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

December 28, 2023

RECEIVED
By Andrew Struska at 4:15 pm, Dec 28, 2023

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

Re: MultiCare Home Health, Hospice, and Palliative Care Certificate of Need Application. Proposal for a Medicare Certified and Medicaid Eligible Hospice Agency in Spokane County.

Dear Mr. Hernandez:

I am pleased to submit this certificate of need application request on behalf of MultiCare Health System ("MultiCare"). MultiCare is requesting approval to develop and operate a new Certificate of Need approved Medicare Certified and Medicaid Eligible Hospice Agency in Spokane County.

MultiCare's vision is to be the highest *value* system of health in the Pacific Northwest. We aspire to deliver world-class health outcomes and exceptional experience that serves all populations. To do this, it is imperative that all patients have timely access to hospice services.

The motivation for this application is to fill the current and increasing gap in care for hospice services in Spokane County. Based on MultiCare's experience as a provider of inpatient services in the Spokane market, potential hospice patients with public payers, especially low-income persons, face longer wait times to hospice discharge and thus shorter periods receiving needed hospice care. As we document in our application, there exist underserved communities within Spokane County which this project proposes to serve. These include low-income individuals in Spokane and members of the Black, Asian, Hispanic, Indigenous, and other non-White communities in Spokane, as well as Spokane's LGBTQ+ community.

Thank you for your assistance regarding this request. Please submit any notices, correspondence, communications and documents to:

Erin Kobberstad, Vice President
Strategic Planning
MultiCare Health System
253-403-8771
ekobberstad@multicare.org

Frank Fox, PhD
HealthTrends
206-366-1550
frankfox@comcast.net

Sincerely,

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

Certificate of Need Application
Hospice Agency

Certificate of Need applications must be submitted with a fee in accordance with Washington Administrative Code (WAC) 246-310-990.

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

Signature and Title of Responsible Officer	**Date:**
K. Erin Kobberstad Vice President, Strategic Planning MultiCare Health System Signature:  **Email Address:** ekobberstad@multicare.org	December 28, 2023 **Telephone Number:** 253.403.8771
Legal Name of Applicant: MultiCare Health System DBA MultiCare Home Health, Hospice, and Palliative Care **Address of Applicant:** 1313 Broadway Suite 200 Tacoma, WA, 98409	**Provide a brief project description:** ☐ New Agency ☒ Expansion of Existing Agency ☐ Other: _____ **Estimated capital expenditure**: $ 66,315
Identify the county proposed to be served for this project. Note: Each hospice application must be submitted for one county only. If an applicant intends to obtain a Certificate of Need to serve more than one county, then an application must be submitted for each county separately. Spokane County Washington	

MultiCare Home Health, Hospice, and Palliative Care Certificate of Need Application

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

December 29, 2023

Table of Contents

Table of Tables

Table of Figures

Exhibit List

No.	Exhibit Title
1	Organizational Chart
2	Letter of Intent
3	DOH 2023-2024 Hospice Need Methodology
4	Financial Assistance Policy
5	Admissions Policy
6	Patient Rights and Responsibilities Policy
7	Non-Discrimination Policy
8	Medical Director Job Description
9	Site Control Documents
10	Financial Pro Forma
11	Letter of Financial Commitment
12	MultiCare Health System Audited Financial Statements
13	MultiCare Health System Draft Charter of the Health Equity Community Advisory Board

I. Introduction and Rationale

MultiCare Health System, a locally-governed, not-for-profit, integrated health system that owns and operates twelve hospitals and over 240 primary, specialty, and urgent care clinics throughout the Puget Sound, Yakima Valley, and Inland Northwest Regions, seeks Certificate of Need approval to operate a Medicare certified and Medicaid eligible hospice agency to serve residents of Spokane County in Washington State. MultiCare provides care for two out of every five inpatients in Spokane County, and the proposed project would represent an expansion of MultiCare Home Health, Hospice, and Palliative Care, which has been providing hospice care services for more than three decades. The proposed hospice agency will complement MultiCare's provision of services across the care continuum, including home health and hospice services in King, Pierce, and Kitsap counties, and inpatient hospital services at its facilities in Spokane, Yakima, Thurston, Pierce, and King counties. It was also recently approved for hospice services in Thurston County (through PNW Hospice, LLC) and home health care in Kitsap County, and provides hospice care through MultiCare Yakima Memorial Hospital in Yakima County.

The motivation for this application is to fill the current and increasing gap in care for hospice services in Spokane County. Based on MultiCare's experience as a provider of inpatient services in the Spokane market, potential hospice patients with public payers, especially low-income persons, face longer wait times to hospice discharge and thus shorter periods receiving needed hospice care. As we document below, there exist underserved communities within Spokane County which this project proposes to serve. These include low-income individuals in Spokane and members of the Black, Asian, Hispanic, Indigenous, and other non-White communities in Spokane, as well as Spokane's LGBTQ+ community. We are aware of no providers of hospice in Spokane which require annual competency training and provide culturally competent end-of-life and palliative care to these LGBTQ+ and minority communities. Where statistics are available, these underserved communities utilize hospice services below the planning area average. This indicates both current and future problems related to access to hospice services for Spokane residents within these populations. This application proposes hospice services which provide culturally competent care and requires annual training for both LGBTQ+ and minority populations, both of which are underserved. This specificity is important in all aspects of health care, including palliative and end-of-life care. Furthermore, the proposed project will not duplicate the services of existing hospice providers, but rather complement these services by focusing on groups within Spokane which are currently underserved.

MultiCare will provide comprehensive hospice services to all qualifying patients in Spokane but will focus on its underserved populations to increase access to and use of hospice services. We plan to leverage the relationships of MultiCare with skilled nursing facilities, assisted living facilities, and other senior care providers within these targeted areas, as well as engage with community organizations and other representatives of these underserved communities. To ensure our success in this area, we plan to hire a Hospice Outreach Coordinator who will be dedicated to our outreach and educational activities in Spokane County. This outreach program will follow the National Outreach Guidelines for Underserved Populations.[1]

Furthermore, MultiCare is developing Health Equity Community Advisory boards within the Inland Northwest, as well as other regions, that consist of community members representing diverse populations. These boards are part of an ongoing effort by MultiCare to provide

[1] National-Outreach-Guideline-Full.pdf (outreach-partners.org), Last Accessed December 26, 2023.

culturally and linguistically appropriate services. The advisory group specific to the Spokane area, facilitated by its Health Equity Outreach Program Manager, will work with the Hospice Outreach Coordinator to engage with the community-based organizations focused on supporting/advocating for our identified underserved populations.

The proposed agency will complement MultiCare's provision of services across the care continuum, including inpatient hospital services at its facilities in Puget Sound, Yakima Valley, and Inland Northwest regions, and hospice services in Yakima, Thurston, Pierce, King, and Kitsap counties. Without hospice services targeted towards the underserved groups in Spokane, these residents will go without needed care. In addition to leading to poorer health outcomes, this would cause a fragmentation of healthcare services, where families of these individuals would be forced to manage and plan the care for their family members without assistance or coordination.

