default under several of the Company's leases and master leases. In addition, other potential defaults related to an individual community may cause a default of an entire master lease portfolio and could trigger cross-default provisions in Ensign's outstanding debt arrangements and other leases. With an indivisible lease, it is difficult to restructure the composition of the portfolio or economic terms of the master lease without the consent of the landlord.

Impact of New Leases Guidance

The adoption of Topic 842 did not result in adjustments to the Company's condensed combined statements of income. The components of operating lease cost, are as follows:

	Three Months Ended September 30,	Nine Months Ended September 30,
	2019	2019
Operating Lease Costs:		
Facility Rent—cost of services	$ 7,813	$ 23,229
Office Rent—cost of services	725	2,139
Rent—cost of services[a]	$ 8,538	$ 25,368
General and administrative expense	39	101
Variable lease cost [b]	1,204	3,402

(a) Rent—cost of services includes the amortization of deferred rent of $42 and $175 for the three and nine months ended September 30, 2019. Rent—cost of services includes short-term leases, which are immaterial.
(b) Represents variable lease cost for operating leases. Includes property and insurance, common area maintenance, and consumer price index increases, incurred as part of our triple net lease, and is included in cost of services for the three and nine months ended September 30, 2019.

Future minimum lease payments for all leases as of September 30, 2019:

Year	Amount
2019 (remainder)	$ 8,359
2020	33,411
2021	32,973
2022	32,291
2023	31,897
2024	31,449
Thereafter	222,225
Total lease payments	392,605
Less: present value adjustments	(151,606)
Present value of total lease liabilities	240,999
Less: current lease liabilities	(13,611)
Long-term operating lease liabilities	$ 227,388

Operating lease liabilities are based on the net present value of the remaining lease payments over the remaining lease term. In determining the present value of lease payments, the Company used its incremental borrowing rate based on the information available at each lease's commencement date to determine each lease's operating lease liability. As of September 30, 2019, the weighted average remaining lease term is 12.4 years and the weighted average discount rate is 8.6%.The Company implemented Topic 842 as described in Note 2, *Summary of Significant Accounting Policies*.

Future minimum lease payments for all leases as of December 31, 2018 were as follows:

Year	Amount
2019	$ 33,055
2020	32,181
2021	31,625
2022	31,241
2023	30,896
Thereafter	243,333
Total lease payments	$ 402,331

On October 1, 2019, in connection with the Spin-Off, the Company amended its master lease agreements with Ensign and certain other landlords. These amendments modify the rental payments, the initial term or both. In accordance with Topic 842, the amended lease agreements are considered to be modified and subjected to lease modification guidance. The ROU asset and lease liabilities related to these agreements will be remeasured based on the change in the lease conditions such as rent payment and lease terms. The incremental borrowing rate will also be adjusted to mirror the revised lease terms which become effective at the date of the modification, which is the date of the Spin-Off. The Ensign Leases and new third-party master lease agreements have initial terms ranging between 14 and 16 years, with extension options and annual rent escalators based on changes in the consumer price index. Annual future minimum lease payments are expected to initially increase by approximately $3,600 due to the modifications.

14. COMMITMENTS AND CONTINGENCIES

Regulatory Matters - The Company provides services in complex and highly regulated industries. The Company's compliance with applicable federal, state and local laws and regulations governing these industries may be subject to governmental review and adverse findings may result in significant regulatory action, which could include sanctions, damages, fines, penalties (many of which may not be covered by insurance), and even exclusion from government programs. The Company is a party to various regulatory and other governmental audits and investigations in the ordinary course of business and cannot predict the ultimate outcome of any federal or state regulatory survey, audit or investigation. While governmental audits and investigations are the subject of administrative appeals, the appeals process, even if successful, may take several years to resolve. The Department of Justice, The Centers for Medicare and Medicaid Services ("CMS"), or other federal and state enforcement and regulatory agencies may conduct additional investigations related to the Company's businesses. The Company believes that it is presently in compliance in all material respects with all applicable laws and regulations.

Cost-Containment Measures - Government and third party payors have instituted cost-containment measures designed to limit payments made to providers of healthcare services, and there can be no assurance that future measures designed to limit payments made to providers will not adversely affect the Company.

Indemnities - From time to time, the Company enters into certain types of contracts that contingently require the Company to indemnify parties against third-party claims. These contracts primarily include (i) certain real estate leases, under which the Company may be required to indemnify property owners or prior operators for post-transfer environmental or other liabilities and other claims arising from the Company's use of the applicable premises, (ii) operations transfer agreements, in which the Company agrees to indemnify past operators of agencies and communities the Company acquires against certain liabilities arising from the transfer of the operation and/or the operation thereof after the transfer, (iii) certain Ensign lending agreements, and (iv) certain agreements with management, directors and employees, under which the subsidiaries of the Company may be required to indemnify such persons for liabilities arising out of their employment relationships. The terms of such obligations vary by contract and, in most instances, a specific or maximum dollar amount is not explicitly stated therein. Generally, amounts under these contracts cannot be reasonably estimated until a specific claim is asserted. Consequently, because no claims have been asserted, no liabilities have been recorded for these obligations on the Company's combined balance sheets for any of the periods presented.

Litigation - The Company's businesses involve a significant risk of liability given the age and health of the patients and residents served by its operating subsidiaries. The Company, its operating companies, and others in the industry may be subject to a number of claims and lawsuits, including professional liability claims, alleging that services provided have resulted in personal injury, elder abuse, wrongful death or other related claims. Healthcare litigation (including class action litigation) is common and is filed based upon a wide variety of claims and theories, and the Company is routinely subjected to these claims in the ordinary course of business, including potential claims related to patient care and treatment, professional negligence and class actions, as well as employment related claims. If there were a significant increase in the number of these claims or an increase in amounts owing should plaintiffs be successful in their prosecution of these claims, this could materially adversely affect the Company's business, financial condition, results of operations and cash flows. In addition, the defense of these lawsuits may result in significant legal costs, regardless of the outcome, and can result in large settlement amounts or damage awards.

In addition to the potential lawsuits and claims described above, the Company is also subject to potential lawsuits under the False Claims Act (the "FCA") and comparable state laws alleging submission of fraudulent claims for services to any healthcare program (such as Medicare) or payor. A violation may provide the basis for exclusion from federally-funded healthcare programs. Such exclusions could have a correlative negative impact on the Company's financial performance. Some states, including California, Arizona and Texas, have enacted similar whistleblower and false claims laws and regulations. In addition, the Deficit Reduction Act of 2005 created incentives for states to enact anti-fraud legislation modeled on the FCA. As such, the Company could face increased scrutiny, potential liability and legal expenses and costs based on claims under state false claims acts in markets in which it does conduct business.

In May 2009, Congress passed the Fraud Enforcement and Recovery Act ("FERA") which made significant changes to the FCA, expanding the types of activities subject to prosecution and whistleblower liability. Following changes by FERA, healthcare providers face significant penalties for the knowing retention of government overpayments, even if no false claim was involved. Providers can now be liable for knowingly and improperly avoiding or decreasing an obligation to pay money or property to the government; including the retention of any government overpayment. The Patient Protection and Affordable Care Act of 2010 (the "ACA") supplemented FERA by imposing an affirmative obligation on healthcare providers to return an overpayment to CMS within 60 days of "identification" or the date any corresponding cost report is due, whichever is later. According to CMS's February 12, 2016, final rule with respect to Medicare Parts A and B, providers have an obligation to proactively exercise "reasonable diligence" to identify overpayments. The 60 day clock begins to run after the reasonable diligence period has concluded, which may take, at most, six months from the receipt of credible information. Retention of any overpayment beyond this period may create liability under the FCA. In addition, FERA extended protections against retaliation for whistleblowers, including protections not only for employees, but also contractors and agents. Thus, there is generally no need for an employment relationship in order to qualify for protection against retaliation for whistleblowing.

The Company cannot predict or provide any assurance as to the possible outcome of any litigation. If any litigation were to proceed, and the Company and its operating companies are subjected to, alleged to be liable for, or agree to a settlement of, claims or obligations under federal Medicare statutes, the FCA, or similar state and federal statutes and related regulations, the Company's business, financial condition and results of operations and cash flows could be materially and adversely affected. Among other things, any settlement or litigation could involve the payment of substantial sums to settle any alleged civil violations, and may also include the assumption of specific procedural and financial obligations by the Company or its operating subsidiaries going forward under a corporate integrity agreement and/or other arrangement with the government.

Medicare Revenue Recoupments - The Company is subject to probe reviews relating to Medicare services, billings and potential overpayments by Unified Program Integrity Contractors (UPIC), Recovery Audit Contractors (RAC), Zone Program Integrity Contractors (ZPIC), Program Safeguard Contractors (PSC), Supplemental Medical Review Contractors (SMRC) and Medicaid Integrity Contributors (MIC) programs, each of the foregoing collectively referred to as "Reviews." As of September 30, 2019, seven of the Company's independent operating subsidiaries had Reviews scheduled, on appeal or in dispute resolution process, both pre- and post-payment. The Company anticipates that these probe reviews will increase in frequency in the future. If an operation fails an initial or subsequent Review, the operation could then be subject to extended Review, suspension of payment, or extrapolation of the identified error rate to all billing in the same time period. As of September 30, 2019, and through the filing of this Quarterly Report on Form 10-Q, the Company's independent operating subsidiaries have responded to the Reviews that are currently ongoing, on appeal or in dispute resolution process.

Concentrations

Credit Risk - The Company has significant accounts receivable balances, the collectability of which is dependent on the availability of funds from certain governmental programs, primarily Medicare and Medicaid. These receivables represent the only significant concentration of credit risk for the Company. The Company does not believe there are significant credit risks associated with these governmental programs. The Company believes that an appropriate allowance has been recorded for the possibility of these receivables proving uncollectible, and continually monitors and adjusts these allowances as necessary. The Company's gross receivables from the Medicare and Medicaid programs accounted for approximately 75.7% and 72.4% of its total gross accounts receivable as of September 30, 2019 and December 31, 2018, respectively. Revenue from reimbursement under the Medicare and Medicaid programs accounted for 56.8% and 55.1% of the Company's revenue for the three and nine months ended September 30, 2019, respectively and 54.0% and 53.2% of the Company's revenue for the three and nine months ended September 30, 2018, respectively.

15. SUBSEQUENT EVENTS

New Credit Agreement

On October 1, 2019, Pennant entered into the Credit Agreement (the "Credit Agreement"), which provides for a revolving credit facility with a syndicate of banks with a borrowing capacity of $75,000 (the "Revolving Credit Facility"). The interest rates applicable to loans under the Revolving Credit Facility are, at the Company's election, either LIBOR ("Adjusted LIBOR" as defined in the Credit Agreement) plus a margin ranging from 2.5% to 3.5% per annum or base rate plus a margin ranging from 1.5% to 2.5% per annum, in each case calculatedbased on the ratio of Consolidated Total Net Debt to Consolidated EBITDA (each, as defined in the Credit Agreement). In addition, Pennant will pay a commitment fee on the undrawn portion of the commitments under the Revolving Credit Facility that is estimated to be 0.6% per annum.

On October 1, 2019, we borrowed $30,000 under the Revolving Credit Facility. The proceeds of $28,700 from the issuance of indebtedness, net of financing costs of $1,300, were used to pay a dividend of $11,600 to Ensign; the remainder was used to pay spin-off related transaction costs and for general working capital purposes.

Spin-Off Related Agreements

On October 1, 2019, in connection with the Spin-Off, Pennant entered into several agreements with Ensign that set forth the principal actions taken or to be taken in connection with the Spin-Off and govern the relationship of the parties following the Spin-Off, including the following:

- Master Separation Agreement: the Company entered into a Master Separation Agreement with Ensign prior to the distribution of shares of the Company's common stock to Ensign stockholders. The Master Separation Agreement provides for the allocation of assets and liabilities between the Company and Ensign and establishes certain rights and obligations between the parties following the Distribution (the "Master Separation Agreement");

- Transition Services Agreement: provides that for a limited time, Ensign is to provide the Company, and the Company is to provide Ensign, with certain services to ensure an orderly transition following the spin-off, including: human resources, accounting, legal and compliance, IT, office facilities, and other general support. Generally, the term for the provision of services under the agreement extends for no longer than two years after the spin-off, subject to certain rights of the parties to extend the term for an additional five months. To the extent transition services are utilized during the first two years after the spin-off, the charges paid by the recipient for the services are generally provided at their market value. Subject to certain conditions, the services may be terminated by the service-receiving party or by mutual written consent (the "Transition Services Agreement");

- Tax Matters Agreement: provides that Pennant is responsible for indemnifying Ensign for a percentage of tax liabilities related to the spin-off and adjustments to the combined entity in the pre-distribution period (the "Tax Matters Agreement)?

- Employee Matters Agreement: governs the parties' obligations with respect to certain employee-related liabilities and certain employee benefit plans, programs, policies and other related matters for employees of Pennant (the "Employee Matters Agreement");

- Master Lease Agreement: provides for the owned real property and leased space allocated to Ensign or us, or in certain cases shared by Ensign and us, as the case may be, in a manner that is consistent with the different business uses and needs of Ensign and us (the "Master Lease Agreement").

Certain Equity Incentive Plans

Prior to the Spin-Off, employees of the Company participated in the Plans, including by receiving stock options and restricted stock awards. A full description of the Company's equity plans is made in Note 12, *Options and Awards*.

- *Conversion of the Plans*: In connection with the Spin-Off, outstanding equity awards related to the Ensign Plans and the Subsidiary Equity Plan held by Pennant employees were modified and replaced with awards of Pennant common stock depending on the awards, and adjusted to maintain the economic value before and after the distribution date using the relative fair market value of the Ensign and Pennant common stock.

- *Issuance of new equity awards:* In connection with the Spin-Off, the Company adopted the OIP and the LTIP . Options and awards were granted to Pennant employees and directors under the OIP. On October 1, 2019, Daniel H Walker received a grant of 1,193 restricted stock units under the OIP, which will vest on the first to occur of (i) the third anniversary of the consummation of the distribution if the participant is then employed by the Company, (ii) a Change in Control if then employed by the Company, or (iii) the termination of the participant's employment by the Company due to death, Disability (as defined in the OIP), or by the Company for any reason other than Cause (as defined in the RSU agreement). Restricted stock awards were also granted to certain Ensign employees and directors under the LTIP.

New Insurance Coverage

In connection with the Spin-off, the Company obtained stand-alone insurance policies to cover general and professional liability, workers compensation, and Directors and Officers liability.

Item 2. ***Management's Discussion and Analysis of Financial Condition and Results of Operations***

You should read the following discussion and analysis in conjunction with our unaudited condensed combined financial statements and the related notes thereto contained in Part I, Item 1 of this Report. The information contained in this Quarterly Report on Form 10-Q is not a complete description of our business or the risks associated with an investment in our common stock. We urge you to carefully review and consider the various disclosures made by us in this Report and in our other reports filed with the Securities and Exchange Commission (SEC), including our Information Statement on Form 10 ("Information Statement", "Form 10"), which discusses our business and related risks in greater detail, as well as subsequent reports we may file from time to time on Forms 10-K, 10-Q and 8-K, for additional information. The section entitled "Risk Factors" filed within the Information Statement, describes some of the important risk factors that may affect our business, financial condition, results of operations and/or liquidity. You should carefully consider those risks, in addition to the other information in this Report and in our other filings with the SEC, before deciding to purchase, hold or sell our common stock.

The Pennant Group, Inc. ("Pennant" or the "Company") was formed on January 24, 2019, as a wholly-owned subsidiary of The Ensign Group, Inc. ("Ensign"), which completed a spin-off of the Company effective October 1, 2019. Following the spin-off, the Company holds, directly or through its subsidiaries, the home health and hospice agencies and substantially all of the senior living businesses of Ensign.

Special Note About Forward-Looking Statements

This Quarterly Report on Form 10-Q contains "forward-looking statements" within the meaning of the safe harbor provisions of the U.S. Private Securities Litigation Reform Act of 1995, that are based on our management's beliefs and assumptions and on information currently available to our management. Forward-looking statements include, but are not limited to, statements related to our expectations regarding the performance of our business, our financial results, our liquidity and capital resources, the benefits resulting from the Spin-Off, the effects of competition and the effects of future legislation or regulations and other non-historical statements. Forward-looking statements include all statements that are not historical facts and can be identified by the use of forward-looking terminology such as the words "outlook," "believes," "expects," "outlook," "potential," "continues," "may," "might," "will," "should," "could," "seeks," "approximately," "goals," "future," "projects," "predicts," "guidance," "target," "intends," "plans," "estimates," "anticipates" or the negative version of these words or other comparable words.

The risk factors discussed in the Form 10 under the heading "Risk Factors," could cause our results to differ materially from those expressed in forward-looking statements. Factors that could cause actual results to differ materially from those in the forward-looking statements include, but are not limited to:

- federal and state changes to, or delays receiving, reimbursement and other aspects of Medicaid and Medicare;
- changes in the regulation of the healthcare services industry;
- increased competition for, or a shortage of, skilled personnel;
- government reviews, audits and investigations of our business;
- changes in federal and state employment related laws;
- compliance with state and federal employment, immigration, licensing and other laws;
- competition from other healthcare providers;
- actions of national labor unions;
- the leases of our affiliated senior living communities;
- inability to complete future community or business acquisitions and failure to successfully integrate acquired communities and businesses into our operations;
- general economic conditions;
- security breaches and other cyber security incidents;
- the performance of the financial and credit markets;
- uncertainties related to our ability to realize the anticipated benefits of the Spin-Off; and
- uncertainties related to our ability to obtain financing or the terms of such financing.

Forward-looking statements involve risks, uncertainties and assumptions. Actual results may differ materially from those expressed in these forward-looking statements. You should not place undue reliance on any forward-looking statements in this Quarterly Report on Form 10-Q. We do not have any obligation to update forward-looking statements after we distribute this Quarterly Report on Form 10-Q except as required by law.

Overview

We are a leading provider of high quality healthcare services to the growing senior population in the United States. We strive to be the provider of choice in the communities we serve through our innovative operating model. We operate in multiple lines of businesses including home health, hospice and senior living services across Arizona, California, Colorado, Idaho, Iowa, Nevada, Oklahoma, Oregon, Texas, Utah, Washington, Wisconsin and Wyoming. As of September 30, 2019, our home health and hospice business provided home health, hospice and home care services from 63 agencies operating across 13 states, and our senior living business operated 52 senior living communities throughout six states.

The following table summarizes our affiliated home health and hospice agencies and senior living communities as of:

	December 31,								September 30,
	2011	2012	2013	2014	2015	2016	2017	2018	2019
Cumulative number of home health and hospice agencies	7	10	16	25	32	39	46	54	63
Cumulative number of senior living communities	8	10	12	15	36	36	43	50	52
Cumulative number of senior living units	887	1,034	1,256	1,587	3,184	3,184	3,434	3,820	3,963
Total number of home health, hospice, and senior living operations	15	20	28	40	68	75	89	104	115

The Spin-Off Transactions

On October 1, 2019, Ensign completed the separation of Pennant (the "Spin-Off"). To accomplish the Spin-Off, Ensign contributed the Company's assets and liabilities into Pennant and distributed to Ensign's stockholders substantially all of the outstanding shares of Pennant common stock. Each Ensign stockholder received a distribution of one share of Pennant common stock for every two shares of Ensign's common stock plus cash in lieu of fractional shares. As a result of the Spin-Off on October 1, 2019, Pennant began trading as an independent publicly traded company on the NASDAQ under the symbol "PNTG."

We expect to benefit from a continuing relationship with Ensign, which will continue to be a holding company comprised of various post-acute businesses, including its skilled nursing, senior living and other ancillary operations in Arizona, California, Colorado, Idaho, Iowa, Kansas, Nebraska, Nevada, South Carolina, Texas, Utah, Washington and Wisconsin.

In connection with the Spin-Off, Pennant and Ensign entered the Transition Services Agreement where we will be providing Ensign with certain services, and Ensign will provide Pennant with certain services, for a two year period, subject to extension upon the agreement of the parties, following the distribution to help ensure an orderly transition. The services that are under the transition services agreement may include certain finance, information technology, human resources, employee benefits and other services.

Effective October 1, 2019, the Company amended its master lease agreements with Ensign and certain other landlords. These amendments modify the rental payments, the initial term or both. In accordance with Topic 842, the amended lease agreements are considered to be modified and subjected to lease modification guidance. The ROU asset and lease liabilities related to these agreements will be remeasured based on the change in the lease conditions such as rent payment and lease terms. The incremental borrowing rate will also be adjusted to mirror the revised lease terms which become effective at the date of the modification, which is the date of the Spin-Off. The Ensign Leases and new third-party master lease agreements have initial terms ranging between 14 and 16 years, with extension options and annual rent escalators based on changes in the consumer price index. Annual future minimum lease payments are expected to initially increase approximately $3.6 million due to the modifications.

See "Certain Relationships and Related Party Transactions—Agreements with Ensign Related to the Spin-Off," contained within the Information Statement as well as the Form 8-K filed with the SEC on October 3, 2019 for further discussion of the agreements entered into with the Spin-Off.

Recent Activities

Acquisitions - From January 1, 2019 through September 30, 2019, we expanded our operations through the acquisition of two stand-alone senior living operations, two home health agencies, five hospice agencies, and two home care agencies. We did not assume any liabilities. The addition of these operations added a total of 143 senior living units to be operated by our operating subsidiaries. We entered into a separate operations transfer agreement with the prior operator as part of each transaction. The aggregate purchase price for these acquisitions was $18.8 million. For further discussion of our acquisitions, see Note 7, *Acquisitions*, in the Notes to Interim Financial Statements.

Trends

When we acquire turnaround or start-up operations, we expect that our combined metrics may be impacted. We expect these metrics to vary from period to period based upon the maturity of the operations within our portfolio. We have generally experienced lower occupancy rates at our senior living communities and lower census at our home health and hospice agencies for recently acquired operations; as a result, we generally anticipate lower consolidated and segment margins during years of acquisition growth.

Regulation

On October 31, 2019, CMS issued its 2020 HH PPS final rule. The final rule implements the Patient-Driven Groupings Model (PDGM), a revised case mix adjustment methodology, for all home health episodes that begin on or after January 1, 2020. PDGM changes the unit of home health payment from a 60-day episode to a 30-day period and refines case mix calculation by removing therapy thresholds and adjusting reimbursement based on patient characteristics such as principal diagnoses and clinical grouping, functional impairment levels, comorbidities, and admission source and timing. CMS estimates the final rule will result in a $250 million (1.3%) increase in payments to home health providers in 2020, including a negative 4.36% behavioral change assumption. The final rule confirms that Requests for Anticipated Payment ("RAPs") will be phased out partially in 2020 and fully eliminated in 2021. With the support of our professional resource team, our local clinical and operational leaders have been preparing for this reimbursement change. While we could experience revenue headwinds related to the included behavioral assumptions and payment disruptions, we anticipate that we will offset any negative impact from PDGM through a mix of behavioral changes and a continued focus on cost control while producing optimal clinical outcomes.

Segments

We have two reportable segments: (1) home health and hospice services, which includes our home health, hospice and home care businesses; and (2) senior living services, which includes the operation of assisted living, independent living and memory care communities. Our reporting segments are business units that offer different services and that are managed separately to provide greater visibility into those operations.

Key Performance Indicators

We manage the fiscal aspects of our business by monitoring key performance indicators that affect our financial performance. These indicators and their definitions include the following:

Home Health and Hospice

- *Total home health admissions*. The total admissions of home health patients, including new acquisitions, new admissions, and readmissions.
- *Average Medicare revenue per completed 60-day home health episode.* The average amount of revenue for each completed 60-day home health episode generated from patients who are receiving care under Medicare reimbursement programs.
- *Average daily census.* The average number of patients who are receiving hospice care during any measurement period divided by the number of days during such measurement period.
- *Hospice Medicare revenue per day*. The average daily Medicare revenue recorded during any measurement period for services provided to hospice patients.

The following table summarizes our overall home health and hospice statistics for the periods indicated:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2019	2018	2019	2018
Home health services:				
Total home health admissions	5,556	4,523	16,723	13,496
Average Medicare revenue per 60-day completed episode	$ 3,173	$ 3,001	$ 3,072	$ 2,968
Hospice services:				
Average daily census	1,788	1,379	1,625	1,310
Hospice Medicare revenue per day	$ 163	$ 159	$ 164	$ 160

Senior Living Services

- *Occupancy.* The ratio of actual number of days our units are occupied during any measurement period to the number of units available for occupancy during such measurement period.

- *Average monthly revenue per occupied unit*. The revenue for senior living services during any measurement period divided by actual occupied senior living units for such measurement period.

The following table summarizes our senior living statistics for the periods indicated:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2019	2018	2019	2018
Occupancy	79.6%	80.0%	79.9%	79.1%
Average monthly revenue per occupied unit	$ 3,111	$ 3,032	$ 3,110	$ 3,046

Critical Accounting Policies and Estimates

A discussion of our critical accounting policies and estimates can be found in the "Management's Discussion and Analysis of Financial Condition and Results of Operations" included in our Information Statement on Form 10. There were no material changes to these critical accounting estimates since the filing of our Information Statement on Form 10.

New Accounting Pronouncements

Please refer to Note 2, *Basis of Presentation and Summary of Significant Accounting Policies,* of the Interim Financial Statements included elsewhere in the Quarterly Report on Form 10-Q for discussion of new accounting pronouncements.

Results of Operations

The following table sets forth details of our revenue, expenses and earnings as a percentage of total revenue for the periods indicated:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2019	2018	2019	2018
Total revenue	100.0%	100.0%	100.0%	100.0%
Expense:				
Cost of services	77.2	74.2	76.3	74.1
Rent—cost of services	9.7	10.7	10.2	10.9
General and administrative expense	9.7	6.1	9.5	6.4
Depreciation and amortization	1.2	1.0	1.2	1.0
Total expenses	97.8	92.0	97.2	92.4
Income from operations	2.2	8.0	2.8	7.6
Interest expense	—	—	—	—
Income before provision for income taxes	2.2	8.0	2.8	7.6
Provision for income taxes	0.2	1.9	—	1.7
Net income	2.0	6.1	2.8	5.9
Less: net income attributable to noncontrolling interest	0.3	0.1	0.3	0.2
Net income attributable to Pennant	1.7%	6.0%	2.5%	5.7%

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2019	2018	2019	2018
	(In thousands)			
Combined GAAP Financial Measures:				
Total revenue	$ 88,398	$ 72,953	$ 249,039	$ 210,721
Total expenses	$ 86,472	$ 67,150	$ 241,974	$ 194,806
Income from operations	$ 1,926	$ 5,803	$ 7,065	$ 15,915

	Home Health and Hospice Services	Senior Living Services	All Other	Total
Segment GAAP Financial Measures:		(In thousands)		
Three Months Ended September 30, 2019				
Revenue	$ 55,171	$ 33,227	$ —	$ 88,398
Segment Adjusted EBITDAR from Operations	$ 8,499	$ 11,574	$ (5,045)	$ 15,028
Three Months Ended September 30, 2018				
Revenue	$ 43,837	$ 29,116	$ —	$ 72,953
Segment Adjusted EBITDAR from Operations	$ 7,423	$ 11,499	$ (3,975)	$ 14,947

	Home Health and Hospice Services	Senior Living Services	All Other	Total
Segment GAAP Financial Measures:		(In thousands)		
Nine Months Ended September 30, 2019				
Revenue	$ 151,496	$ 97,543	$ —	$ 249,039
Segment Adjusted EBITDAR from Operations	$ 23,873	$ 35,703	$ (14,524)	$ 45,052
Nine Months Ended September 30, 2018				
Revenue	$ 124,844	$ 85,877	$ —	$ 210,721
Segment Adjusted EBITDAR from Operations	$ 19,886	$ 34,774	$ (12,034)	$ 42,626

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2019	2018	2019	2018
	(In thousands)			
Total Combined Adjusted EBITDAR from Operations[a]	$ 15,028	$ 14,947	$ 45,052	$ 42,626
Less: Depreciation and amortization	1,071	742	2,843	2,177
Rent—cost of services	8,538	7,776	25,368	23,065
Adjustments to Combined EBITDAR from Operations:				
Less: Costs at start-up operations[b]	60	56	377	92
Share-based compensation expense[c]	268	613	1,395	1,790
Acquisition related costs[d]	72	—	613	—
Spin-off related transaction costs[e]	3,372	—	8,020	—
Add: Net income attributable to noncontrolling interest	279	43	629	413
Combined Income from Operations	$ 1,926	$ 5,803	$ 7,065	$ 15,915

(a) Adjusted EBITDAR from Operations is Net Income attributable to the Company's reportable segments excluding the interest expense; provision for income taxes; depreciation and amortization expense; rent; start-up costs; acquisitions costs; and stock-based compensation expense. General and administrative expenses are not allocated to the reportable segments, accordingly the segment earnings measure reported is before allocation of corporate general and administrative expenses. The Company's CODM uses Adjusted EBITDAR from Operations as the primary measure of profit and loss for the Company's reportable segments and to compare the performance of its operations with those of its competitors. In order to view the operations performance, the Company excludes from the EBITDAR calculations for the reportable segments the following: 1) costs at start-up operations, 2) share-based compensation, 3) acquisition related costs, and 4) transaction costs. Also, the Company's segment measures may be different from the calculation methods used by other companies and, therefore, comparability may be limited.
(b) Represents results related to start-up operations. This amount excludes rent, depreciation and amortization expense.
(c) Share-based compensation expense incurred and included in cost of services.
(d) Acquisition related costs that are not capitalizable.
(e) Costs incurred related to the Spin-Off are included in general and administrative expense.

Performance and Valuation Measures:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2019	2018	2019	2018
	(In thousands)			
Combined Non-GAAP Financial Measures:				
Performance Metrics				
Combined EBITDA	$ 2,718	$ 6,502	$ 9,279	$ 17,679
Combined Adjusted EBITDA	$ 6,494	$ 7,180	$ 19,697	$ 19,583
Valuation Metric				
Combined Adjusted EBITDAR	$ 15,028		$ 45,052	

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2019	2018	2019	2018
	(In thousands)			
Segment Non-GAAP Measures:[a]				
Segment Adjusted EBITDA				
Home health and hospice services	$ 7,778	$ 6,850	$ 21,747	$ 18,237
Senior living services	$ 3,761	$ 4,305	$ 12,474	$ 13,380

(a) General and administrative expenses are not allocated to any segment for purposes of determining segment profit or loss.

The tables below reconciles Combined Net Income to Combined EBITDA, and Combined Adjusted EBITDAR for the periods presented:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2019	2018	2019	2018
	(In thousands)			
Combined Net income	$ 1,803	$ 4,415	$ 6,974	$ 12,327
Less: Net income attributable to noncontrolling interest	279	43	629	413
Add: Provision for income taxes (benefit)	123	1,388	91	3,588
Depreciation and amortization	1,071	742	2,843	2,177
Combined EBITDA	2,718	6,502	9,279	17,679
Adjustments to Combined EBITDA				
Add: Costs at start-up operations[(a)]	60	56	377	92
Share-based compensation expense[(b)]	268	613	1,395	1,790
Acquisition related costs[(c)]	72	—	613	—
Spin-off related transaction costs[(d)]	3,372	—	8,020	—
Rent related to items (a) above	4	9	13	22
Combined Adjusted EBITDA	6,494	7,180	19,697	19,583
Rent—cost of services	8,538	7,776	25,368	23,065
Rent related to items (a) above	(4)	(9)	(13)	(22)
Adjusted rent—cost of services	8,534	7,767	25,355	23,043
Combined Adjusted EBITDAR	$ 15,028		$ 45,052	

(a) Represents results related to start-up operations. This amount excludes rent, depreciation and amortization expense.
(b) Share-based compensation expense incurred.
(c) Acquisition related costs that are not capitalizable.
(d) Costs incurred related to the Spin-Off are included in general and administrative expense.