The proposed project will promote continuity of care and help prevent fragmentation of services within Spokane County. In 2022, MultiCare hospitals accounted for 13,037 discharges of Spokane County residents.[2] This included 5,999 discharges to Spokane residents aged 65 and over. Of these discharges 241 were to a hospice organization.[3] However, another 346 or 52% died without being discharged to hospice. Relative to persons discharged to hospice agencies, these persons who died without being discharged to hospice were more likely to have a primary payer of Medicaid and more likely to identify as non-White.

Some portion of the 346 persons who died prior to discharge could have been likely candidates for hospice services, although these services were not received. These include 14 patients who died with a primary diagnosis related to cancer, 39 who died with a primary diagnosis related to circulatory/heart issues, 27 who died with a primary diagnosis related to kidney disease, and 6 who died with a primary diagnosis related to stroke/cerebrovascular accident.

In addition to those persons who died without hospice services, many inpatients in Spokane who were discharged to hospice waited too long. Persons at MultiCare hospitals in Spokane who received a referral for hospice services waited about 13 days on average if they were enrolled on Apple Health or Medicaid. By comparison, the wait was about six to eight days on average for patients with commercial or Medicare payers. Relative to their commercial and Medicare counterparts, Medicaid patients thus lost nearly a week of access to necessary hospice services.

These numbers are not explicitly allocated as sources of hospice admissions above but represent a potential area of need among patients, especially those among the identified underserved populations, who already receive care within MultiCare's inpatient facilities.

[2] CHARS 2022.
[3] Ibid.

II. Applicant Description

Answers to the following questions will help the department fully understand the role of the applicant(s). Your answers in this section will provide context for the reviews under Financial Feasibility (WAC 246-310-220) and Structure and Process of Care (WAC 246-310-230).

1. **Provide the legal name(s) and address(es)of the applicant(s).**
   Note: The term "applicant" for this purpose includes any person or individual with a ten percent or greater financial interest in the partnership or corporation or other comparable legal entity as defined in WAC 246-310-010(6).

   MultiCare Health System DBA MultiCare Home Health, Hospice, and Palliative Care
   ("MultiCare Home Health")
   1313 Broadway, Suite 200
   Tacoma, WA, 98409

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

   MultiCare Home Health, Hospice, and Palliative Care is a Nonprofit Corporation; its UBI Number: 601-100-682.

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

   K. Erin Kobberstad
   Vice President, Strategic Planning
   MultiCare Health System
   PO Box 5299, MS: 820-4-SBD
   Tacoma WA 98415
   Office phone: (253) 403 – 8771
   Email: ekobberstad@multicare.org

4. **Provide the name, title, address, telephone number, and email address of the consultant authorized to speak on your behalf related to the screening of this application (if any).**

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

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

Please see Exhibit 1 for an organizational chart.

6. **Identify all healthcare facilities and agencies owned, operated by, or managed by the applicant. This should include all facilities in Washington State as well as out-of-state facilities. The following identifying information should be included:**
   - **Facility and Agency Name(s)**
   - **Facility and Agency Location(s)**
   - **Facility and Agency License Number(s)**
   - **Facility and Agency CMS Certification Number(s)**
   - **Facility and Agency Accreditation Status**

   Please see Table 1 for a list of MultiCare facilities. Recent acquisitions include MultiCare Capital Medical Center (April 2021), MultiCare Yakima Memorial Hospital (January 2023), and MultiCare Surgery Center (September 2023).

Table 1: MultiCare Facility List

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

Table 1: MultiCare Facility List

Facility/Agency Name	Address	License Number	Medicare Provider Number	Medicaid Provider Number
MultiCare Good Samaritan Hospital	407 14th Ave. SE Puyallup, WA 98372	HAC.FS.60221541	500079	3308707
MultiCare Good Samaritan Hospital, Inpatient Rehabilitation	401 15th Ave. SE, Puyallup, WA 98372	BHA.FS.61030776	50T079	3200094
NAVOS	2600 Southwest Holden, Seattle, WA 98126	HPSY.FS.00000019	504009	3500311
Wellfound Behavioral Health Hospital*	3402 S. 19th Street, Tacoma, WA 98405	HPSY.FS.60919628	504016	150453
MultiCare Home Health, Hospice and Palliative Care	1313 Broadway Ste 200, Tacoma, WA, 98402	IHS.FS.60081744	HH - 507046; Hospice-501508	HH-1043537; Hospice-2012298
MultiCare Surgery Center	1519 3rd Street, Ste 240, Puyallup, WA 98372	ASF.FS.60534460	Pending	Pending
MultiCare Yakima Memorial Hospital	2811 Tieton Dr, Yakima, WA, 98902-3761	HAC.FS.00000058	500036	3307501
PNW Hospice	1313 Broadway Ste 500, Tacoma, WA 98402	IHS.FS.61337353	Pending	Pending
MultiCare Capital Medical Center	3900 Capital Mall Drive SW, Olympia, WA 98502	HAC.FS.60986502	500139	33065

Notes:
*Wellfound Behavioral Health Hospital is a JV facility.
Recent acquisitions include MultiCare Capital Medical Center (April 2021), MultiCare Yakima Memorial Hospital (January 2023), and MultiCare Surgery Center (September 2023).

III. Project Description

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

MultiCare Home Health, Hospice, and Palliative Care is currently located at 1313 Broadway, Suite 200, Tacoma, WA, 98402.

Given approval of the proposed project, MultiCare will allocate space for the Spokane operations at its medical office building located at 801 W. 5th Avenue, Spokane, Washington 99204.

2. If an existing Medicare and Medicaid certified hospice agency, explain if/how this proposed project will be operated in conjunction with the existing agency.

The addition of Spokane County to the existing licensed agency will create an overall service area that also includes Kitsap, Pierce, and King Counties. Spokane operations will be run out of an office in MultiCare's Medical Office Building located at 801 W. 5th Avenue, Spokane, Washington 99204. This location will provide space for all administrative staff related to intake, scheduling, and billing specific to Spokane, as well as space for supplies, copy/fax machine, internet connectivity, and a meeting place for all field staff.

3. Provide the name and address of the proposed agency. If an address is not yet assigned, provide the county parcel number and the approximate timeline for assignment of the address.

This question is not applicable.

4. Provide a detailed description of the proposed project.

MultiCare seeks Certificate of Need approval to operate a Medicare certified and Medicaid eligible hospice agency to serve residents of Spokane County in Washington State. The proposed project would represent an expansion of MultiCare Home Health, Hospice, and Palliative Care.

The proposed project seeks to increase access to hospice services for underserved populations in Spokane County. Given approval of the proposed project, MultiCare will hire a Hospice Outreach Coordinator position dedicated to our outreach and educational activities in Spokane County. This Outreach Coordinator will work in coordination with MultiCare's Health Equity Outreach Program Manager to engage with community organizations and other representatives of these underserved communities.

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

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

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

Event	Anticipated Month/Year
CN Approval	August 2024
Design Complete (if applicable)	August 2024
Construction Commenced (if applicable)	N/A
Construction Completed (if applicable)	N/A
Agency Prepared for Survey	December 2024
Agency Providing Medicare and Medicaid hospice services in the proposed county	April 2025

7. Identify the hospice services to be provided by this agency by checking all applicable boxes below. For hospice agencies, at least two of the services identified below must be provided.

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

In addition to the categories checked above, MultiCare plans to provide services related to massage therapy, music and aroma therapy, and Reiki therapy.

8. If this application proposes expanding an existing hospice agency, provide the county(ies) already served by the applicant and identify whether Medicare and Medicaid services are provided in the existing county(ies).

The counties that are currently served are Pierce, Kitsap, and King Counties. Medicare and Medicaid services are provided in all service areas.

In addition to the above, MultiCare provides hospice services in Thurston County through PNW Hospice and hospice services in Yakima County through MultiCare Yakima Memorial Hospital.

9. If this application proposes expanding the service area of an existing hospice agency, clarify if the proposed services identified above are consistent with the existing services provided by the agency in other planning areas.

All services listed above are provided in the existing service areas of the agency.

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

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

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

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

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

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

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

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

Table 3: Projected Spokane County Unserved Patients by Age

Projected Patients by Age	Hospice Patient Age Structure
Less than 65 years	5.1%
65 to 74 years	20.8%
75 to 84 years	31.3%
More than 85 years	42.8%

Sources: Hospice Patient Age Structure based on use rates from Table 2 and the OFM Medium Series Estimates for 2020 Spokane County Resident population by age.

From Table 3, the number of unserved patients over the age of 85 is expected to constitute about 43% of all the proposed agencies' patients.

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

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

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

In addition to a hospice patient population with a high number of individuals in the oldest age groups, MultiCare anticipates certain diagnoses to be more prevalent. We present hospice patients by diagnosis for CMS beneficiaries in Table 4.

Table 4: Distribution of Spokane County Hospice CMS Patients by Diagnosis

Diagnosis	2022
Alzheimers, Dementia, Parkinsons	30.6%
Cancer	26.2%
Circulatory/Heart	15.5%
Respiratory	7.6%
Stroke/CVA	6.0%
Malnutrition	5.2%
Kidney disease	3.9%
Other	5.2%

Source: 2022 CMS Hospice LDS

From Table 4, most hospice patients in Spokane County included persons with Alzheimer's, Dementia or Parkinsons diagnoses. These individuals accounted for over 30% of Spokane County hospice patients in 2022. The next largest source of hospice patients was cancer, which accounted for about 26% of patients. Circulatory/Heart accounted for about 16% of patients, Respiratory Disease about 8%, Stroke/Cerebrovascular Accident about 6%, Malnutrition about 5.2% and Kidney Disease about 4%. Hospice patients with a primary diagnosis of COVID-19 represented less than 1% of patients in Spokane County and are included in the "Other" category.

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

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

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

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

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

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

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

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

MultiCare expects its patients to generally be over the age of 18 but will provide care for referrals across all ages. Should a referral for pediatric services arise, MultiCare is prepared to assign clinicians competent to care for patients below the age of 18. If there are no employees with pediatric experience at the time of the referral, MultiCare will either hire such employees or provide services either through a contract with a staffing agency or coordinate services with a pediatric specialty program.

As we describe in more detail below, we also anticipate our patients to primarily belong to traditionally underserved groups such as the African American, Asian, Hispanic, Native American, and low-income communities.

11. Provide a copy of the letter of intent that was already submitted according to WAC 246-310-080 and WAC 246-310-290(3).

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

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

MultiCare Home Health, Hospice, and Palliative Care has the following licensure and Medicare and Medicaid numbers:

IHS.FS.60081744
Medicare #: 507046
Medicaid #: 1043537

IV. Certificate of Need Review Criteria

A. Need (WAC 246-310-210)

WAC 246-310-210 provides general criteria for an applicant to demonstrate need for healthcare facilities or services in the planning area. WAC 246-310-290 provides specific criteria for hospice agency applications. Documentation provided in this section must demonstrate that the proposed agency will be needed, available, and accessible to the community it proposes to serve. Some of the questions below only apply to existing agencies proposing to expand. For any questions that are not applicable to your project, explain why.

1. **For existing agencies, using the table below, provide the hospice agency's historical utilization broken down by county for the last three full calendar years. Add additional tables as needed.**

   The historical hospice utilization of MultiCare Home Health, Hospice, and Palliative is included in Table 5**.**

Table 5: MultiCare Home Health, Hospice, and Palliative Care Historical Admissions

Total Admissions	2020	2021	2022	NOV 2023 YTD
King	173	162	123	161
Kitsap	138	156	192	170
Pierce	1,027	1,059	974	1,152
Total	1,338	1,377	1,289	1,483

Source: DOH 2023-2024 Hospice Numeric Need Methodology and Applicant

2. **Provide the projected utilization for the proposed agency for the first three full years of operation. For existing agencies, also provide the intervening years between historical and projected. Include all assumptions used to make these projections.**

   The projected utilization for the proposed agency is based on a combination of the existing unmet numeric need from the DOH 2023-2024 Hospice Need Methodology, included as Exhibit 3, and an estimate of admissions from planning area underserved groups.

   The need methodology is extrapolated to 2028 to cover the first three full years of operation using linearly interpolated population forecast estimates from the Washington State Office of Financial Management (OFM). We present the forecasted population and extrapolated need estimates in Table 6.

Table 6: Spokane County Forecasted Population and Hospice Need, 2025 to 2028

Spokane County Numeric Need	Row	2025	2026	2027	2028
Population					
0 to 64	1	453,733	455,178	456,625	458,071
65+	2	109,316	112,735	116,155	119,574
Admissions per Capita					
0 to 64	3	0.0008	0.0008	0.0008	0.0008
65+	4	0.0270	0.0270	0.0270	0.0270
Potential Volume					
0 to 64 ([1]*[3])	5	362	363	364	365
65+ ([2]*[4])	6	2,956	3,048	3,141	3,233
All ages ([5]+[6])	7	3,317	3,411	3,505	3,598
Supply	8	3,196	3,196	3,196	3,196
Unmet Admissions ([8]-[7])	9	122	215	309	402
ALOS (WA Avg.)	10	61.11	61.11	61.11	61.11
Unmet Patient Days ([9]*[10])	11	7,435	13,155	18,875	24,595
Unmet ADC ([11]/365)	12	20	36	52	67

Sources: Admissions per person from DOH 2023-2024 Hospice Need Methodology for the 0 to 64 and 65+ age cohort groups. Population from OFM Medium Series and a linear interpolation between forecast years.

Notes: Patient days based on Washington State ALOS average of 61.11. ADC calculated by dividing patient days by 365. Numbers presented in table reflect rounding for presentation purposes.