The tables below reconcile Segment Adjusted EBITDAR from Operations to Segment Adjusted EBITDA for the periods presented:

	Three Months Ended September 30,			
	Home Health and Hospice		Senior Living	
	2019	2018	2019	2018
	(In thousands)			
Segment Adjusted EBITDAR from Operations	$ 8,499	7,423	$ 11,574	$ 11,499
Less: Rent—cost of services	725	582	7,813	7,194
Rent related to start-up operations	(4)	(9)	—	—
Segment Adjusted EBITDA	$ 7,778	$ 6,850	$ 3,761	$ 4,305

	Nine Months Ended September 30,			
	Home Health and Hospice		Senior Living	
	2019	2018	2019	2018
	(In thousands)			
Segment Adjusted EBITDAR from Operations	$ 23,873	$ 19,886	$ 35,703	$ 34,774
Less: Rent—cost of services	2,139	1,671	23,229	21,394
Rent related to start-up operations	(13)	(22)	—	—
Segment Adjusted EBITDA	$ 21,747	$ 18,237	$ 12,474	$ 13,380

The following discussion includes references to certain performance and valuation measures, which are non-GAAP financial measures including Combined EBITDA, Combined and Segment Adjusted EBITDA, and Combined Adjusted EBITDAR

(collectively, "Non-GAAP Financial Measures"). Non-GAAP Financial Measures are used in addition to and in conjunction with results presented in accordance with GAAP, and should not be relied upon to the exclusion of GAAP financial measures. Non-GAAP Financial Measures reflect an additional way of viewing aspects of our operations and company that, when viewed with our GAAP results and the accompanying reconciliations to corresponding GAAP financial measures, we believe can provide can provide a more comprehensive understanding of factors and trends affecting our business.

We believe these Non-GAAP Financial Measures are useful to investors and other external users of our financial statements regarding our results of operations because:

- they are widely used by investors and analysts in our industry as a supplemental measure to evaluate the overall performance of companies in our industry without regard to items such as interest expense, rent expense and depreciation and amortization, which can vary substantially from company to company depending on the book value of assets and the method by which assets were acquired; and
- they help investors evaluate and compare the results of our operations from period to period by removing the impact of our asset base from our operating results.
- in the case of Combined Adjusted EBITDAR, the valuation metric is used by investors and analysts in our industry to value the companies in our industry without regard to capital structures.

We use Non-GAAP Financial Measures:

- as measurements of our operating performance to assist us in comparing our operating performance on a consistent basis;
- to allocate resources to enhance the financial performance of our business;
- to assess the value of a potential acquisition;
- to assess the value of a transformed operation's performance;
- to evaluate the effectiveness of our operational strategies; and
- to compare our operating performance to that of our competitors.

We typically use Non-GAAP Financial Measures to compare the operating performance of each operation. We find that Non-GAAP Financial Measures are useful for this purpose because they do not include such costs as interest expense, income taxes, depreciation and amortization expense, which may vary from period-to-period depending upon various factors, including the method used to finance operations, the date of acquisition of a community or business, and the tax law of the state in which a business unit operates.

We also establish compensation programs and bonuses for our leaders that are partially based upon the achievement of Combined Adjusted EBITDAR targets.

Non-GAAP Financial Measures have no standardized meaning defined by GAAP. Therefore, our Non-GAAP Financial Measures have limitations as analytical tools, and they should not be considered in isolation, or as a substitute for analysis of our results as reported in accordance with GAAP. Some of these limitations are:

- they do not reflect our current or future cash requirements for capital expenditures or contractual commitments;
- they do not reflect changes in, or cash requirements for, our working capital needs;
- they do not reflect the net interest expense, or the cash requirements necessary to service interest or principal payments, on our debt;
- they do not reflect rent expenses, which are normal and recurring operating expenses that are necessary to operate our leased operations, in the case of Combined Adjusted EBITDAR;
- they do not reflect any income tax payments we may be required to make;
- although depreciation and amortization are non-cash charges, the assets being depreciated and amortized will often have to be replaced in the future, and do not reflect any cash requirements for such replacements; and
- other companies in our industry may calculate the same Non-GAAP Financial Measures differently than we do, which may limit their usefulness as comparative measures.

We compensate for these limitations by using Non-GAAP Financial Measures only to supplement net income on a basis prepared in accordance with GAAP in order to provide a more complete understanding of the factors and trends affecting our business.

Management strongly encourages investors to review our Interim Financial Statements in their entirety and to not rely on any single financial measure. Because these Non-GAAP Financial Measures are not standardized, it may not be possible to compare these financial measures with other companies' non-GAAP financial measures having the same or similar names. These Non-GAAP Financial Measures should not be considered a substitute for, nor superior to, financial results and measures determined

or calculated in accordance with GAAP. We strongly urge you to review the reconciliation of income from operations to the Non-GAAP Financial Measures in the table below, along with our Interim Financial Statements and related notes included elsewhere in this report.

We use the following Non-GAAP Financial Measures that we believe are useful to investors as key valuation and operating performance measures:

Performance Measures:

Combined EBITDA

We believe Combined EBITDA is useful to investors in evaluating our operating performance because it helps investors evaluate and compare the results of our operations from period to period by removing the impact of our asset base (depreciation and amortization expense) from our operating results.

We calculate Combined EBITDA as net income, adjusted for net income attributable to noncontrolling interest, before (a) interest expense (b) provision for income taxes and (c) depreciation and amortization.

Combined Adjusted EBITDA

We adjust Combined EBITDA when evaluating our performance because we believe that the exclusion of certain additional items described below provides useful supplemental information to investors regarding our ongoing operating performance. We believe that the presentation of Combined Adjusted EBITDA, when considered with Combined EBITDA and GAAP net income attributable to us is beneficial to an investor's complete understanding of our operating performance.

We calculate Combined Adjusted EBITDA by adjusting Combined EBITDA to exclude the effects of non-core business items, which for the reported periods includes, to the extent applicable:

- costs at start-up operations;
- share-based compensation expense;
- acquisition related costs; and
- spin-off related transaction costs.

Segment Adjusted EBITDA

We adjust Segment Adjusted EBITDAR when evaluating our performance because we believe that the inclusion of rent-cost of services provides useful supplemental information to investors regarding our ongoing operating performance.

We calculate Segment Adjusted EBITDA by adjusting Segment Adjusted EBITDAR to include rent-cost of services.

***Valuation Measure*:**

Combined Adjusted EBITDAR

We use Combined Adjusted EBITDAR as one measure in determining the value of prospective acquisitions. It is also a measure commonly used measure by our management, research analysts and investors, to compare the enterprise value of different companies in the healthcare industry, without regard to differences in capital structures and leasing arrangements. Additionally, we believe the use of Combined Adjusted EBITDAR allows management, research analysts and investors to compare operational results of companies that have operating and finance leases. A significant portion of finance lease expenditures are recorded in interest, whereas operating lease expenditures are recorded in rent expense.

This measure is not displayed as a performance measure as it excludes rent expense, which is a normal and recurring operating expense. This measure does not reflect our cash requirements for leasing commitments. As such, our presentation of Combined Adjusted EBITDAR, should not be construed as a financial performance measure.

The adjustments made and previously described in the computation of Combined Adjusted EBITDAR are also made when computing Combined Adjusted EBITDAR. We calculate Combined Adjusted EBITDAR by excluding rent-cost of services and rent related to start up operations from Combined Adjusted EBITDA.

Three Months Ended September 30, 2019 Compared to the Three Months Ended September 30, 2018

Revenue

	Three Months Ended September 30,			
	2019		2018	
	Revenue Dollars	Revenue Percentage	Revenue Dollars	Revenue Percentage
	(In thousands)			
Home health and hospice services				
Home health[(a)]	$ 21,307	24.1%	$ 18,323	25.1%
Hospice	29,188	33.0	21,577	29.6
Home care and other[(a)]	4,676	5.3	3,937	5.4
Total home health and hospice services	55,171	62.4	43,837	60.1
Senior living services	33,227	37.6	29,116	39.9
Total revenue	$ 88,398	100.0%	$ 72,953	100.0%

(a) Home care and other revenue is included with home health revenue in other disclosures in this report.

Our combined revenue increased $15.4 million, or 21.2%. Revenue from operations acquired on or subsequent to October 1, 2018 increased our combined revenue by $10.1 million or 13.8% during the three months ended September 30, 2019 when compared to the same period in 2018.

Home Health and Hospice Services

	Three Months Ended September 30,			
	2019	2018	Change	% Change
	(In thousands)			
Home health and hospice revenue:				
Home health services	$ 21,307	$ 18,323	$ 2,984	16.3%
Hospice services	29,188	21,577	7,611	35.3
Home care and other	4,676	3,937	739	18.8
Total home health and hospice revenue	$ 55,171	$ 43,837	$ 11,334	25.9%
Home health services:				
Total home health admissions	5,556	4,523	1,033	22.8%
Average Medicare revenue per 60-day completed episode	$ 3,173	$ 3,001	$ 172	5.7
Hospice services:				
Average daily census	1,788	1,379	409	29.7
Hospice Medicare revenue per day	$ 163	$ 159	$ 4	2.5
Number of agencies at period end	63	50	13	26.0%

Home health and hospice revenue increased $11.3 million, or 25.9%. Medicare and managed care revenue increased $8.6 million, or 23.7%. The increase in revenue is due to growth in all key metrics listed above, and primarily driven by increases in total home health admissions of 22.8% and average daily census of 29.7%. Further revenue growth from operations acquired on or subsequent to October 1, 2018 increased our revenue by $6.8 million or 15.6% during the three months ended September 30, 2019 from the addition of thirteen home health, hospice and home care operations.

Senior Living Services

	Three Months Ended September 30,			
	2019	2018	Change	% Change
	(In thousands)			
Revenue	$ 33,227	$ 29,116	$ 4,111	14.1%
Number of communities at period end	52	45	7	15.6%
Occupancy percentage (units)	79.6%	80.0%	(0.4)%	
Average monthly revenue per occupied unit	$ 3,111	$ 3,032	$ 79	2.6%

Senior living revenue increased $4.1 million, or 14.1%, for the three months ended September 30, 2019 when compared to the same period in the prior year. This is due primarily to an increase of $3.3 million or 11.5% in revenue from the addition of seven senior living operations acquired on or subsequent to October 1, 2018.

Cost of Services

The following table sets forth total cost of services by each of our reportable segments for the periods indicated:

	Cost of Services	
	Three Months Ended September 30, 2019	
	2019	2018
	(In thousands)	
Home Health and Hospice	$ 46,570	$ 36,478
Senior Living	21,716	17,689
Total cost of services	$ 68,286	$ 54,167

Combined cost of services increased $14.1 million or 26.1%. Combined cost of services as a percentage of revenue increased by 3.0% to 77.2% compared to the three months ended September 30, 2018.

Home Health and Hospice Services

	Three Months Ended September 30, 2019			
	2019	2018	Change	% Change
	(In thousands)			
Cost of service	$ 46,570	$ 36,478	$ 10,092	27.7%
Cost of services as a percentage of revenue	84.4%	83.2%	1.2%	

Cost of services related to our home health and hospice services segment increased $10.1 million, or 27.7%, primarily due to increased volume and higher operating costs related to acquisitions.

Senior Living Services

	Three Months Ended September 30,			
	2019	2018	Change	% Change
	(In thousands)			
Cost of service	$ 21,716	$ 17,689	$ 4,027	22.8%
Cost of services as a percentage of revenue	65.4%	60.8%	4.6%	

Cost of services related to our senior living services segment increased $4.0 million, or 22.8% and by 4.6% as a percent of revenue as a result of the increase in costs associated with newly acquired communities and additional field-based resources to support our growing infrastructure. Our acquisition focus is to opportunistically acquire underperforming operations. Historically, we generally experienced higher cost of services at newly acquired operations; and therefore, we anticipate fluctuation in cost of services as a percentage of revenue during years of acquisition growth.

Rent - Cost of Services. While actual rent increased from $7.8 million in the three months ended September 30, 2018 to $8.5 million in the three months ended September 30, 2019, rent as a percentage of total revenue decreased by 1.0% to 9.7% in the three months ended September 30, 2019 compared to the three months ended September 30, 2018, as the growth in revenue outpaced the increase in rent expense.

General and Administrative Expense. Our general and administrative expense increased from 6.1% to 9.7%, or from $4.5 million to $8.6 million in the three months ended September 30, 2019, primarily due to an increase in transaction related costs of $3.4 million or 3.8%. Without the transaction costs related to the Spin-Off, general and administrative expense as a percentage of revenue would have slightly decreased. Additionally, in the three months ended September 30, 2019, general and administrative expenses of $0.3 million were incurred as additions to the Company's ongoing cost structure in support of being a public company. The majority of general and administrative expenses relate to cost allocations for certain shared services provided to us by Ensign subsidiaries. Such allocations include, but are not limited to, executive management, accounting, human resources, information technology, compliance, legal, payroll, insurance, tax, treasury, and other general and administrative items. These costs were allocated to us on a basis of revenue, location, employee count, or other measures.

Depreciation and Amortization. Depreciation and amortization expense remained flat as a percentage of total revenue.

Provision for Income Taxes. Income tax expense recorded for the three months ended September 30, 2019 reflects tax benefits of approximately $0.4 million from share-based payment awards that were partially offset by non-deductible items. See *Note 11, Income Taxes*, to the Interim Financial Statements included elsewhere in this Quarterly Report on Form 10-Q for further discussion.

Nine Months Ended September 30, 2019 Compared to the Nine Months Ended September 30, 2018

Revenue

	Nine Months Ended September 30,			
	2019		2018	
	Revenue Dollars	Revenue Percentage	Revenue Dollars	Revenue Percentage
	(In thousands)			
Home health and hospice services				
Home health[(a)]	$ 61,532	24.7%	$ 53,196	25.2%
Hospice	76,866	30.8	61,079	29.0
Home care and other[(a)]	13,098	5.3	10,569	5.0
Total home health and hospice services	151,496	60.8	124,844	59.2
Senior living services	97,543	39.2	85,877	40.8
Total revenue	$ 249,039	100.0%	$ 210,721	100.0%

(a) Home care and other revenue is included with home health revenue in other disclosures in this report.

Our combined revenue increased $38.4 million, or 18.2%. Revenue from operations acquired on or subsequent to October 1, 2018 increased our combined revenue by $19.9 million or 9.4% during the nine months ended September 30, 2019 when compared to the same period in 2018.

Home Health and Hospice Services

	Nine Months Ended September 30,			
	2019	2018	Change	% Change
	(In thousands)			
Home health and hospice revenue				
Home health services	$ 61,532	$ 53,196	$ 8,336	15.7%
Hospice services	76,866	61,079	15,787	25.8
Home care and other	13,098	10,569	2,529	23.9
Total home health and hospice revenue	$ 151,496	$ 124,844	$ 26,652	21.3%
Home health services:				
Total home health admissions	16,723	13,496	3,227	23.9%
Average Medicare Revenue per 60-day Completed Episode	$ 3,072	$ 2,968	$ 104	3.5
Hospice services:				
Average daily census	1,625	1,310	315	24.0
Hospice Medicare revenue per day	$ 164	$ 160	$ 4	2.5
Number of agencies at period end	63	50	13	26.0%

Home health and hospice revenue increased $26.7 million, or 21.3%. Medicare and managed care revenue increased $20.1 million, or 19.3%. The increase in revenue is due to growth in all key metrics listed above, and primarily driven by increases in total home health admissions of 23.9% and average daily census of 24.0%. Further growth was driven by an increase of $11.1 million or 8.9% from the addition of thirteen home health, hospice and home care operations between October 1, 2018 and September 30, 2019.

Senior Living Services

	Nine Months Ended September 30,			
	2019	2018	Change	% Change
	(In thousands)			
Revenue	$ 97,543	$ 85,877	$ 11,666	13.6%
Number of communities at period end	52	45	7	15.6%
Occupancy percentage (units)	79.9%	79.1%	0.8%	
Average monthly revenue per occupied unit	$ 3,110	$ 3,046	$ 64	2.1%

Senior living revenue increased $11.7 million, or 13.6%, for the nine months ended September 30, 2019 when compared to the same period in the prior year. We experienced an increase in occupancy of 0.8%, coupled with an increase of $8.8 million or 10.3% in revenue from the addition of seven senior living operations acquired between October 1, 2018 and September 30, 2019.

Cost of Services

The following table sets forth total cost of services by each of our reportable segments for the periods indicated:

	Cost of Services	
	Nine Months Ended September 30,	
	2019	2018
	(In thousands)	
Home Health and Hospice	$ 128,013	$ 104,782
Senior Living	62,040	51,326
Total cost of services	$ 190,053	$ 156,108

Combined cost of services increased $33.9 million or 21.7%. Combined cost of services as a percentage of revenue increased by 2.2% to 76.3% compared to the nine months ended September 30, 2018.

Home Health and Hospice Services

	Nine Months Ended September 30,			
	2019	2018	Change	% Change
	(In thousands)			
Cost of service	$ 128,013	$ 104,782	$ 23,231	22.2%
Cost of services as a percentage of revenue	84.5%	83.9%	0.6%	

Cost of services related to our home health and hospice services segment increased $23.2 million, or 22.2%, primarily due to increased volume as well higher costs related to acquisitions. Included in cost of services is a one-time broker fee of $0.4 million related to new agencies acquired in the current period. Without this fee, cost of services would have been 84.2%, an increased of 0.3%.

Senior Living Services

	Nine Months Ended September 30,			
	2019	2018	Change	% Change
	(In thousands)			
Cost of service	$ 62,040	$ 51,326	$ 10,714	20.9%
Cost of services as a percentage of revenue	63.6%	59.8%	3.8%	

Cost of services related to our senior living services segment increased $10.7 million, or 20.9%, and by 3.8% as a percent of revenue as a result of the increase in costs associated with newly acquired communities and additional field-based resources to support our growing infrastructure. Our acquisition focus is to opportunistically acquire underperforming operations. Historically, we generally experienced higher cost of services at newly acquired operations; and therefore, we anticipate fluctuation in cost of services as a percentage of revenue during years of acquisition growth.

Rent - Cost of Services. While actual rent increased from $23.1 million in the nine months ended September 30, 2018 to $25.4 million in the nine months ended September 30, 2019, rent as a percentage of total revenue decreased by 0.7% to 10.2% in the nine months ended September 30, 2019 compared to the nine months ended September 30, 2018, as the growth in revenue outpaced the increase in rent expense.

General and Administrative Expense. Our general and administrative expense increased from 6.4% to 9.5%, or from $13.5 million to $23.7 million, primarily due to an increase in transaction related costs of $8.0 million or 3.2%. Without the transaction costs related to the Spin-Off, general and administrative expense as a percentage of revenue would have slightly

decreased. Additionally, in the nine months ended September 30, 2019, general and administrative expenses of $0.6 million were incurred as additions to the Company's ongoing cost structure in support of being a public company. The majority of general and administrative expenses relate to cost allocations for certain shared services provided to us by Ensign subsidiaries. Such allocations include, but are not limited to, executive management, accounting, human resources, information technology, compliance, legal, payroll, insurance, tax, treasury, and other general and administrative items. These costs were allocated to us on a basis of revenue, location, employee count, or other measures.

Depreciation and Amortization. Depreciation and amortization expense remained relatively flat as a percentage of total revenue.

Provision for Income Taxes. Income tax expense recorded for the nine months ended September 30, 2019 reflects tax benefits of approximately $1.7 million from share-based payment awards that were partially offset by non-deductible items. The rate is further impacted by transaction costs related to the Spin-Off that were deductible prior to completing the transaction on October 1, 2019.

See *Note 11, Income Taxes*, to the Interim Financial Statements included elsewhere in this report filed on Form 10-Q for further discussion.

The transaction costs related to the Spin-Off in general and administrative expense were deductible for tax purposes before the Spin-Off occurred. However, with the completion of the Spin-Off during the fourth quarter, a significant portion of those costs will likely be permanently nondeductible. We anticipate the nondeductible portion of the costs incurred in connection with the Spin-Off to date could increase the effective tax rate by between 15% and 25% in the fourth quarter.

Liquidity and Capital Resources

The cash presented in the combined balance sheets represents cash located at our operations. No cash was allocated to us in the Interim Financial Statements because the net activity of cash due to (from) Ensign is reflected in the net parent investment. Following the Spin-Off, we will no longer participate in a cash management arrangement with Ensign. Our principal sources of liquidity following the Spin-Off will be our cash on hand, our ability to generate cash through operations, and any available funding arrangements and financing facilities we enter into.

New Credit Agreement

Subsequent to the period ended September 30, 2019, on October 1, 2019, Pennant entered into a credit agreement (the "Credit Agreement"), which provides for a revolving credit facility with a syndicate of banks with a borrowing capacity of $75.0 million (the "Revolving Credit Facility"). The interest rates applicable to loans under the Revolving Credit Facility are, at the Company's election, either LIBOR ("Adjusted LIBOR" as defined in the Credit Agreement) plus a margin ranging from 2.5% to 3.5% per annum or Base Rate plus a margin ranging from 1.5% to 2.5% per annum, in each case based on the ratio of Consolidated Total Net Debt to Consolidated EBITDA (each, as defined in the Credit Agreement). In addition, Pennant will pay a commitment fee on the undrawn portion of the commitments under the Revolving Credit Facility that is estimated to be 0.6% per annum.

The Revolving Credit Facility will not be subject to interim amortization and the Company will not be required to repay any loans under the Revolving Credit Facility prior to maturity in 2024. The Company will be permitted to prepay all or any portion of the loans under the Revolving Credit Facility prior to maturity without premium or penalty, subject to reimbursement of any LIBOR breakage costs of the lenders.

In connection with the Spin-Off, we incurred outstanding indebtedness of $30.0 million. The amount reflects proceeds from issuance of indebtedness under the Revolving Credit Facility, including approximately $1.3 million in financing cost. The proceeds from the issuance of indebtedness were used to pay a dividend to Ensign of $11.6 million as well as spin-off related transaction costs and for general working capital purposes.

We believe that our existing cash, cash equivalents, cash generated through operations and our access to financing facilities, together with funding through third-party sources such as commercial banks, will be sufficient to fund our operating activities, anticipated capital expenditures and growth needs.

New Insurance Coverage

In connection with the Spin-off, the Company obtained stand-alone insurance policies to cover general and professional liability, workers compensation, and Directors and Officers liability. We believe the change in insurance coverage will not materially impact our cost of service or general and administrative cost structure.

The following table presents selected data from our combined statement of cash flows for the periods presented:

	Nine Months Ended September 30,	
	2019	2018
	(In thousands)	
Net cash provided by operating activities	$ 12,196	$ 16,202
Net cash used in investing activities	(22,506)	(5,545)
Net cash provided by/(used in) financing activities	10,316	(10,652)
Net increase in cash	6	5
Cash at beginning of year	41	36
Cash at end of year	$ 47	$ 41

Nine Months Ended September 30, 2019 Compared to Nine Months Ended September 30, 2018

Our net cash provided by operating activities for the nine months ended September 30, 2019 decreased by $4.0 million. The decrease was primarily due to a decrease in net income as a result of Spin-Off related transaction costs and cash used in support of newly acquired operations.

Our net cash used in investing activities for the nine months ended September 30, 2019 increased by $17.0 million. This use of cash is primarily attributable to our spending on business and asset acquisitions which increased by $16.8 million, and an increase in capital expenditure spending of $1.6 million.

Our net cash provided by/(used in) financing activities in all periods presented reflect net transactions with Ensign resulting from operating and investing activities discussed above.

Contractual Obligations, Commitments and Contingencies

The following table sets forth our lease obligations as of December 31, 2018, including the future periods in which payments are expected:

	2019	2020	2021	2022	2023	Thereafter	Total
	(In thousands)						
Operating lease obligations	$ 33,055	$ 32,181	$ 31,625	$ 31,241	$ 30,896	$ 243,333	$ 402,331

In connection with the Spin-Off, we amended our master lease agreements with Ensign and certain other landlords. Annual future minimum lease payments are expected to initially increase by approximately $3.6 million due to the modifications.

Inflation

We have historically derived a portion of our revenue from the Medicare program. We also derive revenue from state Medicaid and similar reimbursement programs. Payments under these programs generally provide for reimbursement levels that are adjusted for inflation annually based upon the state's fiscal year for the Medicaid programs and in October for the Medicare program. These adjustments may not continue in the future, and even if received, such adjustments may not reflect the actual increase in our costs for providing healthcare services.

Labor and supply expenses make up a substantial portion of our cost of services. Those expenses can be subject to increase in periods of rising inflation, increases to wage minimums, and when labor shortages occur in the marketplace. To date, we have

generally been able to implement cost control measures or obtain increases in reimbursement sufficient to offset increases in these expenses. We may not be successful in offsetting future cost increases.

Off-Balance Sheet Arrangements

We do not have any material off-balance sheet arrangements.

Item 3. *Quantitative and Qualitative Disclosures about Market Risk*

On October 1, 2019, in connection with the Spin-Off, we entered into a $75 million revolving credit facility which exposes us to market risk. Borrowings under the revolving credit facility are subject to variable interest rates. As a result, we will be exposed to fluctuations in interest rates to the extent of our borrowings under the revolving credit facility. See Note 15, *Subsequent Events* to our Interim Financial Statements presented herein and "Management's Discussion and Analysis of Financial Condition and Results of Operations—Liquidity and Capital Resources" for a description of our current indebtedness. We manage our exposure to these risks by monitoring available financing alternatives, through pricing policies and potentially entering into derivative arrangements. We will evaluate our exposure to fluctuations in interest rates and how to manage such exposure on an ongoing basis.

Item 4. *Controls and Procedures*

Evaluation of Disclosure Controls and Procedures

Under the supervision and with the participation of our management, including the Chief Executive Officer and Chief Financial Officer, we have evaluated the effectiveness of our disclosure controls and procedures (as such term is defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended), as of the end of the period covered by this report. Based on that evaluation, the Chief Executive Officer and Chief Financial Officer have concluded that these disclosure controls and procedures were effective to provide reasonable assurance that information we are required to disclose in reports that we file or submit under the Exchange Act is recorded, processed, summarized, and reported within the time periods specified in SEC rules and forms, and that such information is accumulated and communicated to our management, including our Chief Executive Officer and Chief Financial Officer, as appropriate, to allow timely decisions regarding required disclosure.

Changes in Internal Control over Financial Reporting

There were no material changes in our internal control over financial reporting (as such term is defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act) that occurred during our most recent fiscal quarter that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

PART II. OTHER INFORMATION

Item 1. ***Legal Proceedings***

The information provided in Note 14, *Commitments and Contingencies* included in Part 1, Item 1 of this Quarterly Report on Form 10-Q.

Item 1A. **Risk Factors**

We have disclosed under the heading "Risk Factors" in our Information Statement included as Exhibit 99.1 to our Registration Statement on Form 10 (File No. 001-38900), filed with the SEC on September 3, 2019, risk factors that materially affect our business, financial condition or results of operations.

Other than the item discussed below, there have been no material changes from the risk factors previously disclosed. You should carefully consider the risk factors set forth in the Information Statement and the other information set forth elsewhere in this Quarterly Report on Form 10-Q. You should be aware that these risk factors and other information may not describe every risk facing our Company. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial also may materially adversely affect our business, financial condition and/or operating results.

Our revenue could be impacted by federal and state changes to reimbursement and other aspects of Medicaid and Medicare.

On October 31, 2019, CMS issued its 2020 HH PPS final rule. The final rule implements the Patient-Driven Groupings Model (PDGM), a revised case mix adjustment methodology, for all home health episodes that begin on or after January 1, 2020. PDGM changes the unit of home health payment from a 60-day episode to a 30-day period and refines case mix calculation by removing therapy thresholds and adjusting reimbursement based on patient characteristics such as principal diagnoses and clinical grouping, functional impairment levels, comorbidities, and admission source and timing. CMS estimates the final rule will result in a $250 million (1.3%) increase in payments to home health providers in 2020, including a negative 4.36% behavioral change assumption. The final rule confirms that Requests for Anticipated Payment ("RAPs") will be phased out partially in 2020 and fully eliminated in 2021. The final rule also modifies the Home Health Value Based Purchasing model, updates Home Health Quality Reporting Program requirements, and finalizes home unfusion therapy payment provisions.

Item 2. ***Unregistered Sales of Equity Securities and Use of Proceeds***

None.

Item 3. ***Defaults Upon Senior Securities***

None.

Item 4. ***Mine Safety Disclosures***

None.

Item 5. ***Other Information***

None.

Item 6. Exhibits

EXHIBIT INDEX

Exhibit	Description
31.1	Certification of Chief Executive Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
31.2	Certification of Chief Financial Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1	Certification of Chief Executive Officer pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
32.2	Certification of Chief Financial Officer pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
101.INS	XBRL Instance Document - the instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document.
101.SCH	Inline XBRL Taxonomy Extension Schema Document
101.CAL	Inline XBRL Taxonomy Extension Calculation Linkbase Document
101.DEF	Inline XBRL Taxonomy Extension Definition Linkbase Document
101.LAB	Inline XBRL Taxonomy Extension Label Linkbase Document
101.PRE	Inline XBRL Taxonomy Extension Presentation Linkbase Document

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

The Pennant Group, Inc.

November 12, 2019

BY: /s/ JENNIFER L. FREEMAN

Jennifer L. Freeman

Chief Financial Officer (Principal Financial Officer and Duly Authorized Officer)

Exhibit 10

In-Service Training Policies & Procedures

TRAINING/INSERVICE EDUCATION
Policy No. 1-028.1

PURPOSE

To delineate organization policies for inservice education programs designed to increase competence in a specific area and improve overall organization performance of major functions and processes.

POLICY

1. Puget Sound Hospice will provide training and education to give personnel opportunities to learn new skills and improve/expand existing knowledge. Training topics may include information regarding the organization's professional standards of care/practice, performance improvement monitoring results, updates in patient care techniques/resources, and safety/infection control requirements.

2. Mandatory inservices will be attended by all disciplines.

3. Attendance at education programs will be required relative to job classification.

4. Professional personnel will receive at least the number of continuing education units to maintain their licenses. Professional staff (direct care staff) will receive at least twelve (12) hours of inservice training per calendar year.

5. Paraprofessional personnel will receive education as follows:

    A. Aides (CNAs/HAs) must receive at least twelve (12) hours of inservice training per calendar year. This may be provided while the aide is furnishing care to patients. Note: Any education offering must be supervised by a RN.

    B. Personal care workers must receive at least twelve (12) hours of inservice training per calendar year. This may be provided while the worker is furnishing care to patients.

    C. Chore workers must receive at least twelve (12) hours of inservice training per calendar year. This may be provided while the worker is furnishing care to patients.

6. NON DIRECT Care Staff must receive at least eight (8) hours of inservice training per calendar year

PROCEDURE:

1. The written plan for annual inservices will include, but not be limited to:

    A. Safety; patient and personnel including emergency management plan

    B. Infection control

C. Psychosocial considerations, including methods for coping with work related issues of grief, loss and change

D. Skills updates

E. Issues related to patient populations served including cultural diversity and communication barriers

F. Ethical issues

G. Medical Device Act, Safety testing of equipment used in the work environment

H. Emergency/disaster training

I. Patient Bill of Rights including handling of complaints/grievances

J. Compliance Plan and HIPAA

K. OSHA

2. Personnel will receive notification of organization-sponsored programs at least one (1) week in advance.

3. A record will be maintained for each session, including:

   A. Program objectives

   B. Content outline

   C. Speaker (and his/her qualifications)

   D. List of attendees

4. An inservice log will be kept to track the number of inservice hours the aides (CNAs/HAs) and all staff have obtained on a cumulative basis.

5. During ongoing supervision and competency reviews, the supervisors will evaluate if the training and education has improved the competence of the organization personnel.

ORIENTATION
Policy No. 1-022.1

PURPOSE

To provide guidelines for the orientation process.