As indicated in Table 6 and the Department's 2023-2024 Numeric Need Methodology presented in Exhibit 3, numeric need in Spokane County does not meet the 35 ADC threshold for the 2025 forecast year. As such, while in 2025 there is forecast need for additional hospice services, this need is not sufficient, by itself, to justify an additional hospice agency. However, as we describe in our response to Question 8 below, there exist underserved populations in Spokane County who use hospice services at depressed rates. MultiCare will target these underserved populations but will be available and accessible to all residents of Spokane County. As such, we believe it reasonable to expect hospice admissions from the forecast unmet need in Spokane County, as well as admissions from these underserved communities.

Based on our analysis in Table 9, we estimate 148 potential admissions from underserved communities in Spokane County. With this, and the forecast admissions in Table 6, we specify our utilization assumptions in Table 7.

Table 7: Utilization Forecast Assumptions

Utilization Assumptions	Row	2025	2026	2027	2028
Unmet Admissions from Numeric Need	1	121	215	309	402
% of Unmet Numeric Need	2	35%	35%	35%	35%
Admissions from Unmet Numeric Need ([1]*[2])	3	43	75	108	141
Patients per Month ([3]/12)	4	3.5	6.3	9.0	11.7
Residual Admissions from Underserved Populations	5	148	148	148	148
% of Underserved Need	6	20%	30%	40%	50%
Admissions from Undeserved Populations ([5]*[6])	7	30	44	59	74
Patients per Month ([7]/12)	8	2.5	3.7	4.9	6.2

Sources: Table 6, Table 9, and self-calculations.

From the number of unmet admissions in Table 6 and Table 9 and the assumed proportion of unmet need in Table 7, we forecast patient counts and patient days over the first three full years of operation in Table 8. Additional assumptions include an average length of stay ("ALOS") equal to 61.11 and a facility opening date of April 2025.

We note our utilization forecast assumes only a proportion of the forecast unmet need for Spokane County, equal to 35% of forecast numeric need, and 50% of forecast additional need from underserved populations. Furthermore, although non-White populations have grown by about 4 percent per year over the last decade, our utilization forecast holds admissions from these underserved populations constant. As we describe below, these populations will continue to grow and age, and their need for hospice services will increase over time. Thus, this represents a conservative utilization forecast which allows existing providers to expand utilization even with the proposed agency.

Table 8: Projected Utilization

Utilization Forecast	Row	2025	2026	2027	2028
Months	1	9	12	12	12
Patients per Month	2	6.0	10.0	13.9	17.9
Hospice patients ([1]*[2])	3	54.0	120.0	166.8	214.8
ALOS (WA Avg.)	4	61.11	61.11	61.11	61.11
Total visits ([3]*[4])	5	3,300	7,333	10,193	13,126
ADC ([5]/(365*[1]/12))	6.0	12.1	20.1	27.9	36.0

Source: Applicant

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

As we document below, available statistics demonstrate there exist underserved communities within Spokane County which this project proposes to serve. These

underserved communities utilize hospice services below the planning area average, indicating both current and future problems related to access to hospice services for Spokane residents within these populations.

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

In addition, we are aware of no providers of hospice in Spokane who require annual competency training or who provide culturally competent end-of-life and palliative care to the LGBTQ+ and minority communities, specifically. This application proposes hospice services which provide culturally competent care and requires annual training for both LGBTQ+ and minority populations. This specificity is important in all aspects of health care, including palliative and end-of-life care.

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

4. Explain why this application is not considered an unnecessary duplication of services for the proposed planning area. Provide any documentation to support the response.

There currently exist four providers within Spokane County. These include Kindred Hospice, Horizon Hospice, and Hospice of Spokane. In addition, Providence Health & Services was approved to provide hospice services in 2022, although has not yet reported admissions.

Based on our utilization forecast assumptions in Table 7, we expect to serve only 35 percent of the forecast unmet need within Spokane County and ramping up to 50 percent of the need from underserved Spokane County populations. As such, our agency's utilization is based entirely on excess demand for hospice services which is unmet, thus avoiding unnecessary duplication of services in Spokane County.

The motivation for this application is to fill the current and increasing gap in care for hospice services in Spokane County. Based on MultiCare's experience as a provider of inpatient services in the Spokane market, potential hospice patients with public payers, especially low-income persons, face longer wait times to hospice discharge and thus shorter periods receiving needed hospice care. The lower use rates of hospice services for the minority and dual eligible populations in Spokane shows that persons in these communities face barriers to access and are not being adequately served by the existing providers in Spokane.

This application represents the planned provision of hospice services focused on culturally competent care provided to underserved populations in Spokane. We are aware of no providers of hospice in Spokane who require annual competency training or provide this culturally competent care to these populations. Thus, the proposed project will not duplicate

the services of existing hospice providers, but rather complement these services by focusing on groups within Spokane who are currently underserved.

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

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

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

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

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

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

   Furthermore, the proposed project emphasizes outreach and hospice use for traditionally underserved populations. Please see our discussion below that describes how we plan to increase hospice use among underserved groups.

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

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

8. **If there is not sufficient numeric need to support approval of this project, provide documentation supporting the project's applicability under WAC 246-**

310-290(12). This section allows the department to approve a hospice agency in a planning area absent numeric need if it meets the following review criteria:

- **All applicable review criteria and standards with the exception of numeric need have been met;**
- **The applicant commits to serving Medicare and Medicaid patients; and**
- **A specific population is underserved; or**
- **The population of the county is low enough that the methodology has not projected need in five years, and the population of the county is not sufficient to meet an ADC of thirty-five.**

Note: The department has sole discretion to grant or deny application(s) submitted under this subsection.

As indicated in Table 6 and the Department's 2023-2024 Numeric Need Methodology presented in Exhibit 3, numeric need in Spokane County does not meet the 35 ADC threshold for the 2025 forecast year. As such, while in 2025 there is forecast need for additional hospice services, this need is not sufficient, by itself, to justify an additional hospice agency. However, we request approval based on WAC 246-310-290(12). Specifically, our application meets all other applicable review criteria; we are committed to serving Medicare and Medicaid patients; and as discussed below, there are specific populations within Spokane County who are underserved. These include low-income individuals in Spokane and members of the Black, Asian, Hispanic, Indigenous, and other non-White communities in Spokane, as well as Spokane's LGBTQ+ community.

We present 2022 deaths and deaths in hospice by dual eligibility and race and ethnicity for CMS beneficiaries with a Spokane County residence in Table 9. CMS beneficiaries are predominately aged 65 and over but may also reflect younger individuals as well. Dual eligibility is presented only for persons who identified as White given that (1), most CMS beneficiaries across the other demographic categories also identified as dually eligible, and (2) censoring requirements prevent presentation of these categories when cell sizes fall below 10 observations.

Dual-eligible individuals represent persons dually enrolled in Medicare and Medicaid programs and for the purposes of this analysis, reflect individuals with income which does not exceed 200% of the Federal Poverty Level.[4] For 2023, the Federal Poverty Level was $19,720 for a 2-person household[5] while median household income in Spokane County was about $70,000.[6] As such, a 2-person Dual-eligible household would have about half of Spokane County median income.

[4] Dual-eligible individuals are generally classified based on the level of Medicare and Medicaid benefits received according to income level. This analysis considers dual-eligible individuals to be all duals, i.e. both "full" and "partial" duals.
[5] https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines, Last Accessed December 19, 2023.
[6] https://www.census.gov/quickfacts/fact/table/spokanecountywashington/PST045222, Last Accessed December 20, 2023.

Table 9: Hospice use and underserved deaths by race and ethnicity, Spokane County 2022.

	Deaths in Hospice, All Providers	All deaths	% of Deaths in Hospice	Underserved Deaths rel. to White avg.
White, not Dual Eligible	1,477	3,079	48.0%	N/A
White, Dual Eligible	442	1,164	38.0%	117
Black	18	54	33.3%	8
Asian/ Pac Islander	13	38	34.2%	6
Hispanic	CENSORED	12	CENSORED	1
Native American/American Indian	20	50	40.0%	4
Other	17	38	44.7%	2
Unknown	19	60	31.7%	10
Total*	**2,006**	**4,483**	**44.7%**	**148**

Sources: CMS 2022 Hospice Limited Data Set

Notes: Reflects data for CMS beneficiaries only. Cells with less than eleven observations are censored for privacy reasons. Underserved deaths relative to White average calculated through assumption of proportion of White Non-Dual Eligible deaths served in hospice (48.0%) for deaths by other specified categories. "Total" row omits censored observations. The proportion of deaths in hospice for across all categories omits Hispanics as the number of Hispanic deaths in hospice is censored.

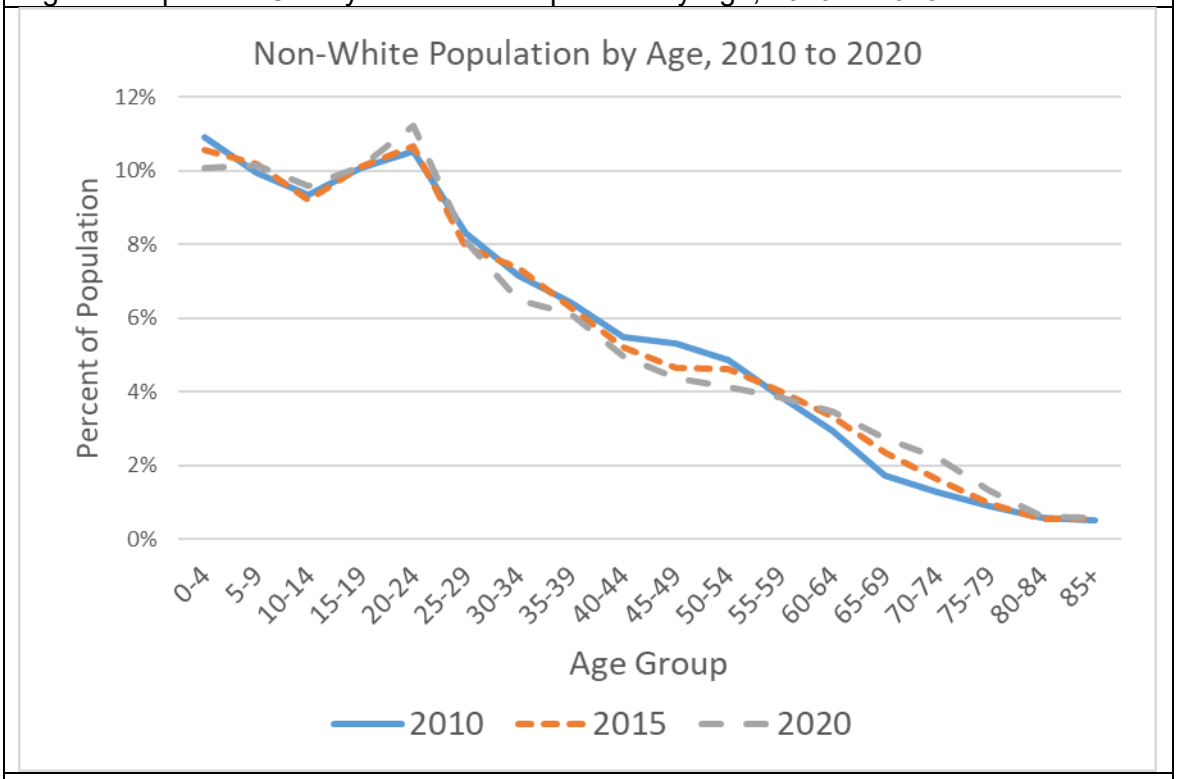
From Table 9, in 2022, there were 3,079 deaths of CMS beneficiaries within Spokane County who both identified as White and were not dually eligible for Medicare and Medicaid. Of these, 1,477, or about 48 percent, died while receiving hospice care. Among the other demographic groups, a lower proportion of deaths occurred while in hospice. For Dual-Eligible White persons, about 38 percent died while in hospice. For Black persons, this rate was about 33 percent, for Asian/Pacific Islanders, about 34 percent, and for Indigenous persons, about 40%. The number of CMS beneficiaries identifying as Hispanic persons in Spokane County was not large enough to permit presentation of their hospice use rate.

Constructing the counterfactual where all persons use hospice at the same rate as White non-Dual-Eligible persons, we would see an additional 117 hospice patients for White Dual Eligible persons, an additional 8 from Black persons, an additional 6 from Asian and Pacific Islander persons, and an additional 4 from Native American persons. In aggregate, had Dual Eligible and non-White persons used hospice services at the same rate as non-Dual Eligible White persons, there would have been an additional 148 hospice admissions in Spokane County. This number is used in Row 5 of Table 7 for the projected utilization from underserved populations. Please note, this figure of 148 hospice admissions is held constant, while, in fact, the number of deaths will increase over time as these populations grow and age.

While our analysis above concentrates on Dual Eligible persons who identify as White since that is the data which is possible to show for CMS beneficiaries, MultiCare will target all low-income populations within Spokane County for increased hospice access. In some cases, this can be achieved passively through MultiCare's financial assistance program and commitment to serving all patients, including those who lack health insurance coverage and who cannot pay for all or part of the essential care they receive. In other cases, this will require active outreach and working with providers serving these low-income communities.

In addition to the existing need for hospice services among these underserved populations, their need for hospice services is likely to increase over time. We present the age distribution for non-White populations in Spokane County for the 2010 to 2020 period in Figure 1.