POLICY

All personnel will be required to attend an orientation program upon employment and at the time of reassignment. The goal of orientation will be to inform and instruct new personnel regarding Puget Sound Hospice's mission, policies and procedures, benefits (if applicable), the performance appraisal process, competency testing, as well as individual responsibilities and relationships to other personnel.

All personnel will demonstrate knowledge and proficiency in skills appropriate to their assigned responsibilities during the orientation period.

All clinical personnel prior to being assigned to care must present documentation of current CPR certification. CPR certification must be renewed per American Heart Association guidelines.

(See "Competency Based Orientation" Policy No. 3-002.)

PROCEDURE

1. The orientation content for all personnel will include the following as applicable and appropriate to the care and service provided:

    A. General company orientation including the organization's mission/philosophy, policy and procedures, environmental safety program, etc.

    B. Review of organizational chart and lines of authority and responsibility

    C. Hours of work

    D. Job related responsibilities (job description), including orientation to equipment, if applicable

    E. Care and services provided by the organization; diseases and medication conditions common to hospice

    F. Baseline skills assessments as applicable to job classification

    G. Infection prevention and control within the organization and the home care setting

    H. Performance standards

I. Confidentiality of organization and patient information/HIPAA regulations

J. Documentation requirements (record keeping and requirements)

K. OSHA compliance

L. Medical Device Reporting/Incident Reporting

M. Equal Employment Opportunity Act

N. Ethical issue identification and resolution including conflict of interest, professional boundaries, etc.

O. Sexual Harassment Act

P. Compensation and benefits information (salary/wages, benefits, etc.)

Q. Unemployment and workers' compensation

R. Malpractice coverage, as applicable

S. Collective bargaining information, as applicable

T. Drug testing

U. Family/State Medical Leave Act

V. Cultural Diversity and communication barriers

W. Client/Patient Rights including Advance Directives

X. Standards of Conduct and Ethical Issues

Y. QAPI and activities

Z. Concept of death, dying, hospice philosophy, bereavement, caregiver as unit of service, etc.

AA. Pain and symptom management

BB. Emotional support of staff and client/patient (stress management)

CC. Compliance Plan and employee compliance responsibilities

DD. Emergency Management Plan for the organization and the employee's family emergency response plan

EE. Handling of patient complaints/grievances

FF. If applicable, converging of charges for care/services

2. The orientation process, for all personnel will consist of both didactic and field supervision. Observation visits will be made by an appropriate supervisor to assess the skills demonstrated by new or reassigned personnel as well as reinforce the information presented during classroom time.

3. The orientation process for contract personnel will consist of the following:

   A. For contract personnel, the contracted organization will have one (1) member of the organization that has been oriented to Puget Sound Hospice policies, procedures, and information presented during orientation. That individual will be responsible for orienting other contract personnel from that organization to Puget Sound Hospice.

   B. For personnel the organization individually contracts with, a preceptor will be assigned during the orientation process.

4. During the orientation process, the supervisor will be responsible for evaluating the knowledge and skills of the personnel being oriented. Any areas of concern will be brought to the immediate attention of the new personnel. Appropriate guidance/monitoring will be provided or additional training recommended, if needed.

5. Assigned personnel will orient newly assigned personnel or volunteers to their responsibilities and to the patient needs when changes in patient assignment occur. The following will be included as appropriate:

   A. Patient needs including physical, psychosocial, and environmental aspects of care and service

   B. Personnel responsibilities

   C. Specific care and services to be provided

6. Orientation of new and reassigned personnel may include verbal or written instructions. Orientation may be provided in the patient's home.

7. Orientation of current employees assigned to new job classifications will include.

   A. Lines of authority and responsibility

   B. Hours of work

   C. Job responsibilities

   D. Skills assessment as applicable to the specific job classification

   E. Documentation responsibilities

8. A Personnel Orientation Checklist (See "Personnel Orientation Checklist" Addendum 1-022.A.) will be completed for all new personnel. New personnel will sign and date when their orientation has been completed.

9. The supervisor will sign and date the checklist when new personnel have completed all the required activities.

10. The probationary period will be 90 days, during which time the orientation process may be extended if the supervisor, or employee feels it is warranted.

ADDENDUM 1-022.A

PERSONNEL ORIENTATION CHECKLIST

PERSONNEL ORIENTATION CHECKLIST

Name: _____ Date:_____

CHECKLIST	DATE COMPLETED	ORIENTATION BY WHOM	PERSONNEL INITIALS
1. Tour of office/Introduction of organization personnel			
2. Introduction to work stations			
3. Completion of all employment forms			
4. Personnel file A. Application B. Sign job description (copy to personnel) C. Professional license, certification, registration, CPR documentation, as appropriate D. Driver's license, as appropriate E. Proof of auto insurance, as appropriate F. Physical exam, drug test, as appropriate G. TB Screening, as appropriate H. Hep B vaccination, as appropriate I. Standard precautions orientation J. Criminal background check/National Sex Offender Registry check K. OIG Exclusion List check verification			
5. Name and Photo Identification			
6. The orientation content for all personnel will include the following as applicable and appropriate to the care and service provided: A. General orientation to organization, including philosophy, mission, and purpose, policies and procedures, environmental safety program B. Review of organizational chart and lines of authority and responsibility C. Hours of work D. Job related responsibilities E. Care and services provided by the organization F. Baseline skills assessments as applicable to job classification G. Infection prevention and control within the organization and home care setting H. Performance standards I. Confidentiality of organization and patient information/HIPAA J. Documentation requirements (Record keeping and reporting) K. OSHA compliance L. Medical Device Reporting M. Equal Employment Opportunity Act N. Ethical issue identification, resolution and boundaries/Standards of Conduct O. Sexual Harassment Act P. Compensation and benefits Q. Unemployment and workers compensation R. Malpractice coverage, as applicable S. Collective bargaining information, as applicable T. Drug testing U. Family/State Medical Leave Act			

CHECKLIST	DATE COMPLETED	ORIENTATION BY WHOM	PERSONNEL INITIALS
V. Cultural Diversity/Communication barriers W. Patient/Client Rights and Handling of patient complaints X. Concepts of death, dying and bereavement Y. Pain and symptom management Z. Emotional support of staff and patient (Stress management) AA. Advance Directives BB. Conflict of Interest CC. QAPI Plan DD. Incident/Variance Reporting EE. Compliance Program/Employee Responsibilities FF. Emergency Management Plan GG. Intro to hospice/hospice philosophy, unit of service, emotional support, psychosocial and spiritual issues HH. Diseases/Conditions common to hospice II. Job specific: medical equipment, special populations			
7. Orientation to job description and job responsibilities (list or cross-reference)			
8. Skills/Competency Assessment (list or cross-reference)			

PERSONNEL DEVELOPMENT
Policy No. 1-023.1

PURPOSE

To ensure ongoing training and development for all personnel to maintain competence in assigned duties.

POLICY

Puget Sound Hospice will provide for personnel development including, but not limited to, continuing education, inservices, training sessions, one-on-one mentoring, and continuing education. Documentation of attendance will be requested and filed in the personnel file.

PROCEDURE

1. The need for training and education is determined by:

   A. Requests of personnel

   B. Specific patient care/service needs

   C. New assignments

   D. New technology

   E. New care/service

2. Needs assessment forms will be distributed to personnel as appropriate to determine their interest for inservice planning. (See "Personnel Development/Inservice Needs Assessment" Addendum 1-023.A.)

3. At the discretion of Puget Sound Hospice, internal and external continuing education will be sponsored.

4. Continuing education provided internally by the organization may take the form of:

   A. Formal presentations

   B. Documented "on the job specialty training"

   C. Distance learning

5. Personnel will be encouraged to participate in self-development and learning through the following means, but not limited to:

A. Membership in professional organization

B. Self-directed learning modules

C. Attendance at continuing education seminars

D. Satellite learning

E. Formal courses of study

F. Mentoring

6. An attendance record of all inservice/organization personnel development programs offered will be maintained by the organization. The organization will also validate continuing education units (CEUs) per applicable state licensure law for direct care, independent contractor, and subcontract personnel.

7. Personnel will be requested to provide feedback using an inservice evaluation form regarding the content, value, and applicability of all inservice education offered by the organization. Personnel feedback will be used to evaluate the education provided by the organization and to assist in the development of future education programs.

8. Puget Sound Hospice requires that each staff member complete a minimum of the following programs each year. Any employee that fails to attend the annual mandatory training is subject to disciplinary action up to and including termination. These mandatory inservices include:

   A. Standard Precautions and Infection Control

   B. Safety Program including OSHA (Safety Data Sheet Elements) and Medical Device Reporting Compliance

   C. Body Mechanics

   D. Emergency Management Plan/Disaster Training

   E. Corporate Compliance and Standards of Conduct

   F. HIPAA

   G. Complaints and Grievances

   H. Cultural diversity and communication barriers

   I. Patient rights and responsibilities

   J. Ethics training

9. In addition, clinical personnel must attend a minimum of the following:

A. CPR (when appropriate).

B. All clinical staff and hospice aides will attend 12 hours of inservice education annually.

10. Non-clinical personnel are required to attend a minimum of eight (8) hours of ongoing education annually, which includes all mandatory inservices listed above.

11. When new information pertaining to discipline specific practice is received by the organization, it will be provided to personnel during the next regularly scheduled personnel meeting.

ADDENDUM 1-023.A

PERSONNEL DEVELOPMENT/INSERVICE NEEDS ASSESSMENT

PERSONNEL DEVELOPMENT/INSERVICE NEEDS ASSESSMENT
PERSONNEL SURVEY

Date: _____

Your classification: _____

Year license/certification received (if applicable): _____

Approximately how many hours per week do you work? _____

Approximately how many continuing educational activities have you attended in the past 12 months?

_____

Were they accredited programs? _____

What type of inservices or personnel development programs would you like to see offered? Please list:

_____

_____

_____

_____

_____

Additional comments: _____

_____

Please return form to the Executive Director/Administrator.

RESOURCE INFORMATION
Policy No. 1-024.1

PURPOSE

To establish guidelines for the maintenance of relevant literature and information.

POLICY

The organization will maintain clinical, scientific, and management literature and identify community resources for use in designing, managing, and improving patient-specific and organizational processes.

PROCEDURE

1. The Education Coordinator will be responsible for maintaining authoritative and up-to-date resource information for the organization.

2. Resource information will include, but will not be limited to:

   A. Industry related journals (i.e., Home Health Line, Caring, etc.)

   B. Home care manuals (i.e., Aspen's Manual of Policies and Procedures)

   C. Clinical resources specific to discipline (i.e., Lippincott's Manual of Nursing Practice)

   D. Performance improvement resources (i.e., QAPI, etc.)

   E. Films/videos (i.e., OSHA Bloodborne Pathogens, etc.)

   F. Listing of community resources available to patients and organization personnel

   G. Pamphlets from national agencies, pharmaceutical companies, etc.

   H. Current medical dictionary

   I. Current statutes and rules related to clinical practice acts

   J. Current billing resources: ICD-10-CM manuals, HCPCS and CPT coding manuals, other revenue code guides

3. All organization personnel will have access to the resource information. Each item will be checked out and returned within a reasonable period of time.

4. Requests for additional resource information will be made to the appropriate supervisor who will respond in a timely manner to the request.

5. Information that is needed but not accessible internally, such as practice guidelines, will be secured, if applicable and accessible, through a community resource such as a hospital library, medical center library, etc.

COMPETENCY PROGRAM
Policy No. 1-025.1

PURPOSE

To ensure that the competence of clinical organization personnel is assessed, maintained, and improved on a continuing basis.

POLICY

Puget Sound Hospice will define and implement an objective, measurable assessment system to evaluate the competency of patient contact personnel.

Personnel will demonstrate knowledge and proficiency of skills appropriate to their assigned responsibilities, including an ability to perform specified duties determined by the organization. Skills will be maintained and improved through continuing education programs, based on the analysis of trends and outcomes identified through the competency program, on-site supervision, and established reviews.

Skill proficiency can be determined by: verbal or written examination; skill demonstration in a lab setting or patient's home; or by completion of a specialized training course specific to a clinical procedure (i.e., PICC Certification).

PROCEDURE

1. The organization will establish and annually re-evaluate its job specific "Competency Based Orientation Checklist" which reflects duties commonly required in the performance of patient contact positions. (See "Competency Based Orientation" Policy No. 3-002.)

2. The organization will establish and annually evaluate a group of specific skills related to patient care/service responsibilities and complexity of care/service provided by personnel. Competencies must be successfully demonstrated before organization personnel complete orientation.

3. The organization will clearly identify and define the skills, which are essential to observe for the determination of competence, for each job category. In the identification of core competence, the essential skills will be demonstrated upon hire and annually thereafter.

4. Specific competencies will be developed for high-risk, problem prone, and specialty service care areas. Personnel providing service in the defined target areas will receive specialty training and provide demonstrated competence prior to the provision of specialty service.

5. A preceptor will be assigned to each new staff member as part of the orientation process. The preceptor/supervisor will observe and deem proficient the indicated skills and core competencies. If necessary, additional training, or inservice education will be provided to the staff member. Organization personnel will not provide the care or service independently until satisfactory completion of required skills competency.

6. After the completion of orientation, competency will be monitored annually thereafter as part of the annual performance evaluation process. Competency will also be monitored when:

   A. Personnel are performing a new procedure, or using a piece of equipment for the first time.

   B. The Orientation Skills Checklist indicates a trend for retraining. The trend can be identified by a demonstrated knowledge deficit when the skill is an invasive procedure, or when the organization expects the skill to be performed routinely in the scope of patient care/service.

   C. Care/service is provided in a specialized area for the first time.

   D. Reporting systems indicate that organization personnel require additional training or supervision.

   E. Requested by personnel.

7. Qualified evaluators will conduct the proficiency demonstration component of the clinical competency program.

8. Clinical competency of qualified evaluators (preceptors, supervisors, peers, clinical specialists) will also be defined and regularly evaluated.

9. Competency of supervisors and/or management personnel is assessed by the individual's immediate supervisor and may include peer evaluation as a component of the process.

COMPETENCY ASSESSMENT
Policy No. 1-026.1

PURPOSE

To outline the process of assessing professional and paraprofessional competence.

POLICY

The competence of all organization clinical personnel (employed, contract, or volunteer) will be assessed during orientation, during the probationary period, periodically throughout the course of the year and during the annual performance evaluation. Educational activities will be based, in part, on the outcomes of the competency evaluation.

Competency of supervisors and/or management staff will be assessed by the individual's immediate supervisor and may include peer review as a component of the process.

PROCEDURE

Orientation and Probationary Period

1. As part of the orientation process, a preceptor/Clinical Supervisor will be assigned to each new person.

2. Using a Competency Skills Performance Checklist, and the Orientation Checklist, the preceptor/Clinical Supervisor will observe the new personnel performing the required skills and activities.

3. Upon completion of the checklists, the new personnel will end orientation and probationary period.

Ongoing Assessments

1. Competency assessments will be completed at least one (1) time per year. Additional competencies may be required for performance issues, new technology, or other appropriate indications.

2. Using a Competency Skills Performance Checklist developed specifically for each clinical job category, the Clinical Supervisor will evaluate the competence in performing and rendering care according to organization policies and standards of practice.

3. Clinical personnel will make a joint visit with a Clinical Supervisor annually for direct observation assessment.

4. Based on the identified clinical needs during reviews, the inservice education plan will incorporate training on issues where trends and patterns are identified for all personnel.

5. Isolated episodes relating to individual performance will be addressed on an individual basis. Actions may include one-on-one counseling and/or mentoring, reviewing resource information, inservice training or continuing education.

Annual Performance Evaluation

1. During the annual performance evaluation, personnel's competence in performing specified activities will be evaluated.

2. Personnel will be asked to demonstrate their core competencies in specific areas relating to their job description and functions (i.e., hospice aides demonstrate skills for ADLs, bathing, toileting, etc.; nurses performing Infusion Therapy demonstrate skills for venipuncture, accessing ports; medical word processors demonstrate skill for word processing.)

3. Improving skills for competency will be part of the annual performance evaluation and performance plans for the next year, as well as establishing individual goals for personal/professional growth and development.

Exhibit 11

Pierce County Hospice Need Methodology Appendix

PIERCE Co. Need Methodology Appendix

The need for additional hospice agencies is determined by the eight step methodology contained in WAC 246-310-290 (7). When applied to Pierce County, a need for 1.7 additional providers by 2021 is indicated. In summary, the CN Program conducts an annual survey of hospice providers and then produces an estimate of numeric need of providers in the given county.

Summary of Results for DOH 260-028 November 2019 When Applied to Pierce County

Step 8 - Numeric Need	**1.70**	Agencies Needed
Step 7 -Unmet ADC 2021	**59.7**	ADC unmet 2021
Step 6 -Unmet patient days	**21777**	Days unmet 2021

Step 1 - Statewide hospice use Rates

Use Rate	Age Cohort
27.9%	0-64
61.6%	65+

Step 2 - Average deaths in county

Avg Deaths	Age Cohort
1928	0-64
4899	65+

Step 3- Project unduplicated patients

Avg Deaths	**Projected Patients**	Age Cohort
1928	**538**	0-64
4899	**3016**	65+

Step 4 - Determine potential volume

Projected Patients	**2020 potential volume**	**2021 potential volume**	Projected Population 2020
538	**557**	**560**	0-64
3016	**3425**	**3584**	65+

Step 5 - Determine potential admits beyond capacity

2020 potential volume	2021 potential volume	Current Capacity	**2020 Admits (Unmet)**	**2021 Admits (Unmet)**
3982	4144	3782	**200**	**362**

Step 6 - Determine unmet need in patient days for projection years

2021 Admits (Unmet)	2021 Admits (Unmet)	Statewide ALOS	**2020 Patient Days (unmet)**	**2021 Patient Days (unmet)**
200	362	60.13	**12054**	**21777**

Step 7 - Determine unmet need in ADC for projection years in county

2020 Patient Days (unmet)	2021 Patient Days (unmet)	**2020 ADC (unmet)**	**2021 ADC (unmet)**
12054	21777	**33**	**60**

Step 8 - Determine numeric need for hospice agencies

2020 ADC (unmet)	2021 ADC (unmet)	**Agencies Needed?**
33	60	**1.70**

Methodology Step by Step (verbatim)

Step 1 Calculate Statewide Hospice Use Rates
Calculate the following two statewide predicted hospice use rates using department of health survey and vital statistics data:

WAC 246-310-290(8)(a)(i) The percentage of patients age sixty-five and over who will use hospice services. This percentage is calculated by dividing the average number of unduplicated admissions over the last three years for patients sixty five and over by the average number of past three years statewide total deaths age sixty-five and over.
WAC246-310-290(8)(a)(ii) The percentage of patients under sixty-five who will use hospice services. This percentage is calculated by dividing the average number of unduplicated admissions over the last three years for patients under sixty-five by the average number of past three years statewide total of deaths under sixty-five.

Hospice admissions ages 0-64	
Year	Admissions
2016	3768
2017	3757
2018	4114
Average	**3880**

Deaths ages 0-64	
Year	Deaths
2016	13557
2017	14113
2018	14055
Average	**13908**

Hospice admissions ages 65+	
Year	Admissions
2016	24738
2017	26365
2018	26951
Average	**26018**

Deaths ages 65+	
Year	Deaths
2016	41104
2017	42918
2018	42773
Average	**42265**

Use Rates	
0-64	**27.9%**
65+	**61.6%**

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Step 2 Calculate average number of deaths:
Calculate the average number of total resident deaths over the last three years for each planning area by age cohort.

0-64				
County	**2016**	**2017**	**2018**	**2016-2018 Average Deaths**
Jefferson	69	69	64	67
Pierce	**1883**	**1936**	**1964**	**1928**
Kitsap	518	485	515	506

65+				
County	**2016**	**2017**	**2018**	**2016-2018 Average Deaths**
Jefferson	293	308	336	312
Pierce	**4751**	**5019**	**4926**	**4899**
Kitsap	1704	1780	1713	1732

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Step 3.
Multiply each hospice use rate determined in Step 1 by the planning areas' average total resident deaths determined in Step 2, separated by age cohort.

0-64		
County	**2016-2018 Average Deaths**	**Projected Patients: 27.90%**
Jefferson	67	19
Pierce	**538**	**1928**
Kitsap	506	141

65+		
County	**2016-2018 Average Deaths**	**Projected Patients: 27.90%**
Jefferson	312	192
Pierce	**4899**	**3016**
Kitsap	1732	1066

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Step 4: <u>Use Rate by Age Cohort</u>
Using the projected patients calculated in Step 3, calculate a use rate by dividing projected patients by the three-year historical average population by county.
Use this rate to determine the potential volume of hospice use by the projected population by age cohort using Office of Financial Management (OFM) data.

0-64

County	Projected Patients	2016-2018 Average Population	2019 projected population	2020 projected population	2021 projected population	2019 potential volume	2020 potential volume	2021 potential volume
Jefferson	19	20,670	20,705	20722	20636	19	19	19
Pierce	**538**	**738,738**	**756,339**	**765,139**	**769,198**	**551**	**557**	**560**
Kitsap	141	215,543	218,538	220035	220614	143	144	144

0-64

Jefferson	Use Rate	0.09%
Pierce	Use Rate	**0.07%**
Kitsap	Use Rate	0.07%

65+

County	Projected Patients	2016-2018 Average Population	2019 projected population	2020 projected population	2021 projected population	2019 potential volume	2020 potential volume	2021 potential volume
Jefferson	192	10,916	11,588	11924	12323	204	210	217
Pierce	**3016**	**119,836**	**130,688**	**136,114**	**142,422**	**3,289**	**3,425**	**3,584**
Kitsap	1066	49,743	53,833	55878	58185	1,154	1,198	1,247

65+

Jefferson	Use Rate	1.76%
Pierce	Use Rate	**2.52%**
Kitsap	Use Rate	2.14%

Step 5:
Combine the two age cohorts. Subtract the average of the most recent three years hospice capacity in each planning area from the projected volumes calculated in Step 4 to determine the number of projected admissions beyond the planning area capacity.

County	2019 potential volume	2020 potential volume	2021 potential volume	Current Capacity	2019 Admits (Unmet)	2020 Admits (Unmet)	2021 Admits (Unmet)
Jefferson	223	229	235	164	59	65	71
Pierce	**3,840**	**3,982**	**4,144**	**3782**	**58**	**200**	**362**
Kitsap	1297	1342	1392	1177	120	165	215

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Step 6:
Multiply the unmet need from Step 5 by the statewide average length of stay as determined by CMS to determine unmet need patient days in the projection years.

Step 6 (Admits* ALOS)=Unmet Patient Days							
County	**2019 Admits (Unmet)**	**2020 Admits (Unmet)**	**2021 Admits (Unmet)**	**Statewide ALOS**	**2019 Patient Days (unmet)**	**2020 Patient Days (unmet)**	**2021 Patient Days (unmet)**
Jefferson	59	65	72	60.13	3,524	3,881	4,329
Pierce	**57**	**200**	**362**	**60.13**	**3,427**	**12,054**	**21,777**
Kitsap	120	165	215	60.13	7,214	9,909	12,905

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Step 7:
Divide the unmet patient days from Step 6 by 365 to determine the unmet need ADC

Step 7 (Patient Days/365)=Unmet ADC						
County	**2019 Patient Days (unmet)**	**2020 Patient Days (unmet)**	**2021 Patient Days (unmet)**	**2019 ADC (unmet)**	**2020 ADC (unmet)**	**2021 ADC (unmet)**
Jefferson	3,524	3,881	4,329	9.66	10.63	11.86
Pierce	**3,427**	**12,054**	**21,777**	**9**	**33**	**60**
Kitsap	7,214	9,909	12,905	19.77	27.15	35.36

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

Step 8 (Patient Days/365)=Unmet ADC				Step 8 -Numeric Need	
County	**2019 ADC (unmet)**	**2020 ADC (unmet)**	**2021 ADC (unmet)**	**Numeric Need?**	**Agencies Needed?**
Jefferson	9.66	10.63	11.86	FALSE	FALSE
Pierce	**9.39**	**33.02**	**59.66**	**TRUE**	**1.70**
Kitsap	19.77	27.15	35.36	TRUE	1.01

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Exhibit 12

Pennant Services Operational Support Services Agreement

CONSULTING, PROFESSIONAL, AND OPERATIONAL SUPPORT SERVICES AGREEMENT

Effective Date:	**October 1, 2019**
CONSULTANT:	**PENNANT SERVICES, INC.**
Address:	1675 E. Riverside Dr., Suite 120 Eagle, Idaho 83616
Phone:	(208) 401-1400
Fax:	(208) 401-1401
AGENCY:	**SYMBOL HEALTHCARE, INC.** **dba PUGET SOUND HOSPICE**
Address:	4002 Tacoma Mall Blvd., Ste., 204 Tacoma, Washington 98409
Phone:	(253) 777-4919
Fax:	(253) 442-6111
FEIN:	61-1698685

THIS CONSULTING, PROFESSIONAL, AND OPERATIONAL SUPPORT SERVICES AGREEMENT ("Agreement") is made and entered into by and between the above-named Consultant and Agency as of the Effective Date, with respect to the following facts and intentions:

R E C I T A L S

A. Agency is an independently operated, licensed and certified home health and/or hospice Agency operating from the address set forth above (the "Agency Primary Location");

B. Consultant is a provider of centralized consulting, professional, and operational support designed to aid the efficient, competitive, and sound operation of entities like Agency;

C. Agency desires to engage the services of Consultant to assist Agency personnel with aspects of Agency's operations and activities, in order to facilitate Agency personnel's focus on Agency's primary mission of rendering superior assisted living services to the Agency's patients and clients.

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

TERMS AND CONDITIONS

1. Incorporation of Exhibits and Recitals. The Recitals set forth above, as well as the exhibits attached hereto, are incorporated herein by this reference as if fully set forth herein.

2. Consultant's Duties. The Consultant agrees to provide such of the following services ("Services") as Agency, at Agency's option and request from time to time, desires to obtain from Consultant during the term of this Agreement, and to perform its duties hereunder in a good, professional and workmanlike manner. Such duties shall include, without limitation (herein the "Services"):

2.1. General Consultant's Duties, Generally.

2.1.1. Consultant will provide Services in substantial conformance to applicable federal and state laws and the established policies of Consultant and Agency in effect from time to time, and Consultant will conduct periodic self-audit/compliance reviews in order to ensure that Consultant substantially complies with federal, state and local statutes and regulations applicable to the provision of the Services. Agency hereby grants to Consultant a limited power of attorney to act in Agency's name and stead for the convenience of Agency and/or Consultant, provided that this power shall not be used except in conjunction with the enumerated Services under this Agreement.

2.1.2. Consultant shall make clear to all parties with whom it deals in the course of rendering the Services that it is an independent contractor and not an employer, employee, partner, co-venturer, or management agency of Agency. At all times while in the Agency and while with Agency's patients, Consultant's employees and representatives shall wear uniforms and/or badges clearly indicating their affiliation with Consultant.

2.2. Specific Duties of Consultant. During the term of this Agreement, Consultant shall provide to Agency the specific Services listed in Exhibit A at the request of the Agency. In the event of any conflict between the terms of Exhibit A and the terms contained in the main body of this Agreement, the terms of Exhibit A shall control. Consultant's duties shall specifically not include (i) the rendition of any direct care to patients or residents, (ii) maintenance or handling of patient trust property, or (iii) any other service not specifically enumerated herein as a part of the Services and requested by Agency, all of which shall be the sole duty and domain of Agency, its administrators, caregivers and other staff.

3. Agency's Duties. Agency shall:

3.1. Operate its business in and from the Agency Primary Location in substantial compliance with applicable laws and regulations, and maintain all federal and state licenses and certifications required to operate the Agency and provide Services to patients (collectively the "Licenses"). Agency shall perform all duties required of a licensee and provider under applicable local, state and federal laws, codes, regulations and provider agreements affecting the operation of the Agency. Within five (5) days of receipt, Agency shall deliver to Consultant notification of any actual revocation or suspension of its Licenses.

3.2. Not unreasonably restrict or limit the Consultant's right to exercise its independent professional judgment, including its right to recommend Services to be rendered

and to render such Services using such methods, technologies and procedures as Consultant deems appropriate.

3.3. Timely furnish Consultant with such information and materials as might ordinarily be expected for Consultant to perform its duties hereunder. Agency shall be solely responsible to assure the accuracy and completeness of all information provided by Agency and its personnel to Consultant, and Consultant shall be entitled to rely thereon without inquiry or diligence of any kind.

3.4. As and to the extent that Consultant's employees and agents require access to the Agency's Primary Location to perform the Services, Agency shall provide adequate working space, equipment and access to Agency's staff for the provision of Services. Equipment and materials placed at the Agency by Consultant shall be used exclusively for the purposes of this Agreement. Upon termination or at Consultant's request, Agency shall return equipment and materials, in the same condition as when delivered to Agency, reasonable wear and tear excepted.

3.5. In addition to the foregoing, during the term of this Agreement, Agency shall cooperate with Consultant and Consultant's other client agencies and businesses as more fully set forth in Exhibit A.

4. Compensation.

4.1. For and in consideration of the Services to be provided under this Agreement, the Agency shall pay to the Consultant as the "Consultant Compensation" a monthly consulting fee equal to five percent (5.0%) of Agency's gross revenue from all sources. A reasonable estimate of anticipated monthly Consultant Compensation shall be paid on or before the first (1st) day of each month during the Term hereof, and shall be "trued up" at the beginning of the next following month with such following month's estimated payment. Payment for any partial month of the Term shall be prorated based on the number of days during the month that Consultant served under this Agreement. In the event Agency closes during any month during the Term, the Consultant Compensation for any such month or partial month shall be calculated, at Consultant's option, based on historical revenues and patient mix. At Consultant's option Consultant shall be entitled to deduct the Consultant Compensation from sums collected for Agency by Consultant, and shall provide Agency with invoices (or if paid by deduction accountings) for the monthly fee by the last day of the month following the month of service.

4.2. In addition to and not as part of the Consultant Compensation, Agency shall reimburse Consultant for all costs and expenses advanced, incurred, or paid by Consultant in the rendition of Services.

5. Insurance.

5.1. Both Consultant and Agency agree to maintain general and professional liability insurance during the term of this agreement in an amount not less than One Million Dollars ($1,000,000) per claim and Three Million Dollars ($3,000,000) in the aggregate.

5.2. Both parties agree to maintain such other and further insurance as may be required by law or the terms of any agreement to which they are parties, including without

limitation worker's compensation insurance (where required by law), crime insurance, directors and officers coverage, automobile and similar liability, and property and casualty insurance, and will list Agency as named insured on all obtained policies.

5.3. All insurance policies shall be issued by insurance companies with a policyholder rating of at least "B+" in the most recent version of Best's Key Rating Guide.

6. Term and Termination. The Term of this Agreement shall commence on the Effective Date and continue thereafter for a period of one (1) year. This Agreement shall automatically extend for additional periods of one (1) year each unless written notice of termination is given not less than sixty (60) days prior to the end of the then-current term. Notwithstanding anything contained herein to the contrary, either party may terminate this Agreement and the Term hereof at any time during the Term upon sixty (60) days written notice; further, in the event of (i) abandonment by a party of its duties hereunder, (ii) nonpayment of any Consultant Compensation within five (5) days after delivery of invoice or other written demand therefor; (iii) any breach or violation of this Agreement (other than non- payment of Consultant Compensation) which is not cured within thirty (30) days following delivery of written notice of such breach or violation, (iv) any material violation of law or regulations, or loss or failure of license or licensure, or violation of the eligibility requirements for reimbursement under any government program by a party, or (v) the occurrence or existence of any condition, practice, procedure, action, inaction or omission of, by or involving a party which, in the reasonable opinion of the other party constitutes either a threat to the health, safety, and welfare of any patient or client or a violation of any law, regulation, requirement, Licenses, eligibility or material agreement governing Agency's or Consultant's operation, then the other party shall have the right to summarily and immediately terminate this Agreement upon written notice to the first party.

7. Regulatory Changes. Agency and Consultant mutually agree that in the event local, state or federal government agencies promulgate regulations which materially affect the terms of this Agreement, including but not limited to changes affecting the cost of providing Services hereunder, this Agreement shall be immediately subject to renegotiation upon the initiative of either party.

8. Warranties.

8.1. Agency's Warranties. Agency hereby makes the following warranties and representations to Consultant in connection with Consultant's entry into this Agreement, which warranties shall survive the termination of this Agreement:

8.1.1. Agency is properly licensed by the State in which the Agency's operation(s) is located by the proper licensing and certification authorities for such State, and all permits and licenses required for the operation of Agency's business(es) have been received and are now currently effective.

8.1.2. As of the Effective Date, except as specifically disclosed on Schedule 1 attached hereto and incorporated herein, there is no litigation, administrative proceedings, event, or hold or similar lien on State or Federal payments to Agency, either underway or threatened, nor are there arbitration proceedings or governmental investigations relating to the Agency, or the business conducted thereon underway or threatened against Agency or brought by the Agency

8.1.3. To the best of Agency's knowledge, the business operations of the Agency at the Commencement Date comply with all local, State and Federal zoning, labor and other applicable laws, ordinances, rules and regulations applicable to the Agency.

8.1.4. Agency has been duly formed in the state of its domicile and remains in good standing in such state, and (if operating in a state other than its domicile) has been duly registered and authorized to do business in the state where its business operation(s) is located and is in good standing in that state as well.

8.1.5. Agency is authorized to consummate the transactions covered by this Agreement.

8.2. Consultant's Warranties. Consultant hereby makes the following warranties and representations to Agency in connection with Agency's entry into this Agreement, which warranties shall survive the termination of this Agreement:

8.2.1. Consultant is a Nevada corporation in good standing, and is registered to do business in, and is in good standing with, the State of Idaho.

8.2.2. Consultant is authorized to consummate the transactions covered by this Consulting Agreement.

9. Licensure, Eligibility and Compliance.

9.1. Consultant acknowledges that its activities under this Agreement may be governed by, *inter alia*, the United States Department of Health and Human Services' Office of the Inspector General's ("OIG") Compliance Program Guidance for Home Health Agencies and/or the OIG's Compliance Program Guidance for Hospices. Consultant represents and warrants that neither Consultant nor any individual or entity with a direct or indirect ownership or control interest of five percent (5%) or more in Consultant, nor any director, officer, agent or employee of such party, is debarred, suspended or excluded under any state or federal healthcare program it is currently eligible to participate in Medicare, Medicaid, and all other federally funded health care programs and is not subject to any sanction or exclusion by any of those programs. Consultant agrees to immediately disclose any actual or threatened federal, state or local investigations or imposed sanctions of any kind, in progress or initiated subsequent to the date of entering into this Agreement. Consultant further represents and warrants that it is not currently sanctioned under any applicable state or federal fraud and abuse statutes, including exclusion from any state or federal health care program. If, during the term of this Agreement, Consultant, its parent, or any officer, director or owner receives such a sanction, or notice of proposed sanction, Consultant shall provide notice of and a full explanation of such sanction or proposed sanction and the period of its duration within ten (10) days of receipt. Agency reserves the right to terminate the Agreement immediately upon receipt of notice that Consultant has been sanctioned under fraud and abuse statutes and/or any other federal, state or local regulation.

9.2. If the Agency Primary Location is located in the state of Texas, Consultant agrees to complete, execute and deliver to Agency upon request a Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion for Covered Contracts on Form 2046 as promulgated by the Texas Department of Protective & Regulatory Services.

9.3. Consultant acknowledges that it has received a copy of Agency's Code of Conduct, and agrees to abide by the provisions thereof governing Vendors and Vendor services.

10. Consultant's Schedule and Availability.

10.1. Consultant shall be reasonably available on an on-call basis to the Agency to fulfill Consultant's duties hereunder.

10.2. Nothing in this Agreement shall be construed as limiting or restricting in any manner Consultant's right to render the same or similar services to other individuals or entities, including but not limited to, other hospice and in-home care during or subsequent to the Term of this Agreement; similarly, nothing in this Agreement shall require Agency to exclusively use all of Consultant's services in the Agency during the Term of this Agreement.

10.3. Consultant's employees and representatives are entitled to be reasonably absent for annual vacations, sick leave, continuing education, and personal reasons; provided that in the event of any absence Consultant shall consult with the Agency concerning the impending absence and cooperate with the Agency in providing alternate resources to Agency to temporarily fulfill Consultant's duties during the period of absence.

11. Contractual Relationship.

11.1. Independent Contractor. It is expressly acknowledged by both parties that Consultant is an independent contractor. Nothing herein is intended to be construed to create an employer-employee, partnership, joint venturer or other relationship between Consultant and the Agency. Agency has and shall retain all statutory liability and responsibility for the continued operation of the Agency as the licensee under Agency's Licenses. No provision of this Agreement shall create any right in the Agency to exercise control or direction over the manner or method by which Consultant performs its duties or renders Services hereunder, nor shall Consultant exercise control or direction over the manner or method by which Agency operates or serves its patients and clients; provided always, that services shall be provided in a manner consistent with all applicable laws, rules and regulations of all governmental authorities, and Agency's Code of Conduct. Agency will not withhold from compensation payable to Consultant hereunder, or be in any way responsible for, any sums for income tax, employment insurance, Social Security, or any other agency and Consultant agrees that the payment of all such amounts as may be required by law are and shall be the sole responsibility of Consultant.

11.2. Fair Market Value. The amounts to be paid to Consultant hereunder have been determined by the parties through good faith and arms-length bargaining to be the fair market value of the services to be rendered hereunder. No amount paid or to be paid hereunder is intended to be, nor will it be construed as, an offer, inducement or payment, whether directly or indirectly, overtly or covertly, for the referral of patients by Consultant to Agency, or by Agency to Consultant, or for the recommending or arranging of the purchase, lease or order of any item or service. For purposes of this section, Consultant and Agency will include each such entity and any affiliate thereof. No referrals are required under this Agreement.

11.3. Work Product. The work product created in the course of Consultant's services under this agreement shall be the exclusive property of Consultant, and all manuals, forms, and documents (including without limitation, all writings, drawings, blueprints, pictures, recordings, computer or machine readable data, and all copies or reproductions thereof) which result from, describe or relate to the services performed or to be performed pursuant to this agreement or the results thereof, including without limitation all notes, data, reports or other information received or generated in the performance of this Agreement (excepting data incorporated in medical records required to be kept and maintained by Agency), shall be the exclusive property of Consultant and shall be delivered to Consultant upon request.

11.4. Non-Solicitation of Consultant's Employees. During the term of this Agreement, Agency shall not solicit the services of, or hire as an employee or independent contractor at the Agency, any Consultant employee, agent or representative who provided, managed or otherwise was involved in the provision of Services to Agency within the previous twelve (12) months (a "Restricted Employee"). Nothing herein shall preclude Agency from advertising available positions or opportunities by posting in the Agency or through newspaper ads or other generally accepted recruiting mediums. The parties acknowledge that the restrictions set forth in this Article are reasonable in scope and important to Consultant's business interests, and that the enforcement of this Article does not restrict Agency from engaging in Services for its own account. In the event that Agency hires a Restricted Employee, Agency shall pay a recruiting fee to Consultant in the amount of Seven Thousand Five Hundred and No/100 Dollars ($7,500.00) per Restricted Employee hired.

12. Indemnification.

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

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

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

13. Access to Books and Records. Pursuant to 42 U.S.C. §1395x(V)(1)(l), during the four (4) year period after completion of services hereunder, the Agency will, upon written request, make available to the Secretary of Health and Human Services or to the Comptroller General, or their duly authorized representatives, this Agreement, books, documents, and

records that are necessary to certify the nature and extent of costs incurred by the Agency under the provisions of this Agreement. This provision shall be in force for any twelve (12) month period during which the total value of services provided or goods delivered hereunder is Ten Thousand Dollars ($10,000) or more. This section shall have no effect unless Consultant is deemed a "subcontractor" under any regulation adopted under the provision of the United States Code cited above.

14. Privacy.

14.1. HIPAA Applicability and Compliance. Agency may be a "Covered Entity" under, and required to comply with, the applicable provisions of the Health Insurance Portability and Accountability Act of 1996 as amended ("HIPAA") and the regulations and guidelines pertaining thereto (collectively with HIPAA the "HIPAA Rules"), and to obtain sufficient assurances that its contracting parties will appropriately safeguard patients' "Protected Health Information" ("PHI") as defined in the HIPAA Rules. In the course of performing Consultant's services, duties and obligations herein, Consultant may receive, create or obtain access to PHI. Consultant agrees to maintain the security and confidentiality of PHI, as required of Agency by applicable laws and regulations, including without limitation the HIPAA Rules, and to execute and deliver such additional documentation and assurances as Agency may reasonably request to comply with HIPAA and any amendments thereto and related laws and regulations, including, but not limited to, the Business Associate Agreement attached hereto as Exhibit B.

14.2. Correlation of Record Handling Requirements. In the event of any conflict between the requirements of this Article 14 and/or between the various laws, statutes, ordinances and regulations relating to or otherwise affecting the subject matter thereof, the requirement or applicable law that that presents the most stringent standard for compliance, as reasonably determined by Agency, shall be followed, such that compliance is achieved or maximized in all cases.

14.3. Confidential Information. Consultant shall preserve the confidentiality of all private, confidential and/or proprietary information disclosed to or discovered by Consultant in connection with this Agreement, including, without limitation, nonpublic financial information, manuals, protocols, policies, procedures, marketing, and strategic information, Agency lists, computer software, training materials, resident/patient health information, resident/patient records, and resident/patient care and outcomes data ("Confidential Information") as and to the extent required by law. Consultant shall not use for its own benefit or disclose or otherwise disseminate to third parties, directly or indirectly, any Confidential Information without prior written consent from Agency, provided however that if Consultant grants Agency access to, and Agency uses, Consultant's databases or information sharing mechanisms, Agency's information may be provided to similar agencies and Agency hereby grants Agency's consent to such information sharing as a condition to Agency's receipt of access to such mechanisms and the data they contain form time to time. Upon termination of this Agreement, all Confidential Information and copies thereof shall be returned to Agency. Consultant and Agency shall comply with applicable federal, state and local laws and regulations with respect to all Confidential Information, including, but not limited to, any disclosures thereof pursuant to this section.

15. Notices. All notices which are required or which may be given pursuant to the terms of this Agreement shall be in writing and shall be sufficient in all respects if given in writing and delivered personally or by registered or certified mail, return receipt requested, or

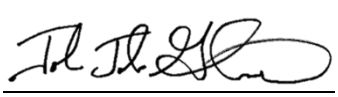
by a comparable commercial delivery system, and notice shall be deemed to be given on the date hand-delivered or on the date which is three (3) business days after the date deposited in United States mail, or with a comparable commercial delivery system, with postage or other delivery charges thereon prepaid, at the addresses first set forth above or such other addresses as Agency and Consultant may designate by written notice to the other from time to time. For a notice from Agency to Consultant to be effective, a true and complete copy of such shall be simultaneously delivered by Agency to Pinnacle Service Center, Inc., Attn: General Counsel, 1600 W. Broadway Road, Suite 100, Tempe, AZ 85282, or such other address as Consultant may from time to time specify.

16. Arbitration.

16.1. Any controversy, dispute or claim arising in connection with the interpretation, performance or breach of this Lease, including any claim based on contract, tort or statute, shall be determined by final and binding, confidential arbitration with Judicial Mediation and Arbitration Service ("JAMS/Endispute") in Ada County, Idaho, provided that if JAMS/Endispute (or any successor organization thereto) no longer exists, then such arbitration shall be administered by the American Arbitration Association ("AAA") in accordance with its then-existing Commercial Arbitration Rules, and the sole arbitrator shall be selected in accordance with such AAA rules. Any arbitration hereunder shall be governed by the United States Arbitration Act, 9 U.S.C. 1-16 (or any successor legislation thereto), and judgment upon the award rendered by the arbitrator may be entered by any state or federal court having jurisdiction thereof. Neither Agency, Consultant, nor the arbitrator shall disclose the existence, content or results of any arbitration hereunder without the prior written consent of all parties; provided, however, that either party may disclose the existence, content or results of any such arbitration to its partners, officers, directors, employees, agents, attorneys and accountants and to any other Person to whom disclosure is required by applicable Legal Requirements, including pursuant to an order of a court of competent jurisdiction. Unless otherwise agreed by the parties, any arbitration hereunder shall be held at a neutral location selected by the arbitrator in Ada County, Idaho. The cost of the arbitrator and the expenses relating to the arbitration (exclusive of legal fees) shall be borne equally by Agency and Consultant unless otherwise specified in the award of the arbitrator, in which case such fees and costs paid or payable to the arbitrator shall be included in "reasonable costs and attorneys' fees" for purposes of Section 17.2, and the arbitrator shall specifically have the power to award to the prevailing party pursuant to such Section 17.2 such party's costs and expenses, including fees and costs paid to the arbitrator.

16.2. NOTICE: BY INITIALING IN THE SPACE BELOW YOU ARE AGREEING TO HAVE ANY DISPUTES ARISING IN THIS "ARBITRATION OF DISPUTES" PROVISION DECIDED BY NEUTRAL ARBITRATION AS PROVIDED HEREIN AND BY IDAHO LAW AND YOU ARE GIVING UP ANY RIGHTS YOU MIGHT POSSESS TO HAVE SUCH DISPUTE LITIGATED IN A COURT OR JURY TRIAL. BY INITIALING IN THE SPACE BELOW, YOU ARE GIVING UP YOUR JUDICIAL RIGHTS TO DISCOVERY AND APPEAL, UNLESS THOSE RIGHTS ARE SPECIFICALLY INCLUDED IN THIS "ARBITRATION OF DISPUTES" PROVISION. IF YOU REFUSE TO SUBMIT TO ARBITRATION AFTER AGREEING TO THIS PROVISION, YOU MAY BE COMPELLED TO ARBITRATE UNDER THE AUTHORITY OF THE IDAHO CODE OF CIVIL PROCEDURE. YOUR AGREEMENT OF THE PARTIES TO THIS ARBITRATION PROVISION IS VOLUNTARY.

BY INITIALLING BELOW YOU AFFIRM THAT YOU HAVE READ AND UNDERSTAND THE FOREGOING AND AGREE TO SUBMIT DISPUTES ARISING OUT OF THE MATTERS INCLUDED IN THIS "ARBITRATION OF DISPUTES" PROVISION TO NEUTRAL ARBITRATION.



CONSULTANT

AGENCY

17. Miscellaneous.

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

17.2. In the event of any dispute between the parties arising under or in relation to this Agreement, the prevailing party in such dispute or litigation shall have the right to receive from the non-prevailing party all of the prevailing party's reasonable costs and attorneys' fees incurred in connection with any such dispute and/or litigation. As used herein, the term "prevailing party" shall refer to that party to this Agreement for whom the result ultimately obtained most closely approximates such party's position in such dispute or litigation.

17.3. This Agreement shall be governed by the laws of the State of Idaho. Notwithstanding anything contained herein to the contrary, venue for any action involving this Agreement shall lie solely in Ada County, Idaho.

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

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

17.6. This Agreement shall binding upon the parties hereto, their heirs, successors and assigns. Notwithstanding the foregoing, the parties mutually acknowledge that a material and substantial consideration in the parties' mutual execution of this Agreement is the identity and reputation of the other party, and each party's subjective perception of the other's value to and compatibility with such party and its officers, employees, facilities and

patients. As such, notwithstanding anything contained herein to the contrary, this Agreement and the rights of the parties hereunder are personal to the parties and may not be assigned or subcontracted to, nor shall the duties and responsibilities of either hereunder be delegated to or rendered by, any other person or entity without the express prior written consent of the other party, which consent may be granted or denied, conditionally or unconditionally, by a party in its sole, absolute and unfettered discretion.

17.7. Notwithstanding the expiration or earlier termination of this Agreement, the obligations and/or liabilities of the parties hereunder, relating to events, occurring during the Term, to which the parties' indemnification obligations under Section 12 apply, shall continue in full force and effect after the Agreement terminates, subject to applicable statutes of limitation. Additionally, the covenants of the parties under Sections 11.4, 13, 14 and 16 shall survive the termination of this Agreement.

17.8. This Agreement is solely between the parties hereto, and shall not create any right or benefit in any third party, including without limitation any creditor, agent, partner, employee or affiliate of Current Operator, or any entity or agency having jurisdiction of any of the Licenses, the Agency or the operation of the business therein.

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

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

CONSULTANT:

PENNANT SERVICES, INC.
a Nevada corporation

BY: _____
Authorized Agent
Date: 12/27/2019

AGENCY:

SYMBOL HEALTHCARE, INC.
a Nevada corporation

BY: _____
Authorized Agent
Date: 12/27/2019

EXHIBIT A
CONSULTING, PROFESSIONAL, AND
OPERATIONAL SUPPORT SERVICES AGREEMENT

THIS EXHIBIT A supplements the foregoing CONSULTING, PROFESSIONAL, AND OPERATIONAL SUPPORT SERVICES AGREEMENT (the "Agreement") made and entered into by and between the therein-named Consultant and Agency and forms a part thereof. The specific duties and obligations described herein may or may not be performed by either party, depending upon the needs, preferences and requests of the other from time to time. The lists of duties and activities are not exhaustive, but where certain duties or activities are expressly limited, excluded or proscribed hereby, such activities shall not be requested or performed. Consultant's services shall be rendered on a non-exclusive basis, and Consultant shall have no duty to limit its services solely to Agency. Any service to be rendered by Consultant hereunder may be, at Consultant's sole option, rendered on a joint or "pooled" basis with or to Agency and other clients of Consultant. Consultant may provide any of its services hereunder through the use or assistance of subcontractors, but such subcontractors shall be subject to all of the terms and conditions of this Agreement. Although Consultant shall have discretion to make certain decisions regarding its Services for Agency in the day-to-day rendition of such services, Agency shall remain solely responsible for all decisions and actions made by, at, for or involving Agency and the operation of Agency's business.

SPECIFIC SERVICES TO BE RENDERED BY CONSULTANT:

1. Technical & Compliance Resource.

A. Assists in the identification and, where requested by Agency the evaluation, of prospective candidates and contractors to serve in clinical and/or leadership roles in the Agency.

B. Assists in designing policies and procedures to periodically review the status of employees to ascertain continued compliance with local and state health regulations for the various specific categories of employees, and proper documentation of compliance.

C. Provides sample form clinical policy and procedure manuals, handbooks and forms; provided that all manuals, materials and forms provided in connection therewith shall be and remain the property of Consultant and may not be copied, reproduced, distributed or used other than with the express written permission of Consultant.

D. Provides a delegate to serve as a resource to and advisory member of the Agency's Quality Assessment and Performance Improvement Committee, who attends and participates in both quarterly and special QAPI meetings; provided that such delegate shall be subject to the same obligations of confidentiality as any other member of the Committee, but shall not be allowed to vote or direct the work of the Committee or the Agency.

E. Assists Agency management in preparing for, reviewing and responding to the various official surveys and inspections of Agency's premises and nursing practices.

F. Participates, solely as a resource and not as a director, in the

development of patient care policies and systems for the Agency.

G. Assists in the identification and, where requested by Agency the evaluation, of prospective candidates and contractors to serve in nursing service, nursing, therapy service and other leadership and line staff roles in the Agency. In addition, and at Agency's request and at Agency's sole cost and expense, facilitates the sharing of nursing resource personnel, including specialists, among Agency and other clients of Consultant who wish to obtain such additional personnel and share the cost of hiring, training, and compensating such personnel.

H. Assists in designing policies and procedures to periodically review the health status of employees to ascertain freedom from infection, compliance with local and state health regulations for the various specific categories of employees, and proper documentation of compliance.

I. Participates, in an advisory capacity, with the utilization review committee to develop norms, standards and criteria for the design and conduct of the committee's medical care evaluation studies. However, Consultant shall not direct in any way the functions of the utilization review committee such as individual patient reviews.

J. Participates in the design and periodic evaluation of the Agency's staff development and nursing in-service programs, provided that all manuals, materials and forms provided in connection therewith shall be and remain the property of Consultant and may not be copied, reproduced, distributed or used other than with the express written permission of Consultant.

K. Provides periodic in-services and other formal and informal trainings as requested by Agency, which may be offered simultaneously and in conjunction with the trainings for other of Consultant's clients. Such trainings shall include no nursing, therapy or direct care services by Consultant's representatives, but may or may not include, without limitation, assistance with patient assessment, charting and similar activities when performed in connection with in-services, survey readiness reviews, mock surveys and other similar nursing consulting and training, in order to assist nursing leadership and staff in the lawful and efficient conduct of caregiving and therapy operations; provided that all trainings and materials provided in connection therewith shall be and remain the property of Consultant and may not be copied, reproduced, distributed or used other than with the express written permission of Consultant.

L. Assists in the development, implementation and periodic valuation of certified nursing assistant training programs and other experience-based nursing training activities, whether conducted by Agency or by a third-party educator at Agency's site under a nursing affiliation agreement.

ADDITIONAL DUTIES TO BE PERFORMED BY AGENCY:

Without limiting any other duty or obligation of Agency at law or under the Agreement, Agency shall do all of the following:

2. Agency shall be solely responsible for (i) naming and managing its own

Governing Body as required by applicable laws and regulations, (ii) hiring, supervising and evaluating its administrator and other employees, and (iii) overseeing the day-to-day conduct of its business and related activities.

3. Agency shall be solely responsible for providing a safe and sanitary environment for Agency personnel.

4. Agency shall be solely responsible for (i) operating its business in and from the Agency location(s) in substantial compliance with applicable laws and regulations, (ii) maintaining all federal and state licenses and certifications required to operate the Agency and provide Services to patients and clients, (iii) performing all duties required of a licensee and provider under applicable local, state and federal laws, codes, regulations and provider agreements affecting the operation of the Agency, and (iv) notifying Consultant of any threatened, pending or actual revocation or suspension of its Licenses.

5. Timely furnish Consultant with such information and materials as might ordinarily be expected for Consultant to perform its duties hereunder. Agency shall be solely responsible to assure the accuracy and completeness of all information provided by Agency and its personnel to Consultant, and Consultant shall be entitled to rely thereon without inquiry or diligence of any kind.

6. Agency shall not unreasonably restrict or limit Consultant's access to necessary information, and acknowledges Consultant's right to exercise its independent professional judgment, including recommending Services and rendering such Services using such methods, technologies and procedures as Consultant deems appropriate.

7. Consultant's corporate address: 1675 E. Riverside Drive, Suite 200, Eagle, ID 83616, shall serve Agency's mailing address and address for service of process.

8. If requested by Consultant, Agency shall send delegates to Consultant's customer service teams, operator forums, evaluation and other service teams, trainings, and other committees and events as reasonably requested and available. In addition, to the extent available Agency delegates shall from time to time participate, both as trainees and trainers, in training and leadership conferences and events for the benefit of Consultant and others.

9. With Agency's acquiescence, and at Consultant's expense to the extent the trainee does not provide value to Agency, Agency agrees to periodically serve as a training site for Consultant's employees, providing (where available) preceptorship and organized training for CITs and other trainees of Consultant. In the event that a compensated trainee does not provide full value to Agency during his/her training program, Consultant shall pay directly, or reimburse Agency for, the portion of the trainee's compensation and training expenses that exceed the reasonable value provided.

Exhibit B

BUSINESS ASSOCIATE AGREEMENT

AGREEMENT EFFECTIVE DATE:	_____, 2019
COVERED ENTITY:	**SYMBOL HEALTHCARE, INC., DBA PUGET SOUND HOSPICE** ADDRESS:
BUSINESS ASSOCIATE:	**PENNANT SERVICES, INC.** ADDRESS: 1675 E. Riverside Dr., Suite 120, Eagle, ID 83616

This Business Associate Agreement ("Agreement") is made and entered into as of the Effective Date listed in this Exhibit A, and between the above-listed Covered Entity and Business Associate, with reference to the following facts:

RECITALS

WHEREAS, Business Associate has been engaged to provide staffing services to Covered Entity pursuant to a separate agreement (the "Services Agreement"), and, in connection with those services, Covered Entity may need to disclose to Business Associate, or Business Associate may need to create on Covered Entity's behalf, certain Protected Health Information (as defined below) that is subject to protection under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("HITECH Act"), and regulations promulgated thereunder by the U.S. Department of Health and Human Services to implement certain privacy and security provisions of HIPAA (the "HIPAA Regulations"), codified at 45 C.F.R. Parts 160 and 164; and

WHEREAS, pursuant to the HIPAA Regulations, all business associates of Covered Entity, as a condition of doing business with Covered Entity, must agree in writing to certain mandatory provisions regarding the privacy and security of PHI (as defined below).

NOW THEREFORE, IN CONSIDERATION OF THE FOREGOING, and the mutual promises and covenants contained herein, Business Associate and Covered Entity agree as follows:

AGREEMENT

Definitions.

Unless otherwise specified in this Agreement, all terms not otherwise defined shall have the meanings established in Title 45, Parts 160 and 164, of the United States Code of Federal Regulations, as amended from time to time. Further, capitalized terms used, but not otherwise defined, in this Agreement shall have the meanings set forth in HIPAA, the HIPAA Regulations and the HITECH Act.

1.1 *Breach* shall have the meaning given to such term in 42 U.S.C. § 17921, and shall include the unauthorized acquisition, access, use, or disclosure of PHI which compromises the security or privacy of such information.

1.2 *Business Associate* shall have the meaning given to such phrase under the HIPAA Regulations and the HITECH Act, including, but not limited to, 45 C.F.R. § 160.103 and 42 U.S.C. § 17938, respectively. For purposes of this Agreement, "Business Associate" shall also refer specifically to the entity or individual set forth in the Preamble above.

1.3 *Covered Entity* shall have the meaning given to such phrase under the HIPAA Regulations including, but not limited to, 45 C.F.R. § 160.103. For purposes of this Agreement, "Covered Entity" shall also refer specifically to the entity set forth in the Preamble above.

1.4 *Data Aggregation* shall have the meaning given to such phrase under the Privacy Rule, including, but not limited to, 45 C.F.R. § 164.501.

1.5 *Designated Record Set* means a group of records maintained by or for Covered Entity that may include (i) medical records and billing records about Individuals maintained by or for a covered health care provider, (ii) the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan, or (iii) records used, in whole or in part, by or for Covered Entity to make decisions about Individuals.

1.6 *Electronic Health Record* shall have the meaning given to such phrase in the HITECH Act, including, but not limited to, 42 U.S.C. § 17921(5).

1.7 *Electronic Protected Health Information* ("ePHI") means individually identifiable health information that is transmitted by, or maintained in, electronic media.

1.8 *Health Care Operations* shall have the meaning given to such phrase under the Privacy Rule, including, but not limited to, 45 C.F.R. § 164.501.

1.9 *Individual* has the same meaning as the term *individual* in 45 C.F.R. § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).

1.10 *Privacy Rule* shall mean the Standards for Privacy of Individually Identifiable Health Information codified at 45 C.F.R. Part 160 and Part 164, Subparts A and E, as amended by the HITECH Act and as may otherwise be amended from time to time.

1.11 *Protected Health Information* ("PHI") means any information, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an Individual; the provision of health care to an Individual; or the past, present or future payment for the provision of health care to an Individual; and (ii) that identifies the Individual or with respect to which there is a reasonable basis to believe the information can be used to identify that Individual; and (iii) shall include the definition as set forth in the Privacy Rule including, but not limited to, 45 C.F.R. § 160.103. For purposes of this Agreement, PHI shall include ePHI.

1.12 *Required By Law* shall have the same meaning as the phrase *required by law* in 45 C.F.R. § 164.103.

1.13 *Secretary* means the Secretary of the U.S. Department of Health and Human Services or his/her designee.

1.14 *Security Incident* means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

1.15 *Security Rule* shall mean the HIPAA Regulations that are codified at 45 C.F.R. Part 160 and Part 164, Subparts A and C, as amended by the HITECH Act and as may otherwise be amended from time to time.

1.16 *Unsecured PHI* shall mean PHI that is not secured through the use of a technology or methodology specified by the Secretary in guidance or as otherwise defined in 42 U.S.C. § 17932(h).

Scope of Agreement.

This Agreement applies to the PHI of Covered Entity to which Business Associate may be exposed as a result of the services that Business Associate will provide to Covered Entity pursuant to the Services Agreement. Business Associate shall abide by HIPAA, the HIPAA Regulations and the HITECH Act with respect to PHI of Covered Entity, as outlined below.

Obligations and Activities of Business Associate.

3.1 *Permitted Uses*. Except as otherwise limited in this Agreement, Business Associate may use PHI (i) for the proper management and administration of Business Associate, (ii) to carry out the legal responsibilities of Business Associate, or (iii) for Data Aggregation purposes for the Health Care Operations of Covered Entity. Business Associate may use PHI to provide services to Covered Entity under the Services Agreement provided that Business Associate shall not use PHI in any manner that would constitute a violation of the Privacy Rule or the HITECH Act if so used by Covered Entity.

3.2 *Permitted Disclosures*. Business Associate may disclose PHI (i) for the proper management and administration of Business Associate; (ii) to carry out the legal responsibilities of Business Associate; (iii) as Required By Law; or (iv) for Data Aggregation purposes for the Health Care Operations of Covered Entity. Business Associate may disclose PHI to provide services to Covered Entity under the Services Agreement, provided that Business Associate shall not disclose PHI in any manner that would constitute a violation of the Privacy Rule or the HITECH Act if so disclosed by Covered Entity.

3.2.1 In addition, if Business Associate discloses PHI to a third party, for Business Associate's management and administration purposes as specified in Section 3.2, Business Associate must obtain, prior to making any such disclosure, (i) reasonable written assurances from such third party that the PHI will be held as confidential as provided pursuant to this Agreement and only disclosed as Required By Law or for the purposes for which it was disclosed to such third party; and (ii) a written agreement from such third party to immediately notify Business Associate of any breaches of confidentiality of the PHI, to the extent such third party has obtained knowledge of such breach.

3.3 *Prohibited Uses and Disclosures*. Business Associate shall not use or disclose PHI for fundraising or marketing purposes. In accordance with 42 U.S.C. § 17935(a), Business Associate shall not disclose PHI to a health plan for payment or Health Care Operations purposes if the patient has requested this special restriction, and has paid out of pocket in full for the health care item or service to which the PHI solely relates. Business Associate shall not directly or indirectly receive remuneration in exchange for PHI, except with the prior written consent of Covered Entity and Individual and as permitted by 42 U.S.C. § 17935(d)(1) and (2); however, this prohibition shall not affect payment by Covered Entity to Business Associate for services provided pursuant to the Services Agreement.

3.4 *Other Business Associates.* As part of its providing functions, activities, and/or services to Covered Entity, Business Associate may disclose information, including PHI, to other business associates of Covered Entity, and Business Associate may use and disclose information, including PHI, received from other business associates of Covered Entity as if this information was received from, or originated with, Covered Entity.

3.5 *Safeguards for Protection of ePHI*. Business Associate agrees to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of Covered Entity. In accordance with 42 U.S.C. § 17931 of the HITECH Act, Business Associate shall be directly responsible for full compliance with the policies and procedures and documentation requirements of the HIPAA Security Rule, including, but not limited to, 45 C.F.R. §§ 164.308, 164.310, 164.312, and 164.316. Business Associate shall implement and at all times use all appropriate safeguards to prevent any use or disclosure of PHI not authorized under this Agreement.