Figure 1: Spokane County Non-White Population by Age, 2010 to 2020

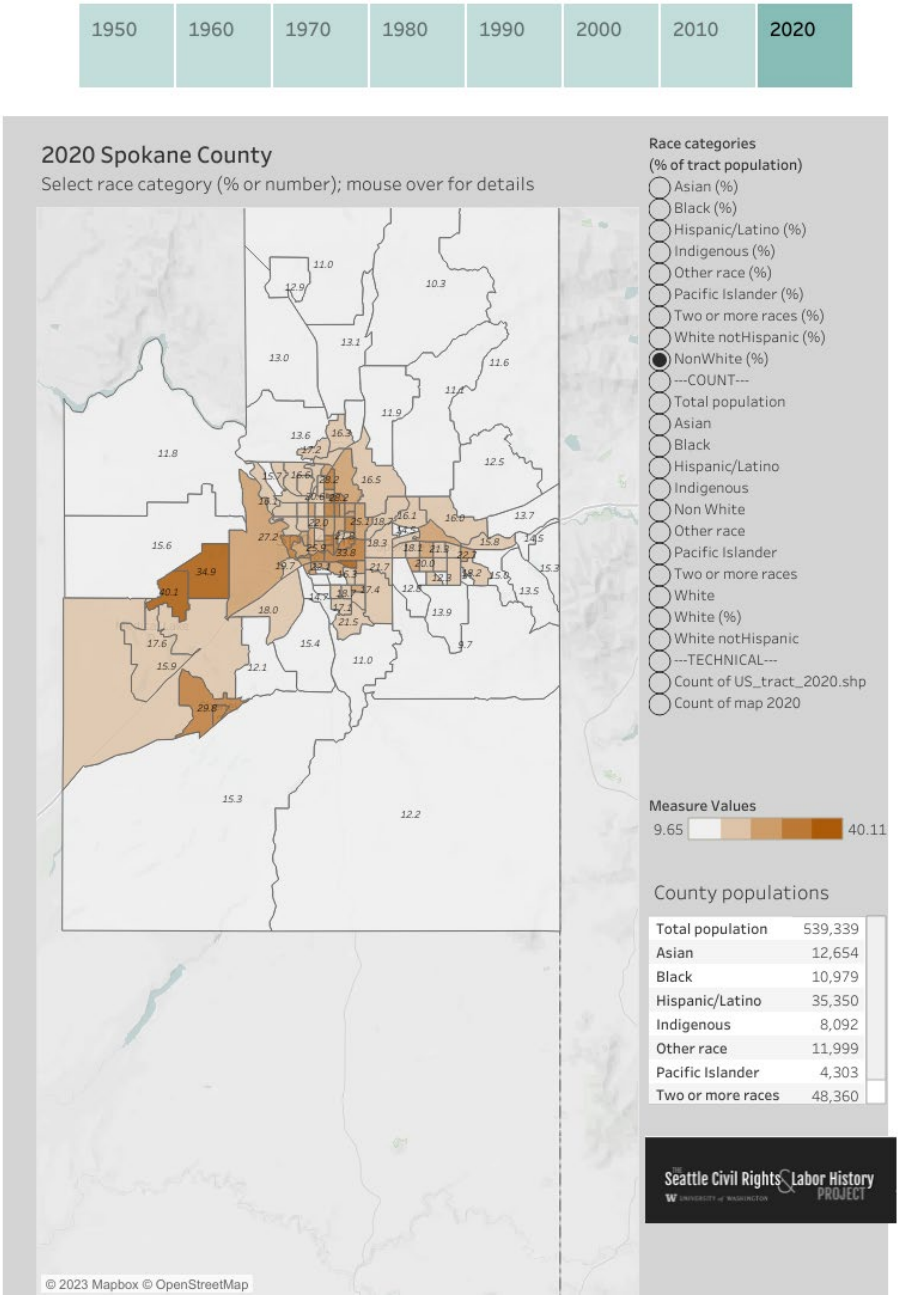


Sources: OFM SADE Estimates by Age, Sex, Race, and Hispanic Origin, https://ofm.wa.gov/washington-data-research/population-demographics/population-estimates/estimates-april-1-population-age-sex-race-and-hispanic-origin, Last Accessed December 14, 2023.

From Figure 1, the non-White population in Spokane County has aged over the last decade and based on its age structure this is likely to continue. Since 2010, the proportion of non-White individuals aged 65 and over has increased from 5 percent to 7.4 percent. Whereas in 2010, the population had greater weight among older working age adults (ages 35 to 55), in 2020, there is greater weight among persons aged 60 and over. We would also note the persistently high proportion of people in their early 20s, reflective of Spokane's college student population.

While the dispersion of minority populations in Spokane County is increasing as the populations grow, most of these individuals reside in a handful of neighborhoods within the city of Spokane. We present the geographic distribution of non-White persons in Spokane County in Figure 2.

Figure 2: Spokane Non-White Population Distribution



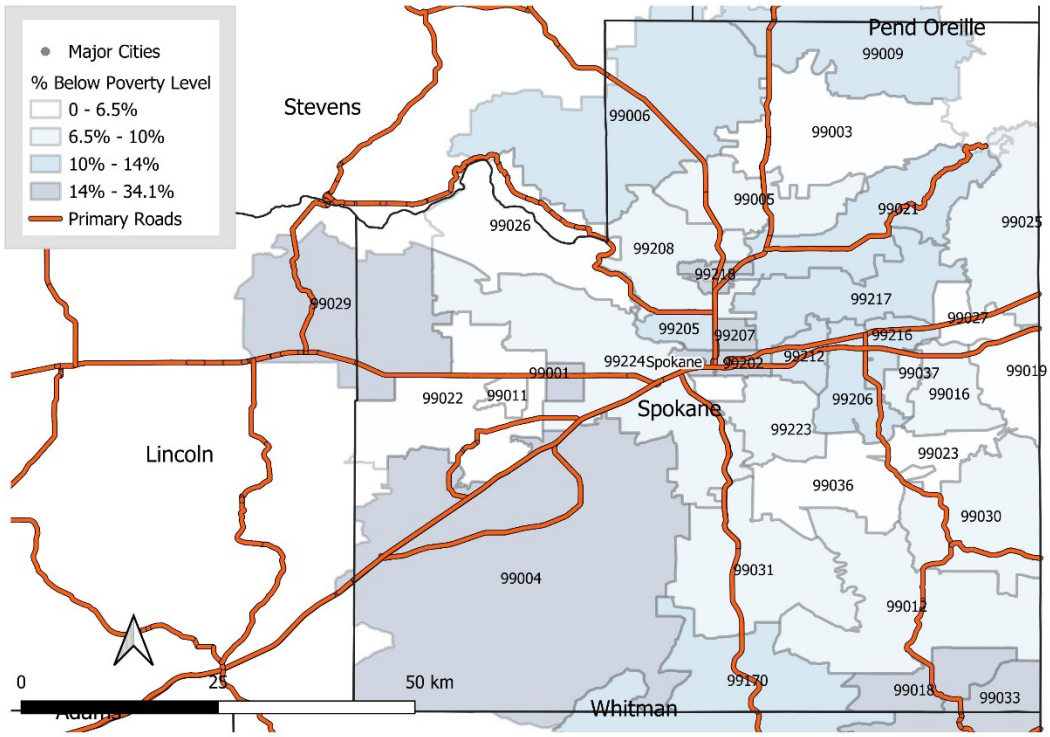
Source: https://depts.washington.edu/labhist/maps-race-seattle.shtml, Last Accessed December 14, 2023. Calculated from Steven Manson, Jonathan Schroeder, David Van Riper, and Steven Ruggles. IPUMS National Historical Geographic Information System: Version 12.0