3.6 *Reporting of Unauthorized Uses or Disclosures and Security Incidents*. Business Associate agrees to report to Covered Entity in writing any access, use or disclosure of the PHI not provided for or permitted by this Agreement and, any Security Incidents of which Business Associate (or Business Associate's employee, officer or agent) becomes aware. Business Associate shall so notify Covered Entity pursuant to this Section within twenty-four (24) hours after Business Associate becomes aware of such unauthorized use, disclosure or Security Incident. The notice to be provided pursuant to this Section shall be substantially in the same form as **Exhibit 1**, which is attached hereto.

3.7 *Reporting of Breach of Unsecured PHI*. Business Associate agrees to report to Covered Entity any Breach of Unsecured PHI of which Business Associate (or Business Associate's employee, officer or agent) becomes aware without unreasonable delay and in no case later than the next business day after Business Associate learns of such Breach, except where a law enforcement official determines that a notification would impede a criminal investigation or cause damage to national security. Business Associate's notification to Covered Entity hereunder shall be substantially in the same form as **Exhibit 1**.

3.8 *Agents and Subcontractors*. Business Associate agrees to ensure that any agent, including a subcontractor, to whom Business Associate provides PHI, agrees in writing to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such PHI, and implement the safeguards required by Section 3.5 above with respect to ePHI.

3.9 *Mitigation of Unauthorized Uses or Disclosures*. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate or one of its agents or subcontractors in violation of the requirements of this Agreement.

3.10 *Authorized Access to PHI*.

3.10.1 *Individual Requests for Access*. Business Associate shall cooperate with Covered Entity to fulfill all requests by Individuals for access to the Individual's PHI that are approved by Covered Entity. Business Associate shall cooperate with Covered Entity in all respects necessary for Covered Entity to comply with 45 C.F.R. §164.524 and applicable State law. If Business Associate receives a request from an Individual for access to PHI, Business Associate shall immediately forward such request to Covered Entity.

3.10.2 *Scope of Disclosure*. Covered Entity shall be solely responsible for determining the scope of PHI and/or Designated Record Set with respect to each request by an Individual for access to PHI. In the event that Covered Entity decides to charge a reasonable cost-based fee for the reproduction and delivery of PHI to an Individual, Covered Entity shall deliver a

portion of this fee to Business Associate in the event any such reproduction or delivery is made by Business Associate, and in proportion to the amount of work done by Business Associate in producing and delivering the PHI.

3.10.3 Designated Record Set. To the extent that Business Associate maintains PHI in a Designated Record Set and at the request of Covered Entity, Business Associate agrees to provide access to PHI in a Designated Record Set to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 C.F.R. § 164.524 and applicable State law. If Business Associate maintains PHI in a Designated Record Set, and maintains an Electronic Health Record, then Business Associate shall provide such Designated Record Set in electronic format to enable Covered Entity to fulfill its obligations under the HITECH Act, including, but not limited to, 42 U.S.C. § 17935(e).

3.10.4 Patient Right to Amend to PHI. A patient has the right to have Covered Entity amend his/her PHI, or a record in a Designated Record Set for as long as the PHI is maintained in the Designated Record Set, in accordance with 42 C.F.R. §164.526. To the extent that Business Associate maintains PHI in a Designated Record Set, Business Associate agrees to make any amendment(s) to PHI in a Designated Record Set at the request of Covered Entity in accordance with 45 C.F.R. § 164.526. Within fifteen (15) business days following Business Associate's amendment of PHI as directed by Covered Entity, Business Associate shall provide written notice to Covered Entity confirming that Business Associate has made the amendments or addenda to PHI as directed by Covered Entity and containing any other information as may be necessary for Covered Entity to provide adequate notice to the Individual in accordance with 45 C.F.R. §164.526.

3.11 Accounting for Disclosures.

3.11.1 Disclosures. In the event that Business Associate makes any disclosures of PHI that are subject to the accounting requirements of the Privacy Rule 45 C.F.R. §164.528 and/or the HITECH Act including, but not limited to, 42 U.S.C. § 17935(c))[1], Business Associate shall report such disclosures to Covered Entity within three (3) days of such disclosure. The notice by Business Associate to Covered Entity of the disclosure shall include the name of the Individual, the recipient, the reason for disclosure, and the date of the disclosure. Business Associate shall maintain a record of each such disclosure that shall include: (i) the date of the disclosure; (ii) the name and, if available, the address of the recipient of the PHI; (iii) a brief description of the PHI disclosed; and (iv) a brief description of the purpose of the disclosure. Business Associate shall maintain this record for a period of six (6) years and make it available to Covered Entity upon request in an electronic format so that Covered Entity may meet its disclosure accounting obligations under 45 C.F.R. §164.528. If Covered Entity provides a list of its business associates to an Individual in response to a request by an Individual for an accounting of disclosures, and the Individual thereafter specifically requests an accounting of disclosures from Business Associate, then Business Associate shall provide an accounting of disclosures to such Individual.

3.11.2 Electronic Health Record. Business Associate acknowledges that, to the extent Business Associate maintains an Electronic Health Record for Covered Entity, Business Associate is only required to provide an Individual with an accounting of disclosures related to treatment, payment or Health Care Operations for a period of three (3) years prior to such Individual's request. Therefore, upon request by an Individual to Covered Entity for an accounting of disclosures related to treatment, payment or Health Care Operations, Business Associate shall provide to Covered Entity, within three (3) days of Business

[1] The provisions of 42 U.S.C. § 17935(c) become effective on the following dates: (i) for users of electronic health records as of January 1, 2009, this section shall apply to disclosures made by the Covered Entity on and after January 1, 2014; (ii) for covered entities that acquire an electronic health record after January 1, 2009, this section shall apply to disclosures made by the Covered Entity after the later of January 1, 2011 or the date it acquires an electronic health record.

Associate's receipt of a written request from Covered Entity, an accounting of such disclosures for the three (3) year period prior to such request. Notwithstanding this Section, a record of disclosures pertaining to information disclosed by Business Associate for treatment, payment or Health Care Operations shall be maintained in accordance with Section 3.11.1, above.

3.12 *Secretary's Right to Audit*. Business Associate agrees to make its internal practices, books, and records relating to the use and disclosure of PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity, available to the Secretary for purposes of the Secretary determining Covered Entity's and/or Business Associate's compliance with HIPAA, the HIPAA Regulations and the HITECH Act. No attorney-client, or other legal privilege will be deemed to have been waived by Business Associate by virtue of this provision of the Agreement. Business Associate shall provide to Covered Entity a copy of any PHI and related documents that Business Associate provides to the Secretary concurrently with providing such documents to the Secretary.

3.13 *Data Ownership*. All PHI shall be deemed owned by Covered Entity unless otherwise agreed in writing.

3.14 *Compliance*. To the extent Business Associate is to carry out a Covered Entity's obligation under the HIPAA Privacy Regulations, Business Associate shall comply with the requirements of the Privacy Regulations that apply to Covered Entity in the performance of such obligation.

4 **Obligations of Covered Entity**.

4.1 *Notice of Privacy Practices*. Upon written request by Business Associate, Covered Entity shall provide Business Associate with Covered Entity's then current Notice of Privacy Practices.

4.2 *Revocation of Permitted Use or Disclosure of PHI*. Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by the patient to use or disclose PHI of Covered Entity, to the extent that such changes may affect Business Associate's use or disclosure of PHI of Covered Entity.

4.3 *Restrictions on Use or Disclosure of PHI*. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 C.F.R. § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

4.4 *Requested Uses or Disclosures of PHI*. Except for Data Aggregation or management and administrative activities of Business Associate, Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the HIPAA Regulations if done by Covered Entity.

5 **Term and Termination**.

5.1 *Term*. The term of this Agreement shall be coterminous with the Services Agreement. However, Business Associate shall have a continuing obligation to safeguard the confidentiality of PHI received from Covered Entity after the termination of the Services Agreement.

5.2 *Termination Without Cause*. Either party may terminate this Agreement without cause or penalty by the delivery of a written notice from the terminating party to the other party. Such termination is effective thirty (30) calendar days from the date that the other party receives such notice.

5.3 *Termination for Cause*. A breach of any provision of this Agreement by Business Associate shall constitute a material breach of this Agreement and shall provide grounds for immediate termination

of this Agreement by Covered Entity, any provision in this Agreement to the contrary notwithstanding.

5.4 *Judicial or Administrative Proceedings*. Either party may terminate the Agreement, effective immediately, if (i) the other party is named as a defendant in a criminal proceeding for a violation of HIPAA, the HIPAA Regulations, the HITECH Act, or other security or privacy laws or (ii) a finding or stipulation that the other party has violated any standard or requirement of HIPAA, the HIPAA Regulations, the HITECH Act or other security or privacy laws is made in any administrative or civil proceeding in which the party has been joined.

5.5 *Effect of Termination*.

5.5.1 Except as provided in Section 5.5.2, herein, upon termination of this Agreement for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity, including PHI in possession of any Business Associate's subcontractors and retain no copies or backup records of such PHI in any form or medium. Business Associate shall certify in writing to Covered Entity that such PHI has been destroyed.

5.5.2 In the event that Business Associate determines that returning or destroying the PHI is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction unfeasible. Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures to those purposes that make the return or destruction of the PHI unfeasible, for so long as Business Associate maintains such PHI.

6 **Breach Pattern or Practice**.

If either party (the "Non-Breaching Party") knows of a pattern of activity or practice of the other party (the "Breaching Party") that constitutes a material breach or violation of the Breaching Party's obligations under this Agreement, the Non-Breaching Party shall either (i) terminate this Agreement in accordance with Section 5 above, or (ii) take reasonable steps to cure the breach or end the violation. If the steps are unsuccessful, the Non-Breaching Party must terminate the Agreement if feasible. The Non-Breaching Party shall provide written notice to the Breaching Party of any pattern of activity or practice of the Breaching Party that the Non-Breaching Party believes constitutes a material breach or violation of the Breaching Party's obligations under this Agreement within three (3) days of discovery and shall meet with the Breaching Party's Privacy Coordinator to discuss and attempt to resolve the problem as one of the reasonable steps to cure the breach or end the violation.

7 **Disclaimer**.

Covered Entity makes no warranty or representation that compliance by Business Associate with this Agreement, HIPAA, the HIPAA Regulations, or the HITECH Act will be adequate or satisfactory for Business Associate's own purposes. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.

8 **Certification**.

To the extent that Covered Entity determines that such examination is necessary to comply with Covered Entity's legal obligation pursuant to HIPAA, the HIPAA Regulations, and the HITECH Act, Covered Entity or its authorized agents or contractors may, at Covered Entity's expense, examine Business Associate's facilities, systems, procedures (including but not limited to review of training procedures for Business Associate's staff) and records as may be necessary for such agents or contractors to certify to Covered Entity the extent to which Business Associate's security safeguards comply with HIPAA, the HIPAA Regulations, the HITECH Act, and this Agreement.

9 **Indemnification**.

Notwithstanding any contrary provision in the Services Agreement, Business Associate agrees to indemnify, defend and hold harmless Covered Entity, its shareholders, directors, officers, employees, affiliates, and agents ("Indemnified Party") against all actual and direct losses suffered by the Indemnified Party from any breach of this Agreement, negligence or wrongful acts or omissions, including, without limitation, failure to perform its obligations under this Agreement or Breach of Unsecured PHI, by Business Associate or its employees, directors, officers, subcontractors, agents or other members of its workforce. Accordingly, on demand, Business Associate shall reimburse the Indemnified Party for any and all actual and direct losses, liabilities, lost profits, fines, penalties, costs or expenses (including reasonable attorneys' fees) which may for any reason be incurred by Indemnified Party or imposed upon the Indemnified Party by reason of any suit, claim, action, proceeding or demand by any third party, as a result of the Business Associate's breach hereunder.

10 **Compliance With State Law**.

Business Associate acknowledges that Business Associate and Covered Entity may have confidentiality and privacy obligations under applicable State law. If any provisions of this Agreement or HIPAA/HIPAA Regulations/HITECH Act conflict with state law regarding the degree of protection provided for PHI and patient medical records, then Business Associate shall comply with the more restrictive requirements.

11 **Miscellaneous**.

11.1 *Amendment*. Business Associate and Covered Entity agree to take such action as is necessary to amend this Agreement from time to time to enable Covered Entity to comply with the requirements of HIPAA, the HIPAA Regulations and the HITECH Act. This Agreement may not be modified, nor shall any provision hereof be waived or amended, except in a writing duly signed and agreed to by Business Associate and Covered Entity.

11.2 *Interpretation*. The provisions of this Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HIPAA Regulations, the HITECH Act, the Privacy Rule and the Security Rule. The parties agree that any ambiguity in this Agreement shall be resolved in favor of a meaning that complies and is consistent with HIPAA, the HIPAA Regulations, the HITECH Act, the Privacy Rule and the Security Rule.

11.3 *No Third Party Beneficiaries*. Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than Business Associate and Covered Entity, and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.

11.4 *Notices*. All notices or other communications required or permitted hereunder shall be in writing and shall be deemed given or delivered (i) when delivered personally, against written receipt; (ii) if sent by registered or certified mail, return receipt requested, postage prepaid, when received; (iii) when received by facsimile transmission; or (iv) when delivered by a nationally recognized overnight courier service, prepaid, and shall be sent to the addresses set forth on the signature page of this Agreement or at such other address as each party may designate by written notice to the other by following this notice procedure.

11.5 *Regulatory References*. A reference in this Agreement to a section in the HIPAA Regulations or the HITECH Act means the section as in effect or as amended, and for which compliance is required.

11.6 *Assistance in Litigation or Administrative Proceedings*. Business Associate shall make itself, and any subcontractors, employees or agents, available to Covered Entity, at no cost to Covered Entity, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being

commenced against Covered Entity, its directors, officers or employees based upon a claimed violation of HIPAA, the HIPAA Regulations, the HITECH Act, the Privacy Rule, the Security Rule, or other laws relating to security and privacy, except where Business Associate or its subcontractor, employee or agent is a named adverse party.

11.7 *Subpoenas*. In the event that Business Associate receives a subpoena or similar notice or request from any judicial, administrative or other party arising out of or in connection with this Agreement, including, but not limited to, any unauthorized use or disclosure of PHI, Business Associate shall promptly forward a copy of such subpoena, notice or request to Covered Entity and afford Covered Entity the opportunity to exercise any rights it may have under law.

11.8 *Survival*. The respective rights and obligations of Business Associate under Section 3 et seq. of this Agreement shall survive the termination of this Agreement. In addition, Section 5.5 (Effect of Termination), Section 7 (Disclaimer), Section 9 (Indemnification), Section 10 (Compliance with State Law), Section 11.4 (Notices), Section 11.6 (Assistance in Litigation and Administrative Proceedings), Section 11.7 (Subpoenas), and Section 11.9 (Governing Law) shall survive the termination of this Agreement.

11.9 *Governing Law*. This Agreement shall be governed by and construed in accordance with the laws of the state in which the covered entity is principally located to the extent that the provisions of HIPAA, the HIPAA Regulations or the HITECH Act do not preempt the laws of that state.

11.10 *Independent Contractors*. Covered Entity and Business Associate shall be independent contractors and nothing in this Agreement is intended nor shall be construed to create an Agency, partnership, employer-employee, or joint venture relationship between them.

[Signature Page to follow]

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

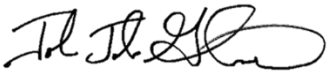
COVERED ENTITY: SYMBOL HEALTHCARE, INC., dba PUGET SOUND HOSPICE	**BUSINESS ASSOCIATE: PENNANT SERVICES, INC.**
Sign: 	**Sign:** 
Name: Lee Johnson	Name: John J Gochnour
Title: Officer	Title: President
Date: ___10/01/2019_____	Date: ___10/01/2019_____

Exhibit 1

Notification to SYMBOL HEALTHCARE, INC., dba PUGET SOUND HOSPICE of Unauthorized Use or Disclosure of PHI/Breach of Unsecured PHI

SYMBOL HEALTHCARE, INC., dba PUGET SOUND HOSPICE
Attn: Privacy Officer
_____
_____
Phone: _____
Fax: _____
Email: _____

This notification is made pursuant to Sections 3.6 and 3.7 of the Business Associate Agreement between Covered Entity and Business Associate.

Business Associate hereby notifies Covered Entity that there has been a breach of protected health information ("PHI") that Business Associate has used or has had access to under the terms of the Business Associate Agreement.

Description of the breach: _____
_____

Date of the breach: _____

Date of the discovery of the breach: _____

Number of individuals affected by the breach: _____

The types of PHI that were involved in the breach (e.g., full name, Social Security number, date of birth, home address, account number): _____
_____

Description of what Business Associate is doing to investigate the breach, mitigate losses, and protect against further breaches: _____
_____
_____
_____

Business Associate contact information: _____
_____
_____

Exhibit 13

2019 Pierce County Community Health Assessment

Community Health Assessment

Pierce County
2019

Overview

In 2018, Tacoma-Pierce County Health Department, MultiCare Health System, CHI Franciscan Health and Kaiser Permanente launched a comprehensive community health planning and assessment process. Undertaken in collaboration with a wide range of community partners, the overall aim of this work was to identify key areas where the community can act to improve community health and address health equity. The assessment also fulfills public health accreditation and healthcare regulatory requirements.

Vision

Building healthy and fair spaces and places for all.

Mission

We will lead the region in growing healthier spaces and places.

Process Principle

Our processes will be collaborative, communicative, data-driven and based on listening, engagement and observation.

Leaders

CHI Franciscan Health:
Laurie Brown and Doug Baxter.

Kaiser Permanente:
Victoria Garcia.

MultiCare Health System:
Lois Bernstein, Kristin Gilman and Dr. Jamilia Sherls.

Tacoma-Pierce County Health Department:
Tommy George, Cindan Gizzi, Karen Meyer, Ingrid Payne and Emily Turk.

Acknowledgements

We thank the many community members who gave their time to complete surveys and participate in community workshops.

We acknowledge the following individuals and organizations who contributed to this report:

- Pierce County Accountable Communities of Health Community Voice Council.
- Bates Technical College.
- Black Infant Health Program (Tacoma-Pierce County Health Department).
- City of Tacoma.
- City of Lakewood.
- City of Puyallup.
- Community Health Care.
- Eatonville Community Coalition.
- Exceptional Families Network.
- Foundation for Healthy Generations, Community Health Advocates.
- Graham Community Coalition.
- Key Peninsula Violence Prevention Coalition.
- Korean Women's Association.
- Pacific Lutheran University.
- Pierce College.
- Pierce County.
- Pierce County Cities and Towns Association.
- Pierce County Human Services.
- Pierce County Community Health Workers Collaborative.
- Pierce County Library System.
- Pierce Transit.
- Prairie Ridge Coalition.
- Rainbow Center.
- Tacoma Pierce County League of Women Voters.
- University of Puget Sound.

This list includes organizations who supported community workshops and/or promoted the 2018 Community Survey. We apologize if we unintentionally missed anyone.

Executive Summary

Tacoma-Pierce County Health Department, in partnership with CHI Franciscan, MultiCare Health System, Kaiser Permanente and University of Washington – Tacoma conducted a Community Health Assessment to identify key health issues based on current data. This Community Health Assessment includes the results of a comprehensive review of key health indicator data and community input, to understand and address the needs of this specific community.

Within this report, the term "community" refers to residents who live, learn, work or play in Pierce County.

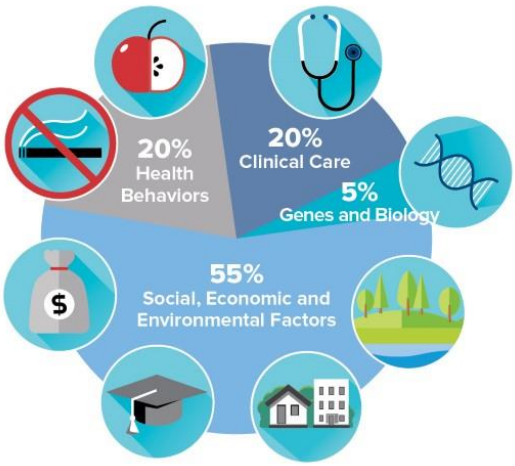
This report presents data on:

- Community demographics.
- Life expectancy and leading causes of death.
- Chronic illness, including behavioral health.
- Injury and violence.

Additionally, the Community Health Assessment process included asking community members about the health of their community, what they need in their neighborhoods to be healthy and what they think could be improved. These community engagement activities included 10 community workshops with residents, 10 interviews with local organizational leaders and an online community survey. MultiCare Health System, CHI Franciscan and Tacoma-Pierce County Health Department pledge to engage community stakeholders throughout the Community Health Assessment process, not simply as sources of input, but as equal partners with shared accountability and investment in addressing health concerns.

Commitment to Health Equity

Throughout the CHA process, social determinants of health provided the framework for both the community engagement process and to focus attention on the importance of neighborhood and community conditions. Income, education, housing and transportation create opportunities or barriers to health. Health should not be determined by zip code, income, race or any other factor. Healthy choices should be easy choices for everyone in Pierce County.



Contents

Introduction

The Community Health Assessment (CHA) process included quantitative analysis and qualitative interviews and focus groups with community leaders and residents of Pierce County representing many sectors and population groups, including low-income residents and others affected by health disparities.

Purpose

The purpose of this report is to share the emerging health needs of Pierce County, including:

- What residents have to say about health and community perceptions.
- Health behaviors and health outcomes of residents.
- This report contains information that can be used to respond to an evolving community and new challenges.

Methods

To develop this report, an array of data sources was analyzed to describe the health of the community. These included:

- Community workshops.
- Community survey.
- Forces of change assessment.
- Selected health indicators.

The report summarizes:

- Community characteristics.
- Life expectancy.
- Leading causes of death.
- Leading causes of hospitalizations.
- Levels of chronic illness.
- Access to healthcare and use of preventive services.
- Maternal and child health.
- Injury and violence prevention.
- Behavioral health.

Details about the sources and methods used to develop this report can be found in the Supplement.

Limitations

For this report, we highlighted data from focus groups, interviews and surveys. While some survey results can be weighted to improve generalizability, focus group and interview results are not entirely generalizable and there are limitations to the strength of the conclusions. Survey data often have issues arising from how, where and from whom the data were collected. For example, stratifying estimates sometimes cannot be done due to small sample sizes.

Community Engagement

We used 3 methods of community engagement to gather input from Pierce County residents about what makes their community healthy, what they need in their neighborhoods and what they think could be improved:

- Community workshops.
- Forces of change assessment workshops.
- Online surveys.

Activities included 10 community workshops with residents, 10 interviews with local organizational leaders and an online community survey. The online survey was available to residents in English, Spanish and Korean.

Top findings across the 3 community engagement activities included the following important issues.

- Community characteristics seen as vital to health:
    - Equitable access to community resources (information, services, activities, parks).
    - Diversity is celebrated.
    - People working together.

- What residents need in their neighborhood or community to be healthy:
    - Affordable housing.
    - Access to healthy food.
    - Transportation.
    - Access to healthcare (emphasizing behavioral health services).

Residents played an active role in community engagement activities, like reviewing questions used for workshops and community surveys and reviewing the summary of results from the interviews and workshops, they participated in. Professional translation services were used to provide the first survey drafts in Korean and Spanish. The drafts were then shared with community members who speak Korean and Spanish natively to confirm contextual accuracy.

Community Workshops

The purpose of the community workshops was to hear directly from residents. Ten community workshops (focus groups) were held throughout Pierce County and were facilitated by trained community residents and Health Department staff.

Tacoma-Pierce County Health Department selected participants from geographic areas identified as "communities of focus" in the 2015 Tacoma-Pierce County Health Department Health Equity Assessment. These communities showed poorer health outcomes and readiness to work collectively to improve these outcomes. Specific populations were identified based on their geographic location and/or health outcomes. Analysts considered literature on stakeholder selection for CHAs produced by the Health Research and Educational Trust, in partnership with Hospitals in Pursuit of Excellence. Tacoma-Pierce County Health Department recruited participants, and, in some cases, participants invited others to attend (i.e., snowball sampling method). Those who attended were promised confidentiality and consented to participate by attending the workshop.

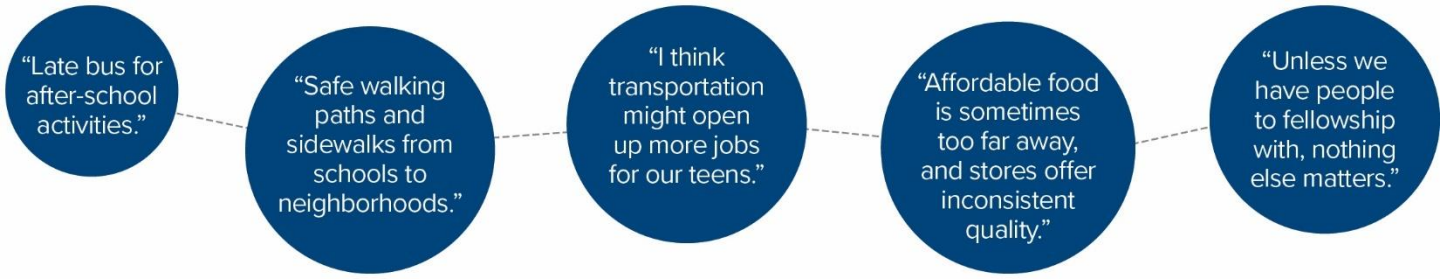
Data analysis of workshop notes was performed simultaneously by the workshop group facilitator and a Tacoma-Pierce County Health Department analyst using coding to identify emergent themes. Analysis was then compared, and themes were mutually identified.

What do you think makes an ideal neighborhood or community?

- Opportunities to give and receive social support.
- Diversity is valued.
- Community resources.
- Organizations and groups willing to partner.

What needs to change about your community or neighborhood?

- Safe sidewalks and trails.
- Buses that meet people where they live, learn, work and shop.
- Access to healthy food.
- Opportunities for physical and social activities.



Community Survey

The purpose of the community survey is to hear directly from residents for the Pierce County Community Survey (see Methods section). The purpose of the survey was to better understand the community's views on issues related to healthcare services, economic opportunity, health problems and concerns, and other issues that impact community health. When asked to rate the overall health of the community, 78% of survey participants rated it as healthy (ranging from somewhat healthy to very healthy). Perceptions of community health can be associated with many factors, like education, poverty, health systems, public and social services and other conditions.

1,620 Pierce County residents responded to the community survey.[1]

Nearly ⅔ of those who participated selected **safe neighborhoods and affordable housing as their most important community needs**, followed by access to healthcare services. When asked about resources available to meet these needs, residents identified parks and outdoor spaces, easily accessible grocery stores and markets as well as safety resources like street lighting and police presence. Survey participants were also asked what is lacking to meet identified needs. From the list provided, residents selected **policies that address local needs, accessible public transit and community resources that contribute to safety** like street lighting, police presence and neighborhood watches. Residents also indicated that policies to protect air and water quality are important and needed.

Residents reported that the top issues facing children and youth include **exposure to crime and violence, poverty and lack of positive relationships**.

Most Important Community Needs

Community Perceptions

Question	Responses				
	Very healthy	Healthy	Somewhat healthy	Somewhat unhealthy	Very unhealthy
How would you rate your community's overall health?	2.7%	27.0%	51.9%	17.1%	2.0%

Question	Responses				
	Very satisfied	Somewhat satisfied	Neutral	Somewhat unsatisfied	Very unsatisfied
How satisfied are you with your community?	28.8%	46.0%	11.8%	10.4%	3.0%

[1] Community Survey respondents by language—English: 1,565; Korean: 41; Spanish: 14.

Question	Responses				
	Very connected	Somewhat connected	Neutral	Somewhat unconnected	Very unconnected
How connected do you feel to your community?	22.5%	45.6%	16.0%	10.5%	5.4%

Who answered the survey?

Respondents' most common zip codes were:

- 98405 (Central Tacoma)— 6%.
- 98406 (North Tacoma)—6%.
- 98391 (Lake Tapps, Bonney Lake)—5%.
- 98404 (East Tacoma)—5%.
- 98407 (North Tacoma, Ruston)—5%.

Efforts were made to distribute the survey to a representative sample of Pierce County residents (by age, race, gender, ethnicity). However, survey participants were disproportionately female and 30 to 60 years old. The n value of demographics for survey respondents is 1,620.

Description of Pierce County

This section describes the entirety of Pierce County using demographic and socioeconomic characteristics. Residents are mostly white (67%), followed by Hispanic (10%), Asian (6%), black (6%) and multiracial (6%) with an increasing number of adults 55 to 74 years old. Immigrants in Pierce County originate from Asia, Latin America and Europe.

8% of Pierce County residents experience poverty versus 13% statewide with significant variations geographically.

Poverty is most prevalent among residents who are American Indian or Alaska Native (25%), Hispanic (24%), and among those who selected “other” for race/ethnicity (27%). These groups are twice as likely as white residents (11%) to experience poverty and reported having high housing costs (greater than 30% of household income) contributing to their poverty status. 43.3% of students last year were eligible for free or reduced-price lunch. This was just slightly higher the state average (42.3%).

The percent of community members living with a disability (13%) is also slightly higher than the state average (12%).

Demographic Characteristics

The characteristics of a community inform what health behaviors and outcomes may be future concerns or help us further understand existing populations health issues.

Race and Ethnicity

This community is primarily white (67.0%) and Hispanic (10.6%). The next largest groups are black (6.8%), Asian (6.5%) and multiracial (6.5%).

Age and Sex

Since 2007, the percent of the population in the 55 to 64 and 65 to 74 year age groups has increased by 2.6% and 3.2%, respectively. The proportion of males to females has remained approximately 1:1.

Demographics (%), Pierce County, 2016

Race and Ethnicity	Count	Percent
American Indian or Alaskan Native (AIAN)	9,646	1.1%
Asian	55,867	6.5%
Black	58,512	6.8%
Hispanic	91,042	10.6%
Multiracial	55,446	6.5%
Native Hawaiian or Pacific Islander (NHOPI)	12,833	1.5%
White	576,054	67.0%

Sex	Count	Percent
Female	435,513	50.7%
Male	423,887	49.3%

Age (Years)	Count	Percent
Under 1	11,995	1.4%
1-4	47,938	5.6%
5-14	115,754	13.5%
15-24	108,888	12.7%
25-34	117,140	13.6%
35-44	109,851	12.8%
45-54	114,446	13.3%
55-64	112,966	13.1%
65-74	74,921	8.7%
75-84	31,772	3.7%
85+	13,730	1.6%

Source: Washington State Office of Fiscal Management, Forecasting Division.

Socioeconomic Characteristics

The social and economic characteristics of a community help public health stakeholders understand available resources and improve community health. Poverty, homelessness and the cost of housing are some examples of important socioeconomic characteristics.

On-Time Graduation

The graduation rate helps describe the educational wellbeing of a community. A higher educational level helps people take advantage of employment opportunities and earn higher incomes, which helps to diminish the burden of poverty on a community.

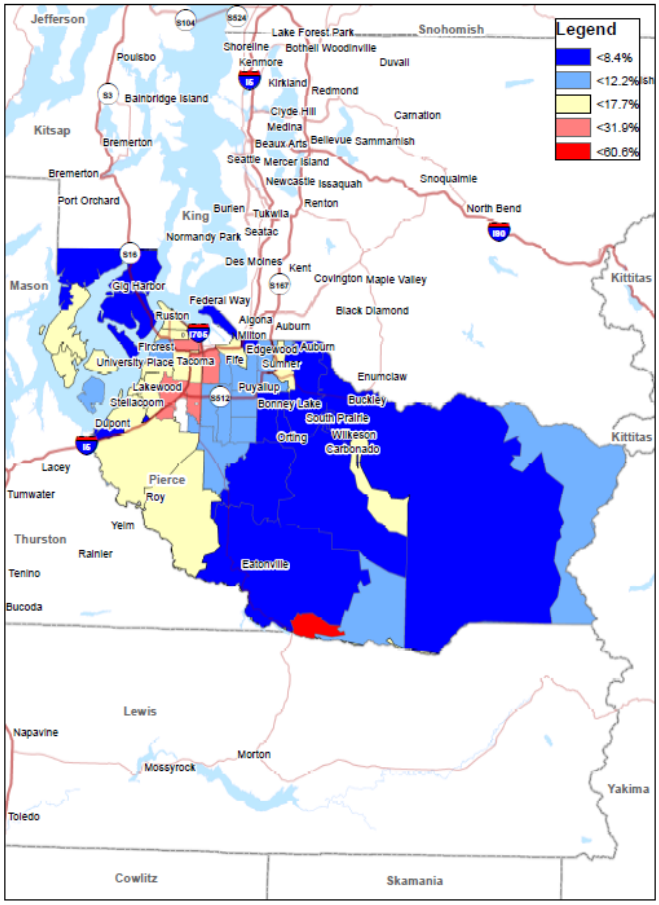
The 2017 4-year graduation rate, gathered from Office of Superintendent of Public Instruction (OSPI) data, in Pierce County was higher (82%) than Washington State (79%).

Poverty and Near Poverty

Poverty—household income less than 100% of the federal poverty limit (FPL)—and near poverty—household income less than 200% of FPL—is a significant burden on households and communities, hindering access to resources promoting good health.

8% of Pierce County residents experienced poverty versus 13% statewide with significant variations geographically.

Poverty by Zip Code, Pierce County, 2016



Source: United States Census Bureau, 2016 American Community Survey (ACS) 5-year estimates, S1701.

High Housing Costs

Seattle was one of the fastest growing United States cities in 2018, driving up housing prices and displacing lower-income residents throughout the area, including Tacoma[2] and Pierce County. A housing cost greater than 30% of household income can be a hardship on individuals and families, especially as persistent poverty continues amidst rising property costs. Housing costs are typically more burdensome among renters.

Poverty and Housing Costs (%), Pierce County, 2016

Income Level	Count	Percent
Poverty (<100% PL)	103,562	13%
Near Poverty (>200% FPL)	237,408	29%

[2] www.census.gov/newsroom/press-releases/2018/estimates-cities.html.

Poverty Racial Breakdown	Count	Percent
AIAN	2,477	25%
Asian	6,556	13%
Black	9,304	17%
Hispanic	19,454	24%
Multiracial	10,033	17%
NHOPI	1,782	16%
White	67,039	11%
Other	6,371	27%

Population with Burdensome Housing Costs	Count	Percent
Renters	59,755	52%
Owners with mortgage	46,085	34%
Owners without mortgage	6,948	14%

Source: United States Census Bureau, 2016 ACS 5-year estimates, S1701 and DP04.

Homelessness

In 2017, City of Tacoma declared a public health emergency related to homelessness. Tacoma joined other west coast cities in this emergency declaration, including Seattle, Portland and Los Angeles. The Homelessness Housing and Assistance Act requires each county in the state to conduct an annual Point in Time count of sheltered and unsheltered people living homeless to estimate the number of people experiencing homelessness.

Overall in Pierce County, 1,628 people living homeless were counted in 2017.

The top 3 zip codes where homeless people were found included 98405 (n=200, 28%), 98402 (n=151, 21%) and 98372 (n=58, 8%). This is primarily north of I-5 in the Central Tacoma and Hilltop areas and Puyallup/Sumner/Bonney Lake.

Free and Reduced-Price Lunch

The free and reduced-price meal program is a federal program for students whose household income is less than or equal to 130% of the FPL (free) or between 130% and 185% of the FPL (reduced-price). This program helps ensure children have access to food with adequate nutritional value.

In Pierce County, 43% of students in the 2016-2017 school year were eligible for free or reduced-price lunch. This is similar to Washington State (42%).

Foster Care

Foster care placement and support services are provided to children who need short-term or temporary protection because they are abused, neglected or involved in family conflict. Foster care placement services are served exclusively out of home, while support services may be in or outside of the child's own home.

Of the 6,200 children who entered out-of-home care in Washington state in 2017, 1,009 were in Pierce County, making it the county with the highest number of children entering care.

Within Pierce County, the rate of children living in out-of-home care was 7.4 per 1,000, which was 35% higher than the Washington State rate of 5.5 kids per 1,000.[3]

Immigrants (Foreign-Born)

Immigrants are a sizable proportion of Washington's population, contributing to diverse community demographics. Estimates of the number of immigrants currently in the United States vary widely depending on their immigration status. Data collected as part of the United States Census help estimate this number.

Foreign-Born Residents (%), Pierce County, 2012-2016

Region of Birth	Count	Estimate	95% Confidence Interval (CI)
Asia	34,729	43.8%	(42.7%-45.0%)
Latin America	21,532	27.2%	(25.8%-28.6%)
Europe	15,527	19.6%	(18.3%-20.9%)
Africa	2,841	3.6%	(2.9%-4.3%)
North America	2,840	3.6%	(3.1%-4.0%)
Oceania	1,771	2.2%	(1.8%-2.7%)
Total*	79,240	9.2%	n/a

*Percent of total population in Pierce County.
Source: United States Census Bureau, 2016 ACS 5-year estimates, DP02 (foreign-born population, excluding born at sea).

Languages Spoken

English continues to be the most common language spoken in the community, followed by Spanish.

Top 10 Languages Spoken (%), Pierce County, 2012-2016

Language	Estimate	95% CI
English	81.1%	(81.0%-81.2%)
Spanish	8.4%	(8.3%-8.4%)
Chinese	1.4%	(1.3%-1.4%)
Vietnamese	0.9%	(0.9%-1.0%)
Russian	0.9%	(0.8%-0.9%)
Tagalog	0.9%	(0.8%-0.9%)
Korean	0.7%	(0.7%-0.8%)
African Language	0.6%	(0.6%-0.7%)
German	0.5%	(0.4%-0.5%)
Other Pacific Island Language	0.5%	(0.4%-0.5%)

Source: United States Census Bureau, 2016 ACS 5-year estimates, B16001.

[3] Partners for our children. pocdata.org/content-data/data/county-reports/county_report_Pierce.pdf. Accessed Dec. 28, 2018.

Limited English Proficiency

While many individuals are multilingual (speak 1 or more languages other than English), some report they either do not speak English or speak English "less than very well." In Pierce County, 6% speak English “less than very well,” compared to 8% statewide.

Speaks English “Less Than Very Well” by Primary Language Spoken (%), Pierce County, 2012-2016

Language	Estimate	95% CI
Vietnamese	67.5%	(57.6%-77.4%)
Arabic	64.1%	(27.9%-100%)
Korean	60.4%	(53.5%-67.2%)
Thai	55.3%	(17.4%-93.2%)
Other Slavic Language	43.5%	(30.4%-56.7%)
Chinese	43.0%	(31.9%-54.1%)
Russian	42.3%	(34.0%-50.5%)
Japanese	41.4%	(32.5%-50.3%)
Other Indo-European Language	37.7%	(18.8%-56.5%)
Laotian	36.8%	(20.8%-52.7%)

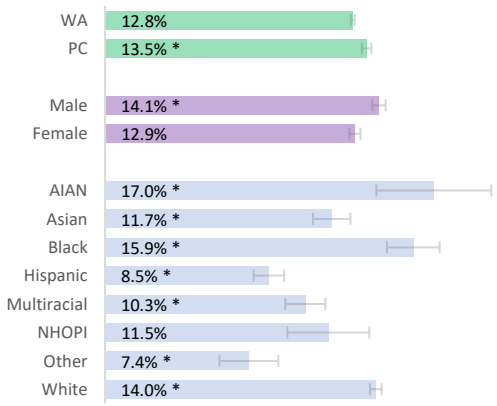
Source: United States Census Bureau, 2016 ACS 5-year estimates, B16001.

Disability

Disabilities can involve or relate to any of five functions: hearing, vision, cognition, ambulatory self-care and independence.

Pierce County disability rates are higher than the state. More males than females in Pierce County are disabled. Disability is more common among American Indian or Alaska Native, black and white people in Pierce County.

Disabled (%), Pierce County, 2012-2016



* Value significantly different than in Washington.
Source: United States Census Bureau, ACS 5-year estimates, S1810 (disability characteristics).

Behavioral Health

Mental health is essential to a person's wellbeing and ability to live a full and productive life. People of all ages, including children and adolescents, with untreated mental health disorders are at an elevated risk for co-occurring disorders, including substance abuse and dependency. Continuing to support systems and policies committed to addressing these concerns can help improve the lives of those who experience mental health issues and strengthen our community. As part of these efforts, Wellfound Behavioral Health Hospital was developed by partners MultiCare Health System and CHI Franciscan, in direct response to increasing rates of mental health and substance abuse disorders (including opiate abuse) among Pierce County residents.

In Pierce County, 5% of adults have experienced, or are experiencing, serious mental illness, which is higher than the Washington State average (3%).

Youth are experiencing depression at rates comparable to Washington State, while adults in Pierce County are experiencing depression at rates higher than the state average. Females are reporting depression at about twice the rate of males (among youth and adults).

Pierce County youth reported similar levels of suicidal ideation as the state average. Females are more likely than males to report suicidal ideation in the past year. Suicide ideation is more common among Multiracial youth, American Indian or Alaska Native and Native Hawaiian or Pacific Islander youth. Pierce County youth reported receiving less education about suicide than the state average. There is no difference in the percent of youth reporting suicide attempts in Pierce County than in Washington.

Youth bullying in Pierce County occurs at similar rates as the state. Female youth reported more frequently being a victim of bullying than male youth. American Indian or Alaska Native and multiracial youth reported being a victim of bullying most frequently.

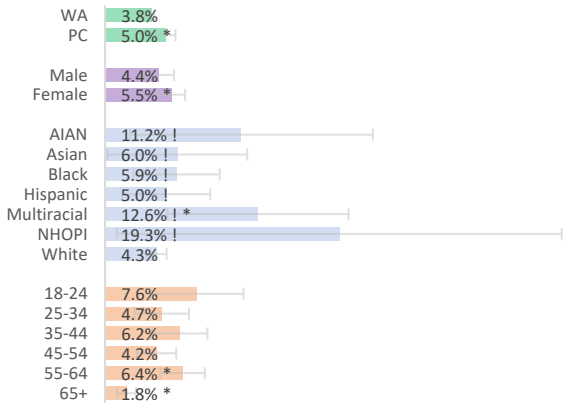
It is important to note that the Wellfound Behavioral Health Hospital was cooperatively proposed and developed in direct response to increasing mental health and substance abuse disorder needs. Reported binge drinking occurred at higher rates by Hispanic and white adults, and among those 25 to 34 years old. Reported marijuana use is highest among adults 18 to 24 years old. Males, multiracial and Native Hawaiian or Pacific Islander adults are more likely to consume marijuana. Black youth are more likely to consume marijuana than their peers.

Serious Mental Illness

The percent of adults with serious mental illness (SMI) is estimated based on a Kepler-6 (K-6) psychological distress scale score of 14 or higher.

SMI is more common in Pierce County than Washington. There are no significant differences by gender or race. Adults older than 65 years are less likely to report SMI than all other age groups.

Serious Mental Illness—Adults (%), Pierce County, 2012-2016



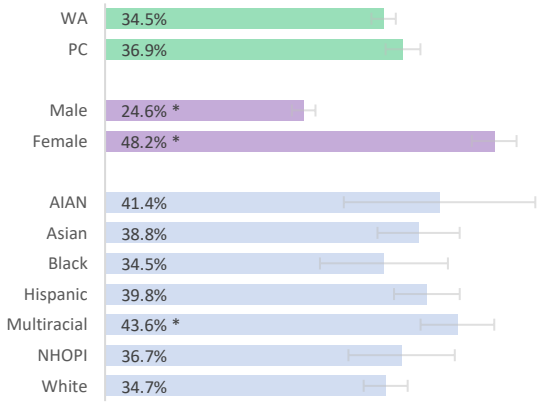
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Source: Behavioral Risk Factor Surveillance System (BHRFSS).

Depression—Youth

Youth are considered to have been depressed when they reported feeling so sad or hopeless almost every day for 2 weeks in a row or more that they stopped doing some usual activities in the past 12 months.

The prevalence of reported youth depression is not significantly different between Pierce County and the state. Females are more likely than males to report depression. There is no significant difference between races.

Self-Reported Depression—Youth (%), Pierce County, 2016



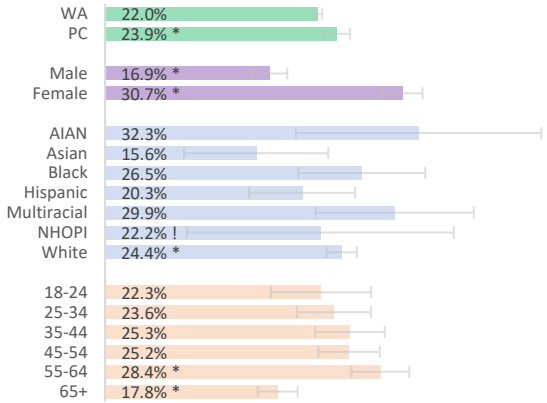
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Source: Healthy Youth Survey (HYS) (10th graders).

Depression—Adults

Depression diagnoses among adults are self-reported through the BHRFSS.

Adult depression is more common in Pierce County than in Washington. Females are more likely to report depression than males. There is no significant difference by race. Adults 65 years and older are less likely than all other age groups to have diagnosed depression.

Diagnosed Depression—Adults (%), Pierce County, 2012-2016



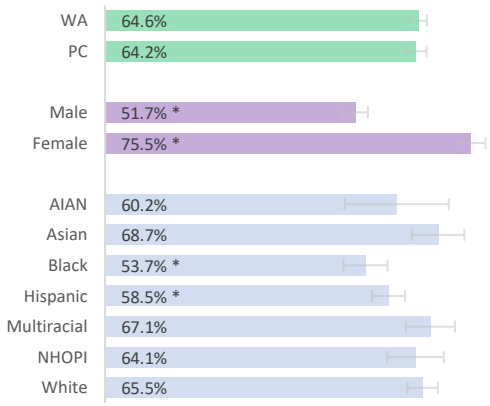
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Source: BHRFSS.

Anxiety—Youth

Anxiety among youth is measured as feeling nervous, anxious or on edge in the past 2 weeks using the HYS.

Youth anxiety prevalence is not significantly different in Pierce County than in the state. Females are more likely to report anxiety than males. Black and Hispanic youth are less likely than Asian and white youth to report anxiety.

Anxiety Some to All Days (%), Pierce County, 2012-2016



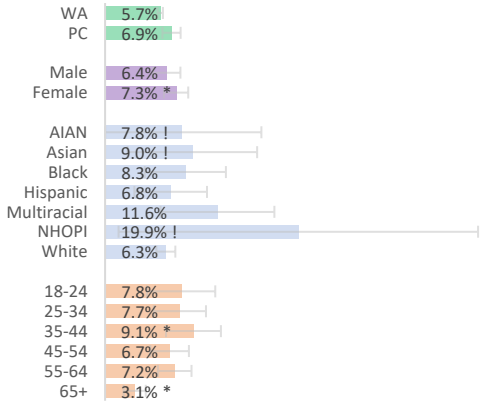
* Value significantly different than in Washington.
Source: HYS (10th graders).

Anxiety—Adults

Anxiety on most or all days is estimated among adults through the BHRFSS.

Anxiety prevalence in Pierce County is not significantly different than in Washington. There are no significant differences by race or gender. Adults 65 years and older report lower levels of anxiety than all other age groups.

Anxiety Most to All Days (%), Pierce County, 2012-2016



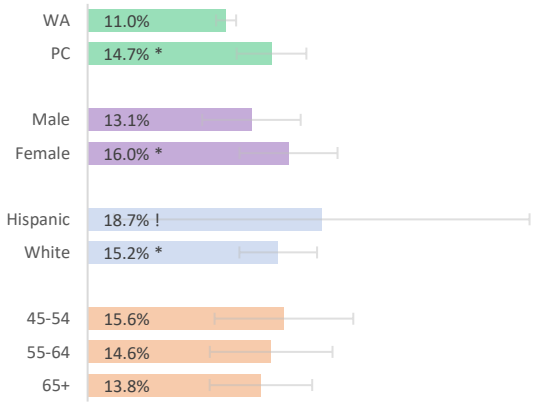
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Source: BHRFSS.

Confusion and Memory Loss

Adults 45 years and older are asked about worsening confusion and memory loss in the past 12 months through the BHRFSS.

Adults in Pierce County report more confusion and memory loss than in the state. There are no significant differences by gender, race or age.

Confusion and Memory Loss (%), Pierce County, 2012-2016



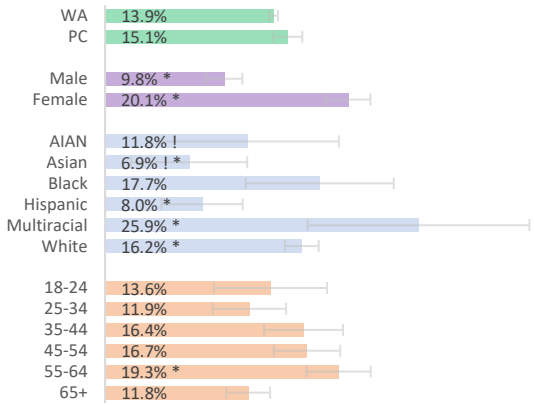
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Race groups excluded due to limited sample size.
Source: BHRFSS.

Mental Health Medication

Adults are asked about medication use for mental health conditions through BRFSS.

There is no significant difference in self-reported mental health medication use between Pierce County and the state. Males are less likely to use mental health medication than females. Asian and Hispanic adults are less likely than white and multiracial adults to use mental health medications.

Mental Health Medication Use (%), Pierce County, 2012-2016



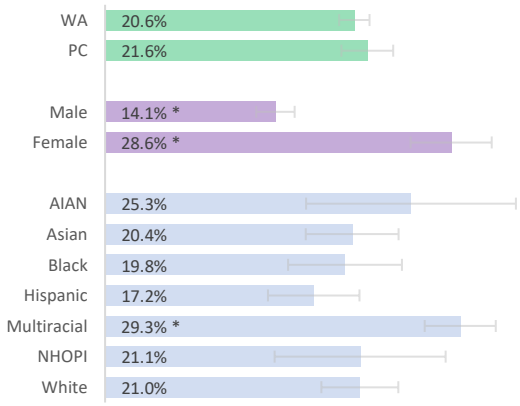
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
NHOPI excluded due to limited sample size.
Source: BHRFSS.

Suicidal Ideation—Youth

The percent of youth reporting suicidal thoughts in the past 12 months is measured from data in HYS.

Youth in Pierce County report similar levels of suicidal ideation as in the state. Females are more likely than males to report suicidal ideation in the past year. Multiracial youth are significantly more likely than all groups except for American Indian Alaska Native, Native Hawaiian or Pacific Islander youth.

Suicidal Ideation in Past Year (%), Pierce County, 2016



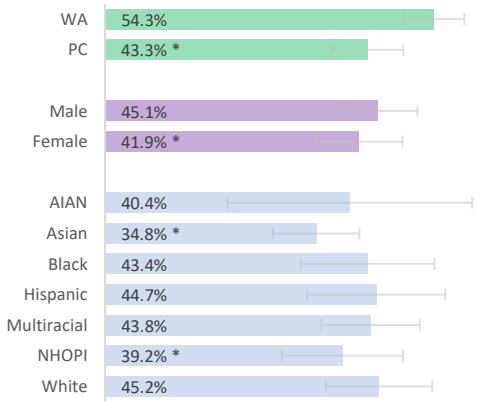
* Value significantly different than in Washington.
Source: HYS (10th graders).

Suicide Education for Youth

The percent of youth who have seen or heard information at school about the warning signs of suicide and how to get help for suicidal thoughts is estimated using the HYS.

Pierce County youth report receiving less education about suicide than the state. There are no significant differences by gender or race.

Suicide Education (%), Pierce County, 2016



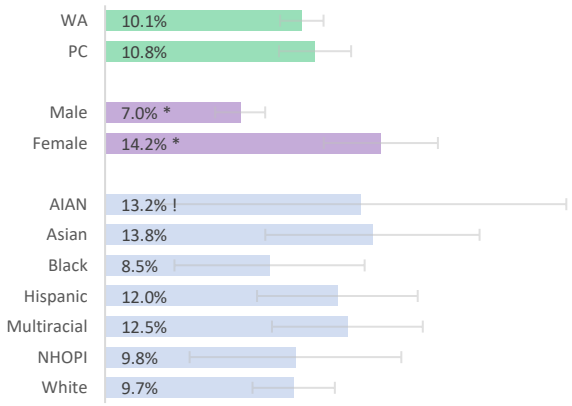
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Source: HYS (10th graders).

Suicide Attempts—Youth

The percent of youth reporting suicide attempts in the past 12 months is measured using the HYS.

There is no difference in the percent of youth reporting suicide attempts between Pierce County and Washington. Females are more likely to attempt suicide than males. There are no significant differences by race.

Suicide Attempts in Past Year (%), Pierce County, 2016



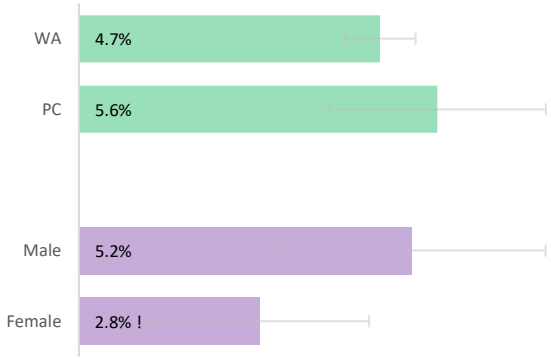
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Source: HYS (10th graders).

Social Support

Adults were asked in BRFSS about how many people they could count on to come help them if they asked for practical help, like help grocery shopping or providing a family member with care.

There is no significant difference in the amount of reported social support between Pierce County and the state. There is no significant difference among Pierce County residents by gender.

No Social Support (%), Pierce County, 2016



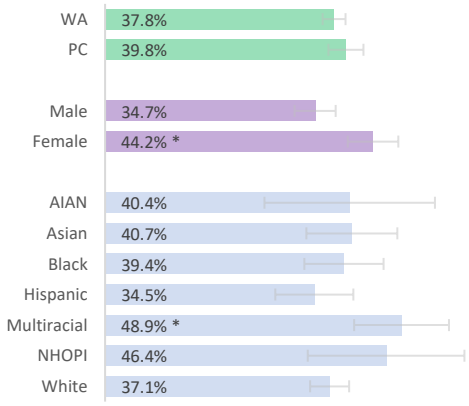
! Relative standard error greater than 30%.
Source: BHRFSS.

Verbally Abused Youth

The percent of youth who were verbally abused by an adult (sworn at, insulted or put down verbally) sometimes, often or very often is estimated using the HYS.

There is no significant difference in the percent of youth who were verbally abused by adults between Pierce County and the state. Females are more likely than males to be verbally abused as youth. There is no significant difference by race.

Verbally Abused (%), Pierce County, 2011-2015



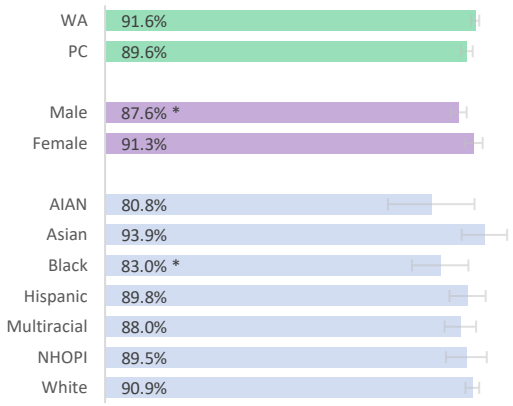
* Value significantly different than in Washington.
Source: HYS (10th graders).

Social-Emotional Skills—Youth

One measure for healthy social-emotional development includes how successfully individuals can understand how others feel and think. This is estimated in HYS.

There was no significant difference between Pierce County and the state. Females reported understanding how others feel and think more often than males. There was no significant difference by race.

Youth Agreed They Understand How Others Feel and Think (%), Pierce County, 2011-2015



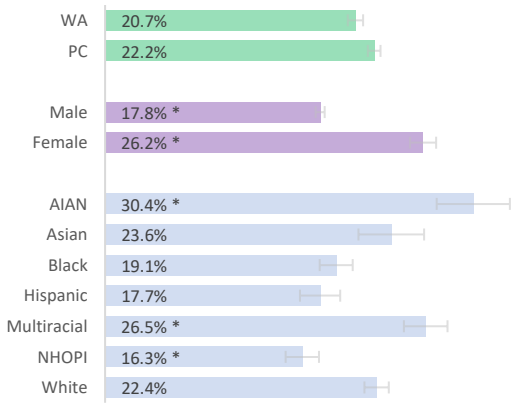
* Value significantly different than in Washington.
Source: HYS (10th graders).

Youth Bullying

The percent of youth reporting being bullied in the past 12 months is measured using the HYS.

Youth bullying in Pierce County occurs at similar rates as the state. Female youth reported more frequently being a victim of bullying than male youth. American Indian or Alaska Native, Asian, multiracial and white youth report being a victim of bullying the most frequently.

Youth Bullied in Past Year (%), Pierce County, 2016



* Value significantly different than in Washington.
Source: HYS (10th graders).

Substance Abuse and Dependency

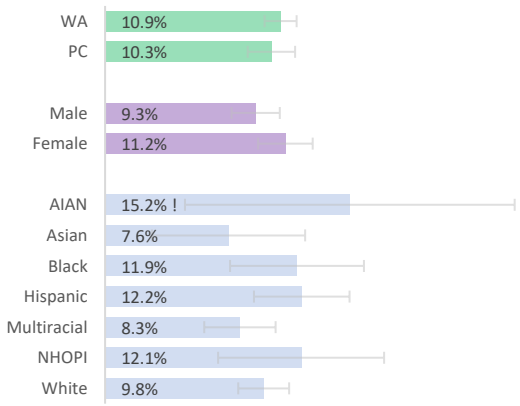
The inappropriate use of substances—legal and illegal—presents major challenges to a community. Alcohol and opioids are well-known contributors to substance abuse and dependency issues. Alcohol and marijuana use among youth, or driving while under the influence of either, are public health concerns. Ensuring an adequate system to assist individuals dealing with substance abuse and dependency issues is key.

Binge Drinking—Youth

Binge drinking among youth is self-reported through HYS. Youth who reported consuming 5 or more drinks in a row in the past 2 weeks were considered to have engaged in binge drinking.

Youth binge drinking rates are not significantly different between Pierce County and Washington. There are no significant differences in binge drinking by gender or race among youth.

Binge Drinking Among Youth, Pierce County, 2016



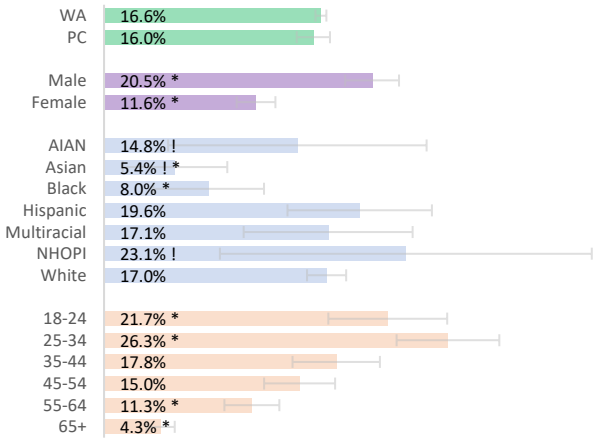
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Source: HYS (10th graders).

Binge Drinking—Adults

Binge drinking among adults is self-reported through BRFSS.

There is no significant difference in binge drinking between Pierce County and the state. Males are more likely than females to binge drink. White and Hispanic adults are more likely to report binge drinking than Asian and black adults. Binge drinking is highest among adults 25 to 34 years old.

Binge Drinking Among Adults, Pierce County, 2016



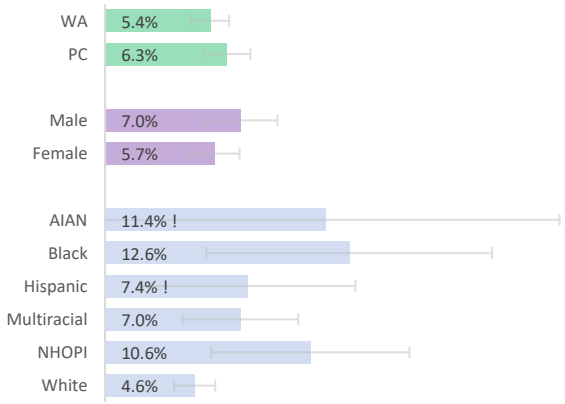
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Source: BHRFSS.

DUI Alcohol—Youth

Driving under the influence (DUI) of alcohol among youth is self-reported using the HYS.

Driving after drinking alcohol reported by Pierce County youth is not significantly different than in Washington. There are no significant differences by gender or race.

DUI Alcohol—Youth (%), Pierce County, 2016



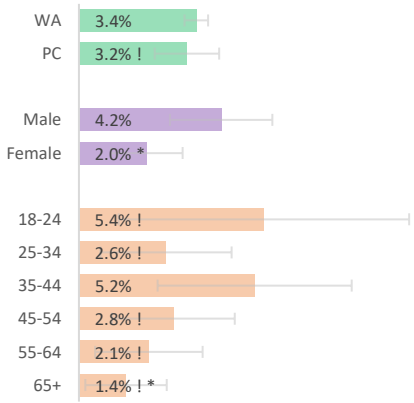
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Asian race excluded due to limited sample size.
Source: HYS (10th graders).

DUI Alcohol—Adults

Driving under the influence of alcohol among adults is self-reported using BRFSS.

There was no significant difference in adults reporting driving after drinking alcohol between Pierce County and the state. There were no significant differences by gender or age. Race data were excluded due to small sample sizes.

DUI Alcohol—Adults (%), Pierce County, 2016



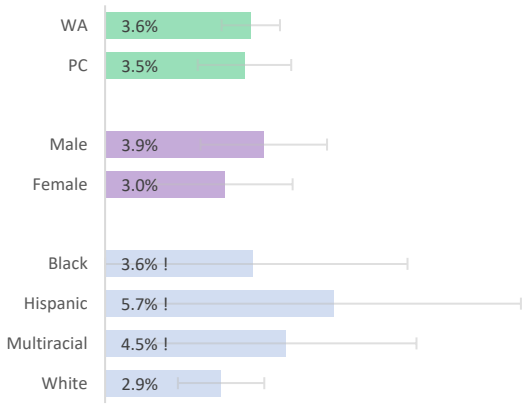
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Race excluded due to limited sample size.
Source: BRFSS.

Opiate Use—Youth

Lifetime heroin use among youth is measured using the HYS.

Lifetime heroin among youth use is not significantly different between Pierce County and Washington. There are no significant differences by gender or race.

Lifetime Heroin Use—Youth, Pierce County, 2016



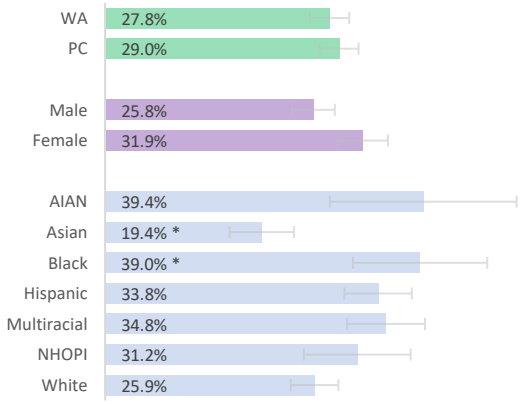
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Some races excluded due to limited sample sizes.
Source: HYS (10th graders).

Marijuana Use—Youth

Lifetime marijuana use among youth is measured using the HYS.

There are no significant differences between Pierce County and Washington or within Pierce County by gender. Asian youth are the least likely group to report lifetime marijuana use.