[Database]. Minneapolis: University of Minnesota. 2017. http://doi.org/10.18128/D050.V12.0

From Figure 2, which was constructed from U.S. Census microsample data by individuals at the University of Washington as part of its Civil Rights and Labor History Consortium, the non-White populations in Spokane County are concentrated primarily within the city of Spokane near I-90 and Highway 2. This reflects the historical segregation endured by families of color in Spokane, where housing and employment opportunities limited where persons in these communities could reside. Spokane County has slowly desegrated, but these communities remain concentrated in Central and West Spokane. The patterns are similar regardless of the specific minority population considered.

The distribution of persons below the poverty level in Spokane is similar. We present the distribution of Spokane County residents below 100 percent of the poverty level in Figure 3.

Figure 3: Spokane Low Income Population Distribution



Source: U.S. Census American Community Survey, 2021.

The data presented in Figure 3 is derived from the U.S. Census American Community Survey and reflects data from 2021 at the Zip Code level. The spatial distribution of low-income persons is similar to that of the non-white populations presented in Figure 2, but with additional concentrations in the rural areas to the South and West of the city of Spokane.

LGBTQ+ Population in Spokane

There is no corresponding data on the use of hospice services or location of LGBTQ+ individuals in Spokane, however we are unaware of hospice providers in Spokane which require annual competency training, or which provide culturally competent end-of-life and palliative care to the LGBTQ+ communities. As such, we consider this an underserved population in Spokane and while we are not able to explicitly model the use of hospice services by these persons, we will seek to provide culturally competent care with annual training for the LGBTQ+ populations.

Plan for Outreach and Engagement

It is these underserved populations in these areas which MultiCare will focus on to increase access to and use of hospice services. We plan to leverage the relationships of MultiCare with skilled nursing facilities, assisted living facilities, and other senior care providers within these targeted areas, as well as engage with community organizations and other representatives of these underserved communities. To ensure our success in this area, we plan to hire a Hospice Outreach Coordinator position dedicated to our outreach and educational activities in Spokane County.

Furthermore, MultiCare is developing Health Equity Community Advisory Boards within the Inland Northwest, as well as other regions, which consist of community members representing diverse populations. These boards are part of an ongoing effort by MultiCare to provide Culturally and Linguistically Appropriate Services. We include a draft charter of the Health Equity Community Advisory Board in Exhibit 13.

The advisory group specific to the Spokane area, facilitated by its Health Equity Outreach Program Manager, will work with the Hospice Outreach Coordinator to engage with the community-based organizations focused on supporting/advocating for our identified underserved populations.

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

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

1. **Provide documentation that demonstrates the immediate and long-range capital and operating costs of the project can be met. This should include but is not limited to:**
   - **Utilization projections. These should be consistent with the projections provided under the Need section. Include all assumptions.**
   - **Pro Forma revenue and expense projections for at least the first three full calendar years of operation. Include all assumptions.**
   - **Pro Forma balance sheet for the current year and at least the first three full calendar years of operation. Include all assumptions.**
   - **For existing agencies proposing addition of another county, provide historical revenue and expense statements, including the current year. Ensure these are in the same format as the projections. For incomplete years, identify whether the data is annualized.**

   Our utilization projections are provided in Table 8 above. Our Pro Forma forecasts, including a Statement of Revenues and Expenses and a balance sheet are included in Exhibit 10. This exhibit also includes documentation of all financial assumptions.

2. **Provide the following agreements/contracts:**
   - **Management agreement.**
   - **Operating agreement**
   - **Medical director agreement**
   - **Joint Venture agreement**

   Note, all agreements above must be valid through at least the first three full years following completion or have a clause with automatic renewals. Any agreements in draft form must include a document signed by both entities committing to execute the agreement as submitted following CN approval.

   None of the listed agreements/contracts are applicable to the proposed project.

3. **Provide documentation of site control. This could include either a deed to the site or a lease agreement for the site.**

   If this is an existing hospice agency and the proposed services would be provided from an existing main or branch office, provide a copy of the deed or lease agreement for the site. If a lease agreement is provided, the agreement must extend through at least the projection year. Provide any amendments, addendums, or substitute agreements to be created as a result of this project to demonstrate site control.

   If this is a new hospice agency at a new site, documentation of site control includes one of the following:

a. **An executed purchase agreement or deed for the site.**
b. **A draft purchase agreement for the site. The draft agreement must include a document signed by both entities committing to execute the agreement as submitted following CN approval.**
c. **An executed lease agreement for at least three years with options to renew for not less than a total of two years.**
d. **A draft lease agreement. For Certificate of Need purposes, draft agreements are acceptable if the draft identifies all entities entering into the agreement, outlines all roles and responsibilities of the entities, identifies all costs associated with the agreement, includes all exhibits referenced in the agreement. The draft agreement must include a document signed by both entities committing to execute the agreement as submitted following CN approval.**

MultiCare Health System currently leases the First, Second, and Fifth floors of the building at 1313 Broadway in Tacoma, WA in which its Home Health, Hospice, and Palliative Care operations are located. In Exhibit 9, we include the lease (Exhibit 9a) and first amendment to lease and commencement date memorandum (Exhibit 9b) to demonstrate MultiCare has control over the site of its existing operations.

Given approval of the proposed project, Spokane operations will be run out of an office in MultiCare's Medical Office Building located at 801 W. 5th Avenue, Spokane, Washington 99204. MultiCare plans to allocate Suite 510 (2,016 square feet) within this office building to the proposed project. In Exhibit 9c, we include the Bargain and Sale Deed to the proposed property which demonstrates MultiCare owns this medical office building. This medical office building represents Parcel C in the Bargain and Sale Deed.

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

Table 10: Project Capital Expenditures

Item	Cost
a. Land Purchase	
b. Utilities to Lot Line	
c. Land Improvements	
d. Building Purchase	
e. Residual Value of Replaced Facility	
f. Building Construction	
g. Fixed Equipment (not already included in the construction contract)	
h. Movable Equipment	$60,840
i. Architect and Engineering Fees	

j. Consulting Fees	
k. Site Preparation	
l. Supervision and Inspection of Site	
m. Any Costs Associated with Securing the Sources of Financing (include interim interest during construction	
1. Land	
2. Building	
3. Equipment	
4. Other	
n. Washington Sales Tax (8.9%)	$5,475
Total Estimated Capital Expenditure	$66,315

Sources: See Equipment List in Table 13.

5. Identify the entity responsible for the estimated capital costs identified above. If more than one entity is responsible, provide breakdown of percentages and amounts for each.