Lifetime Marijuana Use—Youth, Pierce County, 2016



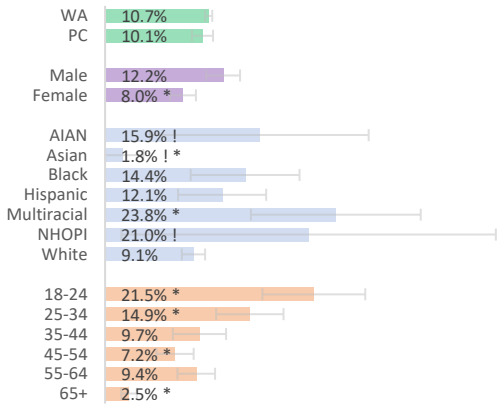
* Value significantly different than in Washington.
Source: HYS (10th graders).

Marijuana Use—Adults

Marijuana use in the past 30 days among adults is measured using BRFSS.

The percent of adults reporting current marijuana use in Pierce County is not significantly different than in Washington. Females are less likely to consume marijuana than males. Asian and white adults are less likely than multiracial adults to consume marijuana. The highest rate of marijuana use by age occurs among adults 18 to 24 years old.

Current Marijuana Use, Pierce County, 2016



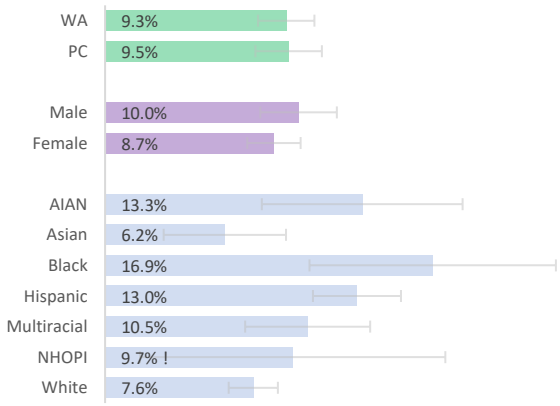
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Source: BHRFSS.

DUI Marijuana—Youth

Driving under the influence of marijuana among youth is self-reported using the HYS.

There are no significant differences in the percent of youth who consume marijuana and drive when comparing Pierce County to Washington. Black and Hispanic youth are significantly more likely than Asian and white youth to report consuming marijuana and driving.

DUI Marijuana Prevalence (%), Pierce County, 2016



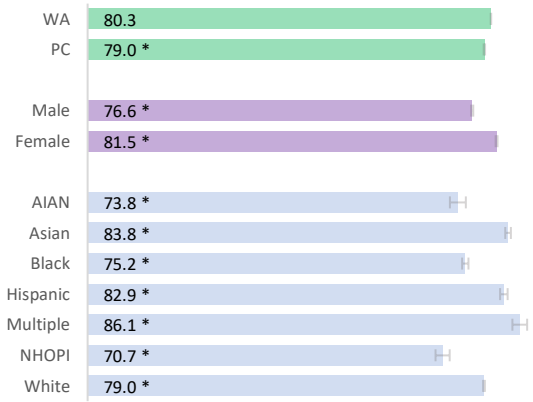
* Value significantly different than in Washington.
Source: HYS (10th graders).

Life Expectancy

Life expectancy—the average number of years a person at birth can expect to live, given current death rates—is a widely used measure of the overall health of a population.

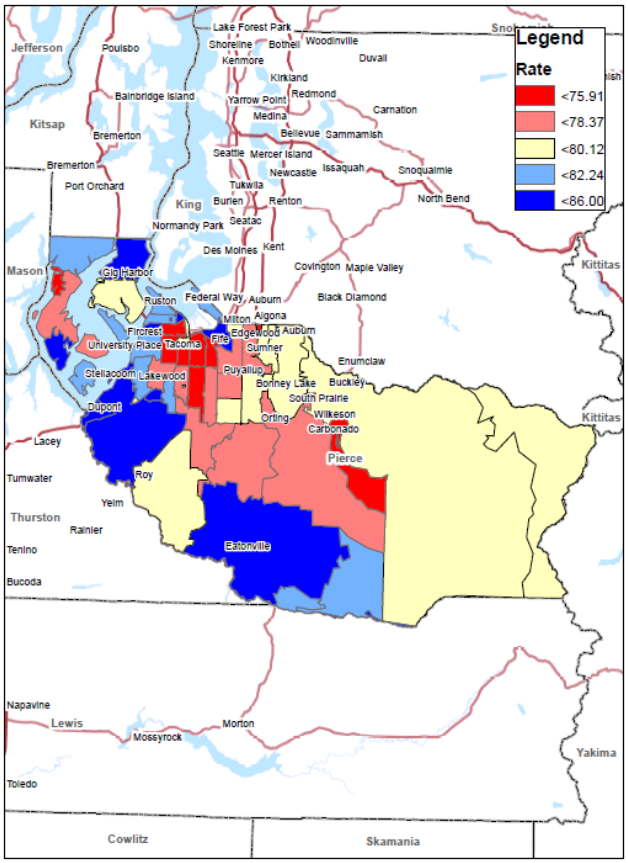
Life expectancy in Pierce County is significantly lower than in Washington. Within Pierce County, females have a higher life expectancy than males. Black, American Indian or Alaska Native and Native Hawaiian or Pacific Islander life expectancies are lower than Asian, Hispanic and white life expectancies.

Life Expectancy by Demographics, Pierce County, 2012-2016



Source: Washington State Department of Health Center for Health Statistics (CHS), Death Certificate Data, 1990-2016, Community Health Assessment Tool (CHAT), October 2017.

Life Expectancy by Zip Code, Pierce County, 2012-2016



Source: Washington State Department of Health CHS, Death Certificate Data, 1990-2016, CHAT, October 2017.

Leading Causes of Death

The leading causes of death in our community are important in planning future public health solutions. Life expectancy is another important indicator for the health of a community. Variation in life expectancy can be explained by differences in socioeconomic status and race/ethnicity, along with behavioral and metabolic risk factors (risk factors that raises your risk for heart disease and other health problems, like diabetes and stroke).[4]

Chronic diseases like cancer, heart disease and lower respiratory disease are the leading causes of death in Pierce County. The leading causes of hospitalization are injury, diseases of the digestive system and diseases of the circulatory system (like strokes and heart disease).

[4] Dwyer-Lindgren L, Bertozzi-Villa A, Stubbs RW, et al. Inequalities in Life Expectancy Among US Counties, 1980 to 2014 Temporal Trends and Key Drivers. *JAMA Intern Med.* 2017;177(7):1003–1011.

Pierce County has a significantly lower life expectancy (79 years) than Washington state (80 years). Native Hawaiian/Pacific Islanders have the lowest life expectancy (70 years) followed by American Indian/Alaska Native (73 years) and black residents (75)—revealing racial disparities.

Diabetes prevalence in the community is twice as high among black residents (16%) compared to Washington State (8%) and white residents (9%).

Lung cancer incidence is higher among American Indian and Alaska Native, Native Hawaiian and Pacific Islander and white residents. Breast cancer incidence is more common among black, white and Native Hawaiian or Pacific Islander residents.

Asthma prevalence is significantly higher among black residents (16%) compared to white residents (10%) and the Washington State average (9%).

Top 10 Causes of Death, Pierce County, 2012-2016

Cause of Death	Rate*
Cancer	168.10
Heart disease	157.30
Chronic lower respiratory disease (asthma, emphysema, COPD)	45.19
Alzheimer's disease	42.34
Unintentional injuries	40.56
Stroke	40.13
Diabetes	22.24
Suicide	17.74
Influenza and pneumonia	11.67
Chronic liver disease	11.18

* Age-adjusted death rate per 100,000 people
Source: Washington State Department of Health CHS, Death Certificate Data, 1990-2016, CHAT, October 2017.

Top 10 Causes of Death by Gender, Pierce County, 2012-2016

Cause of Death	Rate* in Males
Heart disease	207.49
Cancer	197.95
Unintentional injuries	52.66
Chronic lower respiratory disease (asthma, emphysema, COPD)	48.21
Stroke	41.28
Alzheimer's disease	35.48
Diabetes	28.07
Suicide	26.64
Chronic liver disease	16.15
Influenza and pneumonia	13.60

Cause of Death	Rate* in Females
Cancer	146.40
Heart disease	117.39
Alzheimer's disease	46.16
Chronic lower respiratory disease (i.e. asthma, emphysema, COPD)	43.09
Stroke	38.66
Unintentional injuries	28.85
Diabetes	17.59
Influenza and pneumonia	10.08
Suicide	9.27
Hypertension	7.88

* Age-adjusted death rate per 100,000 people
Source: Washington State Department of Health CHS, Death Certificate Data, 1990-2016, CHAT, October 2017.

Leading Causes of Hospitalizations

Hospitalizations occur due to a wide array of health concerns. Understanding these hospitalizations is crucial to prioritizing how we allocate resources, what types of interventions are undertaken and where these interventions should be focused.

Males are more likely than females to be hospitalized due to injury and circulatory system diseases, like stroke and heart disease. The leading causes of hospitalizations for females, excluding pregnancy-related hospitalizations, are diseases of the circulatory and digestive systems.

Top 10 Leading Causes of Hospitalization by Gender, Pierce County, 2011-2015

Cause of Hospitalization	Rate* in Males
Diseases of the circulatory system	1614.34
Diseases of the digestive system	887.27
Injury and poisoning	806.38
Diseases of the respiratory system	756.32
Diseases of the musculoskeletal system and connective tissue	583.40
Infectious and parasitic diseases	555.76
Mental illness	426.18
Cancer	369.52
Diseases of the genitourinary system	346.57
Endocrine, nutritional, and metabolic diseases and immunity disorders	304.12

Cause of Hospitalization	Rate* in Females
Diseases of the circulatory system	1211.98
Diseases of the digestive system	948.41
Injury and poisoning	763.46
Diseases of the respiratory system	751.62
Diseases of the musculoskeletal system and connective tissue	657.87
Infectious and parasitic diseases	501.43
Diseases of the genitourinary system	501.13
Mental illness	476.08
Cancer	389.25
Endocrine; nutritional; and metabolic diseases and immunity disorders	356.13

* Age-adjusted rate per 100,000 people
Source: Washington Hospital Discharge Data, Comprehensive Hospitalization Abstract Reporting System (CHARS).

Chronic Disease

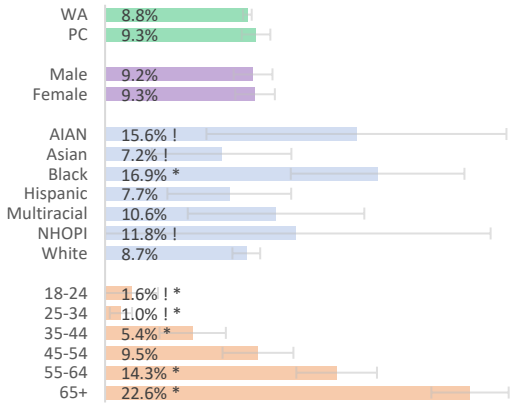
Chronic diseases and conditions—like diabetes, cancer and heart disease—encompass many of the most common, costly and preventable health concerns in our communities.

Diabetes—Adults

The prevalence of diabetes diagnoses among adults is self-reported as part of BRFSS.

Diabetes in Pierce County is not significantly different than in Washington. Black residents have a significantly higher rate than white residents.

Adults with Diabetes (%), Pierce County, 2012-2016



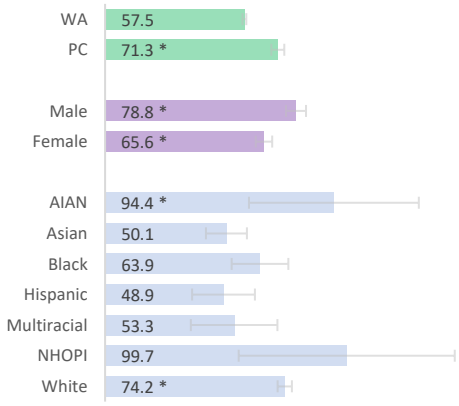
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Groups excluded if cell size less than 10.

Lung Cancer

The number of new cases, or incidence, of lung cancer is available through the Washington State Cancer Registry.

The incidence of lung cancer in Pierce County is significantly higher than in Washington. Lung cancer is more common among males compared to females. Asian residents have a significantly lower lung cancer incidence compared to white residents.

Lung Cancer Incidence, Pierce County, 2011-2015



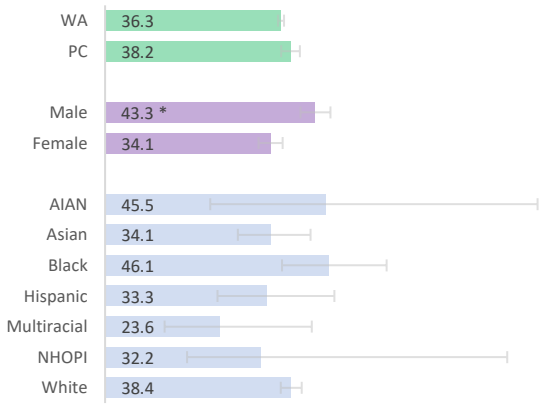
* Value significantly different than in Washington.
Rate: New cancer cases per 100,000 residents.
Source: Washington State Cancer Registry.

Colorectal Cancer

Cancer of the colon or rectum is a common cancer that, when detected early, can often be successfully treated.

Colorectal cancer incidence is similar in Pierce County and Washington. Males have a higher colorectal cancer incidence than females. There are no significant differences by race.

Colorectal Cancer Incidence, Pierce County, 2011-2015



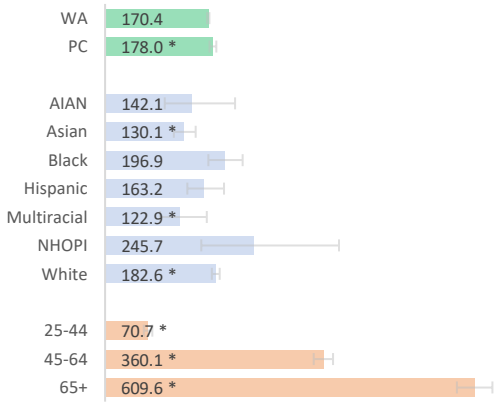
* Value significantly different than in Washington.
Rate: New cancer cases per 100,000 residents.
Source: Washington State Cancer Registry.

Breast Cancer

Cancer of the breast is a common cancer among females. Regular screening can detect this early and increase the chance of successful treatment.

Breast cancer is more common in Pierce County than in Washington. Breast cancer is more common among black and white adults compared to Asian adults.

Breast Cancer Incidence, Pierce County, 2011-2015



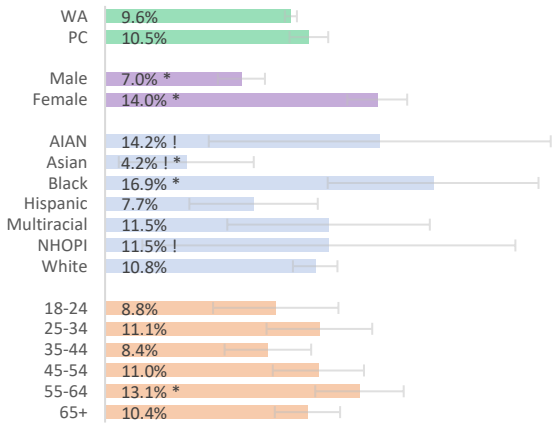
* Value significantly different than in Washington.
Rate: New cancer cases per 100,000 residents.
Source: Washington State Cancer Registry.

Asthma—Adults

Among adults, asthma prevalence is the proportion of adults reporting they have ever been diagnosed with asthma by a healthcare professional.

Asthma prevalence in Pierce County is not significantly different than in Washington. Females are more likely to have asthma than males. Asian adults are significantly less likely to have asthma compared to white and black adults.

Current Asthma—Adults (%), Pierce County, 2012-2016



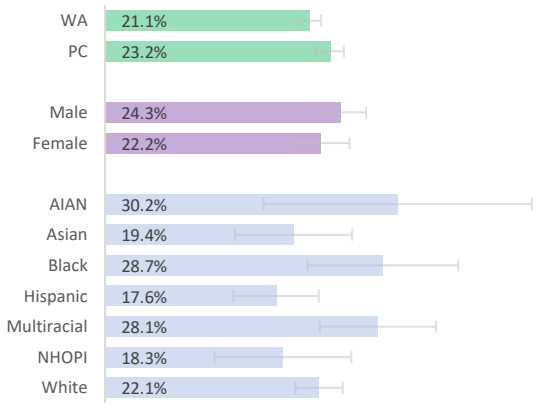
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Groups excluded if cell size less than 10.
Source: BHRFSS.

Asthma—Youth

Asthma affects people of all ages, but most often starts in childhood. Asthma prevalence among children in Washington is estimated using the HYS, where students report if a doctor had ever diagnosed them with asthma.

Youth asthma prevalence in Pierce County is not significantly different than in Washington. There are no significant differences within Pierce County.

Current Asthma—Youth (%), Pierce County, 2016



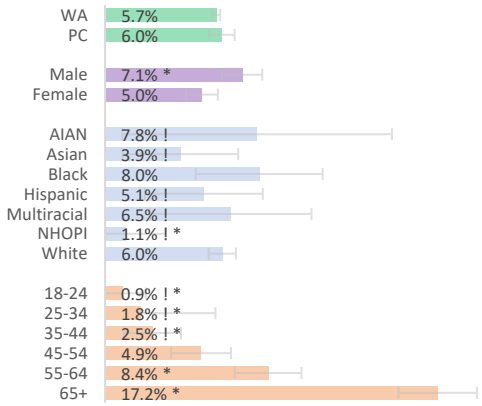
* Value significantly different than in Washington.
Source: HYS (10th graders).

Heart Disease

Heart disease is one of the leading causes of hospitalizations and deaths in Pierce County. BRFSS provides estimates of heart disease diagnoses among adults 18 years and older.

Heart disease prevalence is not different in Pierce County than in Washington. Males are more likely to have heart disease than females.

Heart Disease Prevalence (%), Pierce County, 2016



* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Groups excluded if cell size less than 10.
Source: BHRFSS.

Health Behaviors

A healthy and active lifestyle has been shown to have a profound impact on reducing the burden of chronic illness described in the previous section. A healthy diet and regular physical activity are protective factors promoting our health and wellbeing, while tobacco use, and a multitude of environmental exposures are some factors that may lead to negative health outcomes.

Across Pierce County, obesity among adults is significantly more prevalent than in Washington. Black adults are significantly more likely to be obese than white or Asian adults.

Obesity prevalence among Native Hawaiian or Pacific Islander youth is 3 times higher than among white youth. Obesity prevalence among multiracial youth is twice as high as white youth.

Females are more likely to avoid sugar-sweetened beverages than males. Black youth were the most likely to consume these beverages, while Asian youth were the least likely.

The percent of adults currently smoking is significantly higher in this area than in Washington. The percent of Alaska Native and American Indian adults who smoke cigarettes (42%) is significantly higher than that of white adults (18%) and the state (15%).

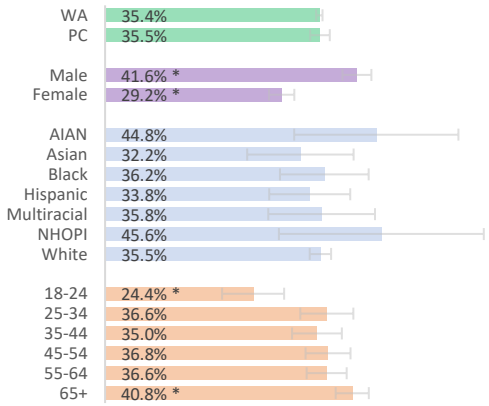
Obesity, Physical Activity and Nutrition

Many chronic diseases discussed in the previous section share the same root causes, like high-calorie diets with low nutritional value and lack of physical activity. Negative behaviors (risk factors) balanced with positive behaviors (protective factors) across a person's lifetime have a profound role in the development of chronic disease.

Overweight—Adults

Body mass index (BMI) is a measure of body fat based on height and weight. It is associated with a wide array of poor health outcomes. Adults are overweight if their BMI is greater than or equal to 25 but less than 30. The percent of adults who are overweight is not significantly different in Pierce County than in Washington. Males are more likely to be overweight compared to females.

Overweight Adults (%), Pierce County, 2012-2016



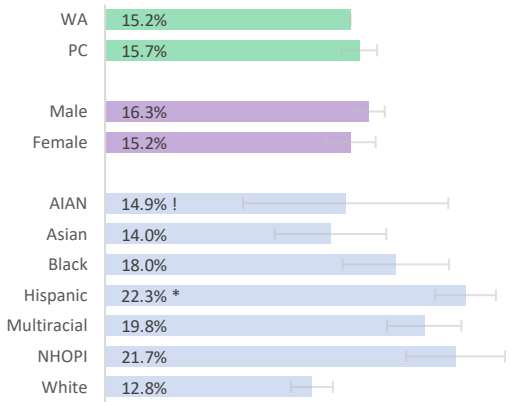
* Value significantly different than in Washington.
Source: BHRFSS.

Overweight—Youth

BMI groups are determined using the HYS responses from students in 6th through 12th grade. "Overweight" includes students who are in the top 15% for BMI by age and gender, but not the top 5%, based on growth charts from the Centers for Disease Control and Prevention (CDC).

The percent of overweight youth in Pierce County is not significantly different than in Washington. White youth are significantly less likely to be overweight when compared to black, Hispanic, multiracial and Native Hawaiian or Pacific Islander youth.

Overweight Youth (%), Pierce County, 2016



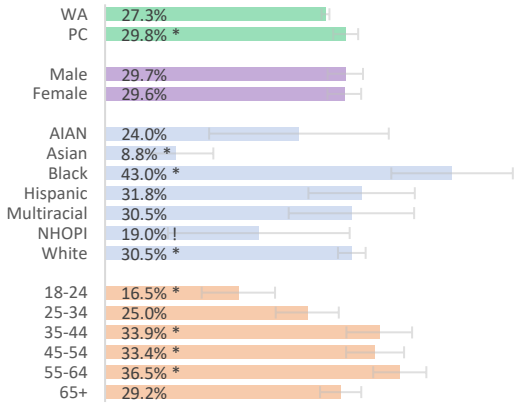
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Source: HYS (10th graders).

Obesity—Adults

Adults are classified as obese when their BMI is greater than or equal to 30. People whose BMI is in this category are at a significantly greater risk for heart disease and a host of other chronic diseases.

Obesity is more common in Pierce County than in Washington. Black adults in Pierce County are significantly more likely than white and Asian adults to be obese.

Adult Obesity (%), Pierce County, 2012-2016



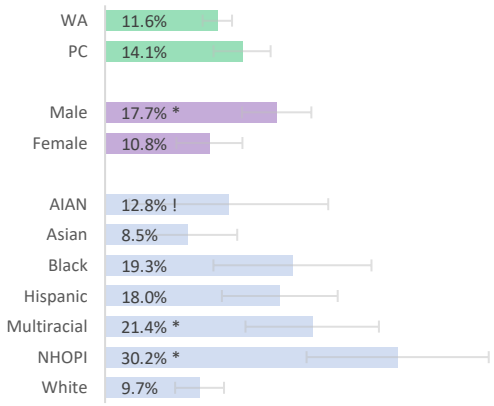
* Value significantly different than in Washington.
Source: BHRFSS.

Obesity—Youth

Youth are classified as obese when they are in the top 5% for BMI by age and gender based on growth charts developed by CDC. The percent of obese youth in Pierce County is not significantly different than in Washington.

Male youth are more likely than female youth to be obese. Asian and white youth are significantly less likely than Native Hawaiian or Pacific Islander youth to be obese.

Youth Obesity (%), Pierce County, 2016



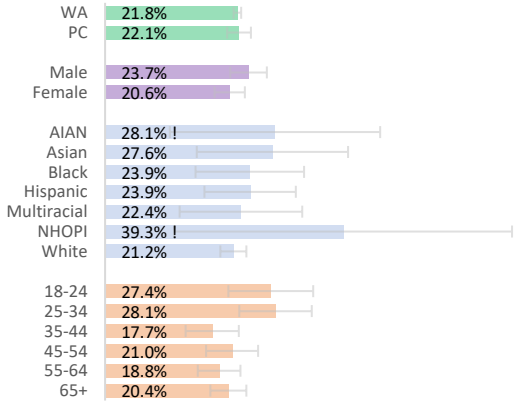
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Source: HYS (10th graders).

Physical Activity—Adults

Meeting recommended physical activity guidelines for aerobic exercise and strength conditioning helps reduce the burden of chronic disease related to fitness.

The percent of adults meeting physical activity recommendations is not significantly different between Pierce County and Washington. There are no significant differences by gender, race or age.

Met Physical Activity Recommendations (%), Pierce County, 2011-2015 (odd years)



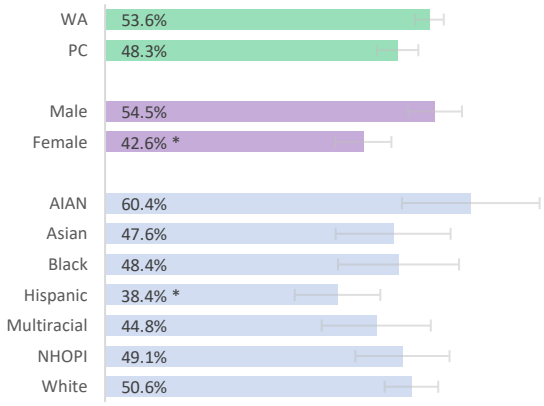
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Source: BHRFSS.

Physical Activity—Youth

Engaging in physical activity in youth is important for developing a healthy lifestyle as an adult. Physical activity reported among Pierce County youth is not significantly different than in Washington.

Males are more likely to be physically active compared to females. There are no significant differences in physical activity by race.

1 Hour of Physical Activity 5 Days a Week (%), Pierce County, 2016



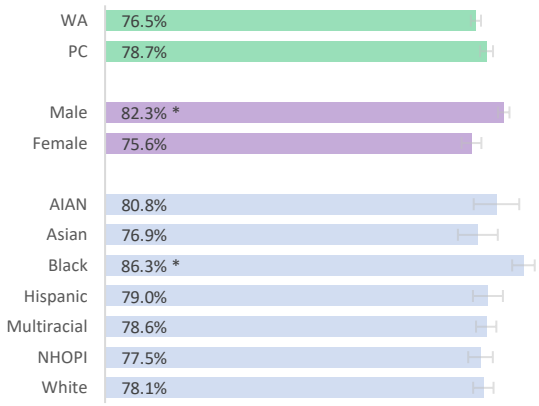
* Value significantly different than in Washington.
Source: HYS (10th graders).

Sugar-Sweetened Beverages

The availability and consumption of sugar-sweetened beverages by youth can lead to the development of unhealthy behaviors and chronic disease later in life. Sugar-sweetened beverage consumption among Pierce County youth is not significantly different than in Washington.

Males are more likely to consume sugar-sweetened beverages compared to females. Asian youth are significantly less likely than black youth to consume sugar-sweetened beverages.

No Sugar-Sweetened Beverage Consumption (%), Pierce County, 2016



* Value significantly different than in Washington.
Source: HYS (10th graders).

Tobacco

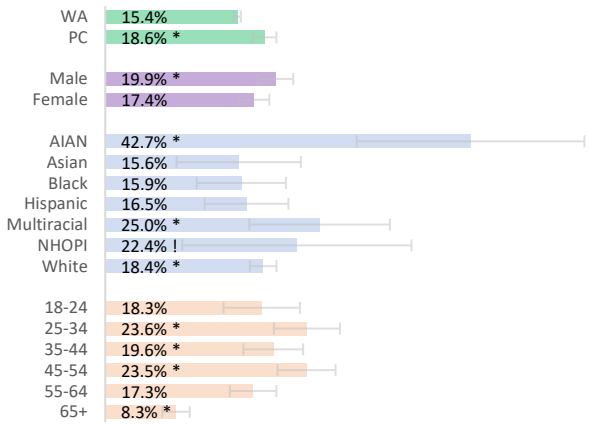
Tobacco use remains one of the most prevalent risky behaviors in communities across the United States, despite a robust body of evidence that tobacco use increases the risk of heart disease, cancer and many other negative health outcomes. Despite a general trend of decreasing tobacco use nationwide, an increase in electronic cigarette availability, attempts to replace traditional cigarettes with electronic cigarettes and vaping product popularity among youth continue to be a concern.

Current Cigarette Use—Adults

Current cigarette use among adults is estimated using responses from BRFSS. Current smoking is more common in Pierce County than in Washington.

Current cigarette use is more common among males compared to females. American Indian or Alaska Native adults are significantly more likely to currently use cigarettes than all other groups, except Native Hawaiian or Pacific Islander and multiracial adults.

Current Cigarette Use—Adults (%), Pierce County, 2012-2016



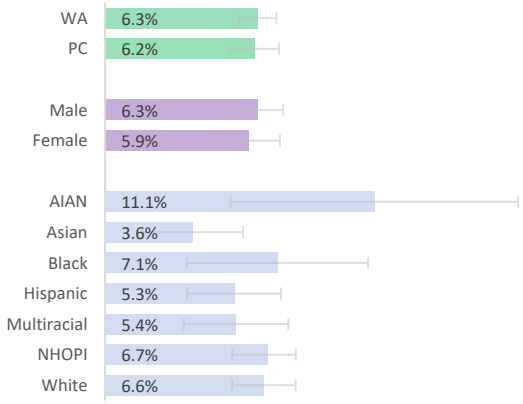
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Source: BHRFSS.

Current Cigarette Use—Youth

While the rate of tobacco use initiation is declining nationwide, tobacco use among youth remains a concern. Preventing youth from forming a smoking habit reduces the risk of smoking in adulthood.

Cigarette use among youth in Pierce County is not significantly different than in Washington. There are no significant differences by gender or race.

Cigarette Use in the Past 30 Days—Youth (%), Pierce County, 2016



* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Source: HYS (10th graders).

Social Connections

One-third of the United States population reports they are socially isolated (have 2 or less people they can count on in times of need).[5] People with stronger social relationships had a reduced risk of dying (i.e., 50% increased likelihood of survival) than those with weaker social relationships.[6]

Neighborhoods with stronger belonging and trust have lower obesity, hypertension and diabetes rates.[7] [8] [9]

Pierce County residents reported having people they could count on, and connectedness with their community members at similar frequencies as the state.

Further qualitative research may provide more evidence of the types and number of connections people are experiencing, to supplement this data.

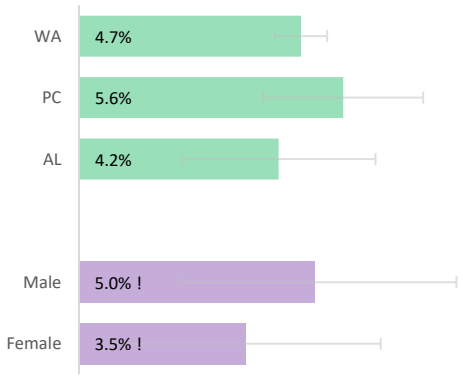
Social Support

Adults were asked about how many people they could count on to come help them if they asked for practical help, like grocery shopping or caring for a family member.

The percent of adults in Pierce County who report no social support is not significantly different than in Washington. There is no significant difference by gender.

[5] Perissinotto CM, Stijacic Cenzer I, Covinsky KE. Loneliness in older persons: a predictor of functional decline and death. Arch Intern Med. 2012;172(14):1078–1083.
[6] Holt-Lunstad J, Smith TB, Layton JB. Social relationships and mortality risk: a meta-analytic review. PLoS Med. 2010;7(7):e1000316. Published July 27, 2010.
[7] Chang VW, Hillier AE, Mehta NK. Neighborhood racial isolation, disorder and obesity. Soc Forces. 2009;87(4):2063-2092.
[8] Kaiser, P., Diez Roux, A., Mujahid, M., Carnethon, M., Bertoni, A., Adar, S. et al. (2016). Neighborhood environments and incident hypertension in the multi-ethnic study of atherosclerosis. American Journal of Epidemiology, 183 (11) p. 988–997.
[9] Liu L, Núñez AE. Multilevel and urban health modeling of risk factors for diabetes mellitus: a new insight into public health and preventive medicine. Adv Prev Med.

No Social Support (%), Pierce County 2016



! Relative standard error greater than 30%.
Source: BHRFSS.

Access to Care and Use of Clinical Preventive Services

This section includes information about access to care, like percentages of residents who are have medical insurance, a usual primary care physician, and the general availability of physicians and healthcare workforce capacity in the geographic area. This section also includes statistics on oral healthcare and preventable care services, like vaccinations and cancer screening.

Pierce County residents generally have insurance coverage rates comparable to state rates—with people 25 to 34 years old being the least likely age group to be insured. Hispanic residents were insured at significantly lower rates than the state. The percent of people who did not see a doctor due to cost was higher (15%) than Washington (13%), with significantly higher percentages among Hispanic (23%) and black (20%) residents.

The percentages of residents reporting not having a usual primary care provider ("medical home") were highest among Native Hawaiian and Pacific Islander residents (46%), followed by Hispanic residents (45%). These percentages were significantly higher than white residents (22%) and Washington (24%).

Pierce County has 5 health professional shortage areas (HPSAs): 3 primary care, 1 mental health and 1 oral health. All HPSAs are on Key Peninsula (see Workforce Capacity section).

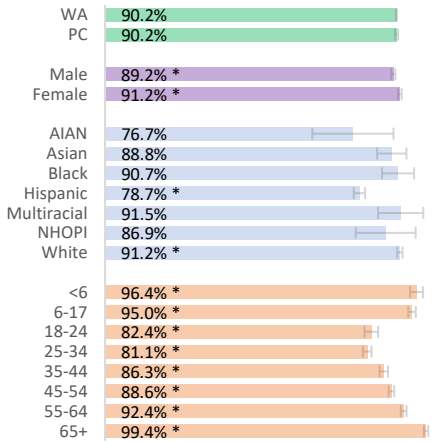
The lack of healthcare access can be particularly burdensome for individuals who don't have adequate health insurance. Following the implementation of the Patient Protection and Affordable Care Act, the proportion of residents reporting no insurance decreased significantly.

Insurance Coverage

The availability of insurance coverage can impact how likely somebody is to get important medical care. Insurance coverage also allows individuals to engage the healthcare system before conditions develop and reduce the cost of neglected health. Unfortunately, segments of our population continue to be uninsured and have trouble accessing care.

The percent of people with insurance coverage in Pierce County is not significantly different than in Washington. Females are significantly more likely to be insured compared to males. Hispanic are the least likely group to be insured.

Insurance Coverage (%), Pierce County, 2012-2016



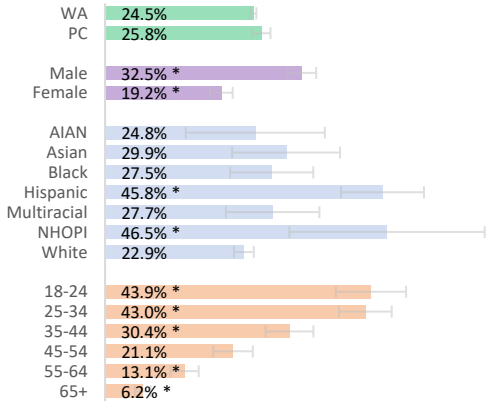
* Value significantly different than in Washington.
Source: United States Census, 2012-2016, ACS 5-year estimates, S2701.

Medical Home—Adults

A medical home is defined in this report as having a primary care provider. The prevalence of individuals with a medical home is estimated as the percent of people with a usual primary care provider.

The percent of adults with no medical home is higher in Pierce County than in Washington. Males are more likely than females to not have a medical home. White and black adults are significantly more likely than Native Hawaiian or Pacific Islander adults to have a medical home.

No Usual Primary Care Provider—Adults (%), Pierce County, 2012-2016



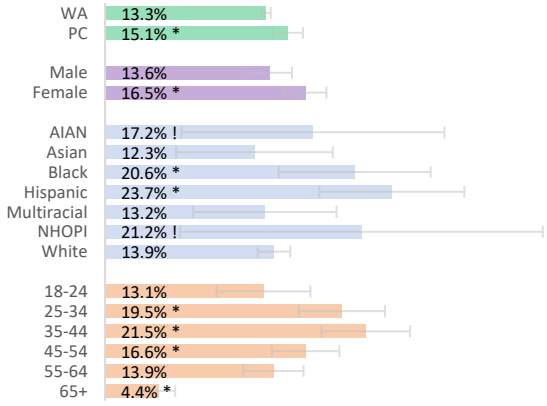
* Value significantly different than in Washington.
Source: BHRFSS.

Cost and Healthcare Access

When an individual needs healthcare, cost can often be a factor in whether they obtain care. Adults are asked if they needed to see a doctor but could not because of cost.

The percent of adults who could not see a doctor due to cost was higher in Pierce County than in Washington. Females are more likely than males to report not being able to see a doctor due to cost. Hispanic residents are more likely than white residents to not be able to see a doctor due to cost.

Did Not See a Doctor Due to Cost (%), Pierce County, 2012-2016



* Value significantly different than in Washington.
Source: BHRFSS.

Workforce Capacity

Another important factor in preventing, treating and rehabilitating negative health outcomes is the workforce capacity of our medical community—including long-term, dental, mental and primary care providers. Ensuring an adequate workforce is available to serve the community is a crucial component of an effective public health system.

Health Professional Shortage Areas

HPSAs are identified by the Health Resources and Services Administration for primary care, mental health and oral health. All Pierce County HPSAs are on Key Peninsula (Gig Harbor and Longbranch).

- 3 primary care HSPAs, all on Key Peninsula.
- 1 mental health HSPA, on Key Peninsula.
- 1 oral health HSPA, on Key Peninsula.

Injury and Violence Prevention

Injuries and violence adversely affect everyone, regardless of background. Injuries and violence are leading causes of death and disability at all levels of our society but are preventable. Those who survive these traumatic experiences may face lifelong mental and physical problems.

This section includes information on intentional and unintentional injuries that have occurred in Pierce County.

Suicide rates are higher in Pierce County compared to Washington State, and more common among males, and American Indian or Alaska Native and White residents.

Homicide rates are also higher in Pierce County compared to Washington State averages. Males are more likely than females to die of homicide. Black residents are nearly 5 times as likely to die of homicide than white residents.

Accidental injuries are higher among males, people older than 65 years (most likely due to falls) and American Indian or Alaska Native residents. American Indian or Alaska Native die from accidental injuries (77%) at nearly the twice the rate of white residents (41%).

Accidental hospitalizations caused by unintentional injuries (motor vehicle accidents, falls or poisonings) are significantly higher than the Washington State average and are more common among men, increase with age and are significantly more common in people over age 65 years of age (most likely due to falls).

Intentional Injuries

Injuries that are intentional, both fatal and non-fatal, are prevalent in Pierce County communities. Hospitalizations and deaths—suicide or homicide—are often preventable.

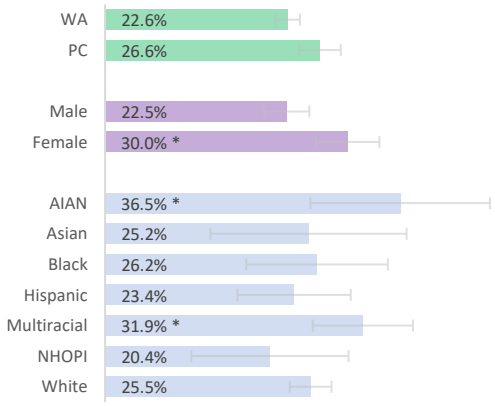
Intentional injuries are described as self-inflicted, assault and other.

Physically Abused Youth

The percent of youth who are physically abused by an adult is estimated using the HYS.

The percent of Pierce County youth reporting physical abuse was not significantly different than in Washington. Females are more likely than males to be physically abused. There is no significant difference in physical abuse rates by race.

Physically Abused Youth (%), Pierce County, 2011-2015



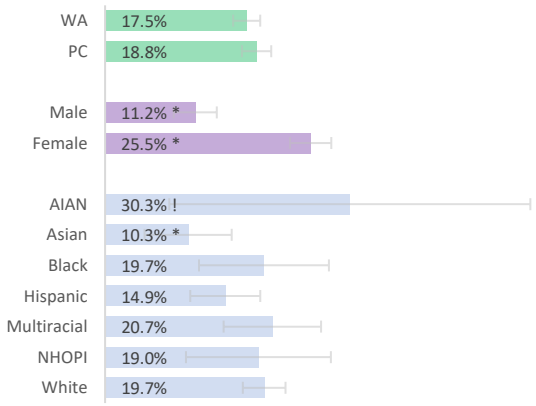
* Value significantly different than in Washington.
Source: HYS (10th graders).

Sexually Abused Youth

The percent of youth who were sexually abused is estimated using the HYS.

There is no significant difference between sexually abused youth in Pierce County than in Washington. Females are more likely to be sexually abused than males and white youth are more likely to be sexually abused than Asian youth.

Sexually Abused Youth (%), Pierce County, 2011-2015



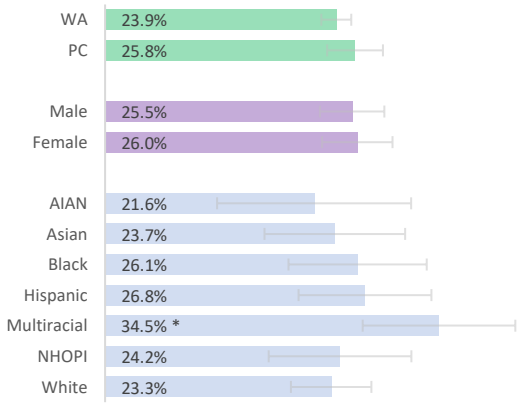
* Value significantly different than in Washington.
Source: HYS (10th graders).

Witnessed Physical Violence—Youth

The percent of youth who witnessed physical violence in the past 12 months is estimated using the HYS.

The percent of youth witnessing physical violence in Pierce County is not significantly different than in Washington. There are no significant differences by gender or race.

Witnessed Physical Violence—Youth (%), Pierce County, 2011-2015



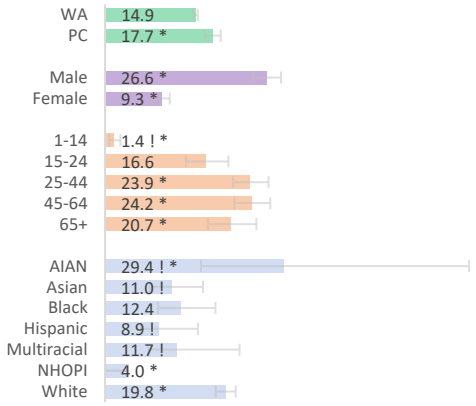
* Value significantly different than in Washington.
Source: HYS (10th graders).

Suicide

Suicide is one of the leading causes of death. The rate of suicide is the number of deaths due to intentional self-harm per 100,000 people.

Suicide rates in Pierce County are higher than in Washington. Males are more likely to die from suicide compared to females. White residents are significantly more likely than Asian and black residents to die from suicide.

Suicides per 100,000 People, Pierce County, 2012-2016



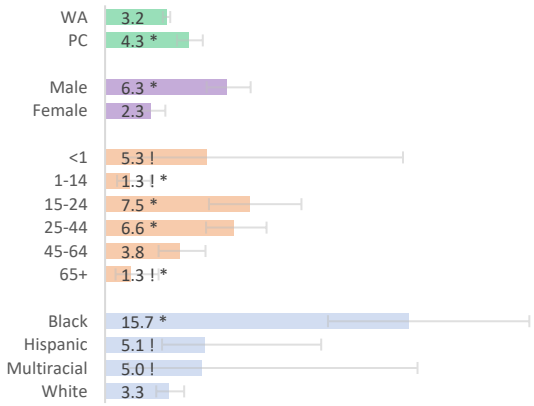
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Excluded 0-1 years, no suicide deaths.
Source: Washington State Department of Health CHS, Death Certificate Data, 1990–2016, CHAT, June 2017.

Homicide

The rate of homicide is the number of deaths due to intentional harm by another person per 100,000 people.

Homicide is more common in Pierce County than in Washington. Males are more likely than females to die of homicide. Black residents are nearly 5 times as likely to die of homicide than white residents.

Homicides per 100,000 People, Pierce County, 2012-2016



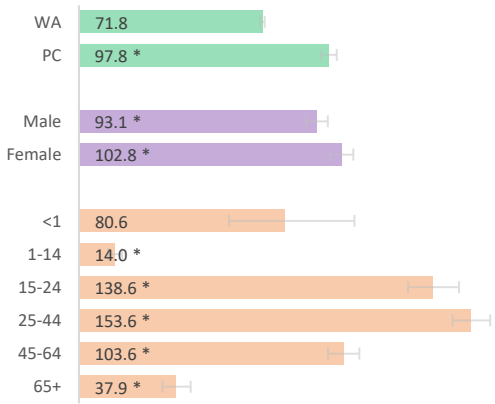
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Groups with cell size less than 10 excluded.
Source: Washington State Department of Health CHS, Death Certificate Data, 1990–2016, CHAT, June 2017.

Hospitalizations

Intentional injuries are primarily self-inflicted or assault but can also fall into an “other” category. Hospitalization rates due to intentional injuries are generated using the same 3 categories.

Pierce County residents are hospitalized due to self-harm at higher rates than the state. Females are more likely than males and people 15 to 44 years old are more likely than other ages to be hospitalized due to self-harm.

Intentional Injury Hospitalizations, Pierce County, 2011-2015



* Value significantly different than in Washington.
Source: WA Hospital Discharge Data, CHARS 1987-2015. Washington State Department of Health CHS, CHAT, August 2016.

Unintentional Injuries

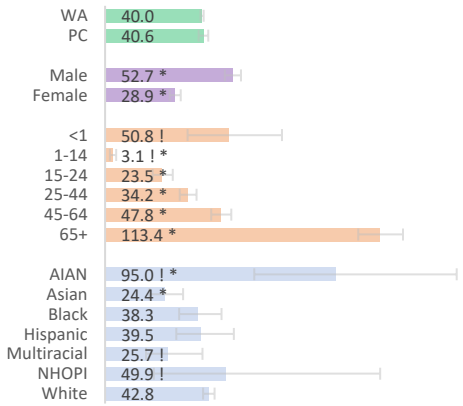
Accidental injuries are 1 of the leading causes of hospitalization and death nationwide. Typically, unintentional injuries are due to poisonings, motor vehicle crashes and falls.

Accidental Deaths

The rate of accidental deaths is the number of unintentional deaths per 100,000 people, which is measured using death certificate data.

Accidental deaths occur at similar rates in Pierce County and Washington. Males are more likely to die from unintentional injuries. American Indian and Alaska Native residents are more likely than all groups except Native Hawaiian or Pacific Islander residents to die from unintentional injuries.

Accidental Deaths per 100,000 People, Pierce County, 2012-2016



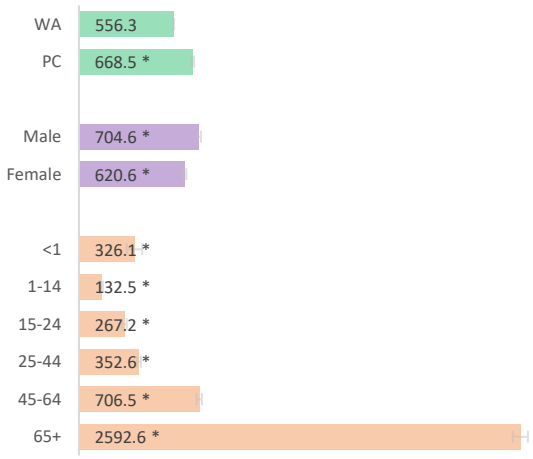
* Value significantly different than in Washington.
! Relative standard error greater than 30%.
Source: Washington State Department of Health CHS, Death Certificate Data, 1990–2016, CHAT, June 2017.

Accidental Hospitalizations

Hospitalizations caused by unintentional injuries are reported as a rate per 100,000 people from hospital discharge data.

Hospitalizations due to accidental injuries are more common in Pierce County than in Washington. Hospitalizations due to unintentional injuries are more common among males and with increasing age.

Unintentional Injury Hospitalizations, Pierce County, 2011-2015



* Value significantly different than in Washington.
Source: WA Hospital Discharge Data, CHARS 1987-2015. Washington State Department of Health CHS, CHAT, August 2016.

Supplement

Quantitative Data Sources

The data sources included in the quantitative analysis range from those providing aggregate results for the populations of interest to those with raw data available for analysis where estimates were generated by Tacoma-Pierce County Health Department.

American Community Survey

American Community Survey (ACS) is a mailed survey is an annual supplement to the 10-year census. The ACS location of residence is based on census tracts, which are converted to zip code tabulation area (ZCTA) for analysis.

Agency for Healthcare Research and Quality

Prevention quality indicators (PQIs) are a set of measures generated using hospital discharge data (CHARS) based on guidance from the Agency for Healthcare Research and Quality (AHRQ).

Behavioral Risk Factor Surveillance System

The Behavioral Risk Factor Surveillance System (BRFSS) is the largest, continuously conducted telephone health survey in the world. The survey collects information on a vast array of health conditions, health-related behaviors and risk and protective factor about individual adults. In 2011, a new data weighting approach was implemented, making data before 2011 unreliable for comparison to 2011 and later data.

Comprehensive Hospitalization Abstract Reporting System

Comprehensive Hospitalization Abstract Reporting System (CHARS) houses hospital discharge data, including records on inpatient and observation patient hospital stays.

Community Health Assessment Tool

Community Health Assessment Tool (CHAT) is a web application that allows authorized users to generate estimates for different geographies depending on the data source. Data from an array of data sources is used to generate estimates by zip code, county and state.

Washington State Department of Social and Human Services

Foster care placement services, foster care support services and Child Protective Services aggregate estimates at the county level and school district level are available using the online reporting system available through Washington State Department of Social and Human Services (DSHS).

Enhanced HIV/AIDS Reporting System

The Enhanced HIV/AIDS Reporting System (eHARS) reporting system was developed by CDC and is managed by the Washington State Department of Health. It collects and stores HIV/AIDS case surveillance data. Reported case counts from these data are generated for Pierce County upon request.

Health Resources and Services Administration

Health Professional Shortage Areas (HPSA) information was obtained through the Health Resources and Services Administration (HRSA) Data Warehouse and Map Tool available online, including shapefiles of polygon and point data for HPSAs in mental, dental and primary care.

Healthy Youth Survey

The Healthy Youth Survey (HYS) is a school-based survey is administered in even-numbered years throughout Washington State to students in 6th, 8th, 10th and 12th grades. 10th grade data is used to approximate each indicator for all 8th through 12th grade youth.

Office of Superintendent of Public Instruction

The Washington State Office of Superintendent of Public Instruction (OSPI) provides data on graduation and free or reduced-price meal data through the Comprehensive Education Data and Research System (CEDARS), an online system that captures information regarding student graduation, transfers and drop-outs. The adjusted cohort method follows a single cohort of students for 4 years based on when they first entered 9th grade. The cohort is adjusted by adding in students who transfer into the school and subtracting students who transfer out of the school.

Point-in-Time Count

The Homeless Housing and Assistance Act (ESSHB 2163-2005) requires each county to conduct an annual point-in-time count (PIT) of sheltered and unsheltered homeless people (RCW 43.185C.030) in accordance with the requirement of the United States Department of Housing and Urban Development (HUD). Data was made available for this assessment by Pierce County; however, data for zip codes outside Pierce County were not available. Estimates were generated using data with a geographic identifier (city or zip code).

Birth Certificate Data

The birth certificate record system contains records on all births occurring in the state and nearly all births to residents of Washington State. Information is gathered about the mother, father, pregnancy and child. The information is collected at hospitals and birth centers through forms completed by parents or medical staff, a review of medical charts or a combination of both. Midwives and family members who deliver the baby complete the birth certificate and collect the information from a parent or from their records. Data are compiled by the Washington State Department of Health Center for Health Statistics (CHS).

Death Certificate Data

Funeral directors collect information about the deceased person from an informant who is usually a family member or close friend of the deceased. A certifying physician, medical examiner or coroner generally provides cause of death information. Cause of death data is derived from underlying causes of death. For example, if a person dies of a complication or metastasis of breast cancer, breast cancer would be the underlying cause of death. Data are compiled by the Washington State Department of Health CHS

Washington State Cancer Registry

Washington State Cancer Registry (WSCR) monitors the incidence of cancer in the state to better understand, control and reduce the occurrence of cancer. In 1995, WSCR received funding through CDC's National Program of Central Cancer Registries. This program is designed to standardize data collection and provide information for cancer prevention and control programs. Estimates based on this data were obtained through the Washington State Department of Health's CHAT.

Washington State Immunization Information System

Washington State Immunization Information System (WSIIS) is a lifetime registry that keeps track of immunization records for people of all ages. Estimates were acquired from WSIIS. Immunization reports included data on children 19 to 35 months old, 13 to 17 years old and 15 to 17 years old.

Washington Tracking Network

Washington Tracking Network (WTN) is a collection of environmental public health data. Estimates available through this resource are collected from an array of data sources and serve as a single location to see various measures affecting environmental public health.

Quantitative Methods

Estimates are generated for Washington and Pierce County. In most cases we use SAS 9.4 software to analyze data. In some cases, estimates are provided from an external source. Estimates for sub-populations are also generated and maps are displayed when possible and appropriate. The following definitions help understand the contents of this report:

Rate

A rate is a standardized proportion (or ratio) expressed as the number of events (e.g., live births per year) that have occurred with respect to a standard population, within a defined time period (usually 1 year). Rates help compare disease risk between groups while controlling for differences in population size. The size of the standard population used can vary depending on whether the events are common or rare. For example, since HIV is a rare condition in Washington, HIV incidence rates are expressed as new cases per 100,000. Crude rates are rates calculated for a total population, while age-specific rates are calculated for specific age groups.

Age-Adjustment

All age-adjusted mortality and disease rates in this report are adjusted to the 2000 United States population. The risk of death and disease is affected primarily by age. As a population ages, its collective risk of death and disease increases. As a result, a population with a higher proportion of older residents will have higher crude death and disease rates. To control for differences in the age compositions of the communities being compared, death and certain specific disease rates are age-adjusted. This aids in making comparisons across populations.

Averages

Multiyear average estimates were used in order to increase sample sizes and to minimize widely fluctuating frequencies from year to year.

Confidence Intervals

Pierce County comparisons to Washington State and comparisons among subpopulations were calculated using 95% confidence intervals (CIs). CIs (error bars on graphs) indicate the margin of error for the value estimated by describing an upper and lower limit of an estimate. Using CIs is an approach to determine if differences among groups are statistically significant. If the confidence interval of 2 different estimates do not overlap, we most often can conclude that the difference is statistically significant and not due to chance.

Standard Error

Standard errors (SEs) are used to determine significance between groups in the analysis. Unless noted, these are based on 95% CIs, or an alpha of 0.05. Relative standard error (RSE) is used to determine what statistics are reported. If the RSE is greater than 30% and/or the sample size is too limited to have confidence in these estimates, then they are excluded. If the RSE is greater than 30%, but the estimates may still be reliable, then they are presented but with a "!" to draw attention to this concern.

Stratification

Where possible (i.e., population size or counts were adequate to determine significance and protect anonymity), we analyzed the indicators by race/ethnicity or gender. We used the following terms to describe race/ethnicity:

- NH: Non-Hispanic.
- Asian: Non-Hispanic Asian.
- AIAN: Non-Hispanic American Indian/Alaska Native.
- Black: Non-Hispanic black or African American.
- Hispanic: Hispanic as a race.
- Multiracial: More than 1 race.
- NHOPI: Non-Hispanic Native Hawaiian or Pacific Islander.
- White: Non-Hispanic white or Caucasian.

For some indicators, these stratification levels may not have a sample size adequate to draw reliable conclusions about that population and are therefore excluded from this report. Groups are typically not combined due to concerns about over-generalizations made based on those results.

Selection of Priority Health Needs

Key findings were identified as priority health needs using 4 criteria. A public health epidemiologist reviewed data from each CHA and applied the following criteria:

1. When compared to Washington State, Pierce County numbers are statistically significantly worse (1 point).
2. Existing estimates present a trend in the negative direction (1 point).
3. The measure is related to listed themes from community engagement activities (1 point).
4. There is an appearance of inequity by gender or by race (2 points).

All health indicators and themes are scored and ranked using the above criteria. Based on the results of the ranking, at least 3 and no more than 6 key findings are identified per CHA report.

Appendix 1—Community Workshop Summary

Workshop Methods

The purpose of the community workshops was to hear directly from residents. Ten community workshops (focus groups) were held throughout Pierce County. The same questions were used at all workshops. Four workshops were facilitated by trained community residents. The remainder were facilitated by Tacoma-Pierce County Health Department staff. Notes were handwritten on flip charts or typed on laptops. Participants were promised confidentiality and gave their consent to participate by attending the workshop.

Participant Selection Criteria

Participants from 10 geographies and populations were identified based, in part, on priority communities identified in the 2015 Tacoma-Pierce County Health Department Health Equity Assessment. Specific populations were identified based their geographic location and health outcomes. We also referred to literature on stakeholder selection for Community Health Needs Assessments (CHNAs) produced by the Health Research and Educational Trust, in partnership with Hospitals in Pursuit of Excellence. Participants were recruited by facilitators or Tacoma-Pierce County Health Department staff and some workshops were held at scheduled activities (e.g., community dinner, support group). In some cases, participants invited others to attend (i.e., snowball sampling method).

What We Heard—Major Themes

Question 1: What do you think makes an "ideal" community/neighborhood? What do you like about your community/neighborhood? What do you need?

- **Opportunities to give and receive social support.**
  - People know and care for each other.
  - Cultural knowledge and traditions are shared.
  - Residents care about issues and volunteer often.

- **Diversity is valued.**
  - All people are accepted.
  - Ethnic and cultural diversity are celebrated.
  - Everyone is respected for the value they bring.

- **Community resources.**
  - Reliable source of community information.
  - Parks and other opportunities for physical activities.
  - Unique physical setting of community.
  - Access to services.
  - Behavioral health services and support, including opportunities for training.

- **Organizations and groups willing to partner.**
  - Groups, coalitions and others who provide active leadership.
  - Questions are answered in layman's terms.
  - Regular consensus-building feedback.

Question 2: What needs to change about your community/neighborhood? What is missing? What do you need?

- **Safe sidewalks and trails.**
  - Trails for biking and walking.
  - Americans with Disabilities Act- (ADA-) compliant sidewalks and trails.
  - Connections to schools and services.

- **Buses that meet people where they live, learn, work and shop.**
  - More transit and public transportation.
  - Free bus passes for those who need it.
  - More bus stops.

- **Access to healthy food.**
  - Grocery stores.
  - Healthy eating and cooking education.
  - Farmers markets.

- **Opportunities for physical and social activities.**
  - More parks.
  - Sharing of cultural knowledge—music, dance, drama.
  - Teen-friendly places to hang out.

- **Reliable source of community resource information.**
  - Youth and family support.
  - Programs to meet seniors' needs.
  - Parent training and involvement opportunities.

- **Behavioral health resources.**
  - Substance abuse treatment.
  - Mental health services.
  - Anti-stigma efforts related to mental health.

Appendix—2 Forces of Change

Overview

The Forces of Change Assessment is 1 of 4 assessments conducted as a part of the Community Health Assessment/Community Health Improvement Plan process. This assessment focuses on identifying factors that affect Pierce County residents' health.

Four assessment workshops were held:

- Key Peninsula (rural community partners).
- Tacoma-Pierce County Board of Health.
- Tacoma (urban community partners).
- Tacoma-Pierce County Health Department staff.

The workshops used 4 social determinants as a framework:

- Transportation.
- Food.
- Jobs.
- Housing.

Participants were asked to consider the question: What happened in the past, is happening now or may happen in the future that can affect Pierce County residents' quality of life?

- Trends—Patterns over time, like migration in and out of a community or a growing disillusionment with government.
- Factors—Discrete elements, like a community's large ethnic population, an urban or rural setting or the community's proximity to a major waterway.
- Events—One-time occurrences, like a business or hospital closing, a natural disaster or the passage of new legislation.

Transportation

- + Link light rail expanding in Tacoma.
- Lack of comprehensive transit options.
- Roads are at or near capacity.
- Lack of public transit options in many places.
- Increased commute times contribute to CO^2 emissions.
- Lack of safe sidewalks and crosswalks in some neighborhoods.

Food

- + Food bank network.
- + Trend toward community gardens as source of local fresh produce and community gathering.
- Poverty is a driving force; unhealthy choices are cheaper.
- Time pressures—i.e., families don't have time to prepare healthy meals.
- Disparities related to healthy food access between neighborhoods. Quality of choices vary by area.
- Increase in obesity, diabetes and heart disease.

Jobs

- + Innovative programs and partnerships—e.g., Tacoma Public Schools/MultiCare, Tacoma-Pierce County Health Department/University of Washington—Tacoma.
- + Community colleges offer trade skills and a pathway to 4-year degrees.
- Lack of family-wage jobs.
- Emphasis on 4-year degrees vs. trade schools/programs. This limits those entering the workforce and creates a culture that isn't an appropriate expectation or realistic for all students.
- Cost of commuting.
- Aging workforce.

Housing

- + Trend toward walkable communities.
- Homelessness.
- Housing affordability.
- Challenge for those wanting to own homes and build wealth.
- Housing costs too great a percentage of income.
- Gentrification in some communities.
- Lack of rental options; cost of renting.
- Pierce County residents work in King County (Tacoma and Pierce County as bedroom communities).

General comments

- We are not giving opportunities for everyone to "get in the room at the same time" (to talk about needs and issues). Need high-level, as well as the individual affected by it personally.
- Immigrants moving into Pierce County and the result of the housing squeeze in King County are a perceived driver in the housing market.
- Displacement from King County (due to cost) is causing many issues.
- Access to community resources—e.g., informational resources. Making sure community members know who to talk to, and how to advocate for yourself to improve your conditions. And understand the legislative process.

Appendix—3 Communities of Focus

Health Equity in Action

In 2015, Tacoma-Pierce County Health Department looked at Pierce County data by zip codes to see if any patterns were identifiable. This Health Equity Assessment Report showed which zip codes had the worst health outcomes in the county.

Based on this assessment, Tacoma-Pierce County Health Department established Communities of Focus as an initiative to prioritize efforts in areas of the county with the worst health outcomes. The communities were selected based on health outcome data and if the community has established partnerships and current Health Department programs that could be built on.

In 2015, East Tacoma (98404) was established as the first Community of Focus. In 2017, Key Peninsula (98394 and surrounding areas) and Springbrook (98439) were added. In 2018, work was started in White River (98391 and surrounding areas), Parkland (98444) and South Tacoma (98409).

Communities of Focus is one of the ways Tacoma-Pierce County Health Department demonstrates health equity. Specifically, we direct investments to communities, coordinate Health Department programs to maximize effectiveness and collaborate with partners to improve equity outcomes. Community empowerment is central to Communities of Focus work. An example of this strategy is to empower communities by working directly with residents to help draw out and identify the issues of greatest importance and to facilitate action planning with community driven priorities.

Community Snapshots

Assessments have been prepared for each community to understand key health data, existing partnerships and other important background information. These assessments, or “snapshots,” are intended to be iterative. Tacoma-Pierce County Health Department and each community can use them to mutually update and share important issues and actions:

- East Tacoma.
- Key Peninsula.
- Parkland.
- South Tacoma.
- Springbrook.
- White River.

Each community is in a different phase of development (e.g., little community input received, community engagement in process, priorities established). Working with residents and local leaders to share information and determine important issues and needs will take different levels of effort and engagement within each community. These reports will be updated at regular intervals.