MultiCare Health System will be responsible for the estimated capital costs identified above. Please see Exhibit 11 for a Letter of Financial Commitment.

6. Identify the amount of start-up costs expected to be needed for this project. Include any assumptions that went into determining the start-up costs. Start-up costs should include any non-capital expenditure expenses incurred prior to the facility opening or initiating the proposed service. If no start-up costs are expected, explain why.

It is expected that, in addition to the CON Application Fee and Equipment expenditures listed in Table 13, MultiCare will incur start-up costs equal to about $81,063. These expenses represent a month of all 2025 operational expenses except for Depreciation.

7. Identify the entity responsible for the estimated start-up costs identified above. If more than one entity is responsible, provide breakdown of percentages and amounts for each.

MultiCare Health System will be responsible for the estimated capital costs identified above. Please see Exhibit 11 for a Letter of Financial Commitment.

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

MultiCare's rates are primarily based on fee schedules with CMS and principal payers. Thus, the proposed project will not impact costs or charges for health services.

9. Explain how the costs of the project, including any construction costs, will not result in an unreasonable impact on the costs and charges for health services in the planning area.

The proposed project requires only modest capital expenditures for furniture, computers, and other IT equipment. Furthermore, MultiCare's rates are primarily based on fee schedules with CMS and principal payers. Thus, the proposed project will not result in an unreasonable impact on costs or charges for health services in the planning area.

10. Provide the projected payer mix by revenue and by patients by county as well as for the entire agency using the example table below. Medicare and Medicaid managed care plans should be included within the Medicare and Medicaid lines, respectively. If "other" is a category, define what is included in "other."

Please see Table 11 for the projected payer mix by source.

Table 11: Projected Payer Mix

Payer	Pct. of Gross Revenue	Pct. Patients
Medicare/ Managed Medicare	91.0%	91.0%
Medicaid/ Managed Medicaid	3.6%	3.6%
Commercial	2.5%	2.5%
Self-Pay	0.3%	0.3%
Health Care Exchange	0.3%	0.3%
Other (1)	2.2%	2.2%
Total	**100%**	**100%**

Source: Applicant

Notes: Row totals in each column may not sum exactly to "Total" row for each column due to rounding. "Other" payers include Tricare, Veterans Admin., Worker Compensation, and Healthcare Exchange payers.

11. If this project proposes the addition of a county for an existing agency, provide the historical payer mix by revenue and patients for the existing agency. The table format should be consistent with the table shown above.

Table 12: Historical Payer Mix (Nov 2023 YTD)

Payer	Pct. of Gross Revenue	Pct. Patients
Medicare/ Managed Medicare	91.0%	91.0%

Medicaid/ Managed Medicaid	3.6%	3.6%
Commercial	2.5%	2.5%
Self-Pay	0.3%	0.3%
Health Care Exchange	0.3%	0.3%
Other (1)	2.2%	2.2%
Total	**100%**	**100%**

Source: Applicant

Notes: Row totals in each column may not sum exactly to "Total" row for each column due to rounding. "Other" payers include Tricare, Veterans Admin., Worker Compensation, and Healthcare Exchange payers.

12. Provide a listing of equipment proposed for this project. The list should include estimated costs for the equipment. If no equipment is required, explain.

Equipment proposed for this project includes furnishings and other office machines and related equipment. Please see Table 13 for a full list of equipment with costs.

Table 13: Equipment List

Furniture	Unit Cost	Units	Total Cost
Desks	$1,362	12	$16,339
Conf Room Table	$1,128	1	$1,128
Conf Room Chairs	$245	8	$1,960
Office Chairs	$99	12	$1,188
Subtotal			**$20,615**
Sales Tax			$1,855
Furniture Total			**$22,470**
Equipment & Phone	**Unit Cost**	**Units**	**Total Cost**
Laptop Computer	$1,589	13	$20,657
Docking Station	$200	13	$2,600
24-inch Monitor, Keyboard and Mouse	$188	26	$4,888
Cables /Wires	$20	13	$260
Color copier, scanner, printer, and fax	$9,000	1	$9,000
Extra drawers/cabinet	$220	1	$220
Desk/Office Phone	$200	13	$2,600
Subtotal			**$40,225**

Sales Tax			$3,620
Equipment & Phone Total			**$43,845**
Equipment Total			**$66,315**

Sources: Furniture, equipment, and phone costs from Applicant experience.

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

MultiCare will finance the capital expenditures and the start-up costs identified above. Please see Exhibit 11 for a letter of financial commitment.

14. If this project will be debt financed through a financial institution, provide a repayment schedule showing interest and principal amount for each year over which the debt will be amortized.

This question is not applicable.

15. Provide the most recent audited financial statements for:

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

Please see Exhibit 12 for MultiCare audited financial statement for the period 2021 and 2022.

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

Projects are evaluated based on the criteria in WAC 246-310-230 for staffing availability, relationships with other healthcare entities, relationships with ancillary and support services, and compliance with federal and state requirements. Some of the questions within this section have implications on financial feasibility under WAC 246-310-220.

1. **Provide a table that shows FTEs [full time equivalents] by category for the county proposed in this application. All staff categories should be defined.**

Table 14: Projected Staffing by Occupational Category – Spokane Hospice Only

Spokane Hospice Staffing Forecast	2025	2026	2027	2028
Clinical Supervisor	0.38	0.50	0.50	0.50
HHA	0.41	0.64	0.88	1.14
Intake / Scheduling	0.38	0.50	0.75	0.75
LPN	0.21	0.28	0.28	0.33
Medical Director	0.21	0.28	0.28	0.34
MSW	0.51	1.14	1.58	2.04
Other Administrative	0.38	0.75	0.75	0.75
Other Clinical	0.21	0.28	0.31	0.40
RN	1.23	2.73	3.79	4.88
Hospice Outreach Coordinator	0.38	0.50	1.00	1.00
Total	**4.27**	**7.57**	**10.12**	**12.13**

Source: Applicant

Notes: Row totals in each column may not sum exactly to "Total" row for each column due to rounding. Clinical positions include HHA, LPN, Medical Director, MSW, Other Clinical, and RN. Administrative positions include Clinical Supervisor, Intake/Scheduling, Other Administrative, and Hospice Outreach Coordinator

2. **If this application proposes the expansion of an existing agency into another county, provide an FTE table for the entire agency, including at least the most recent three full years of operation, the current year, and the first three full years of operation following project completion. There should be no gaps in years. All staff categories should be defined.**

Table 15: MultiCare Home Health and Hospice Staffing, 2020 to June 2023 YTD

HH&H Combined	2020	2021	2022	2023 June YTD
Administrator	1.00	1.00	0.30	1.00
Clinical Supervisor	7.25	4.90	2.87	5.00

Table 15: MultiCare Home Health and Hospice Staffing, 2020 to June 2023 YTD

COTA	3.21	2.81	3.62	4.00
HHA	14.01	12.21	11.67	11.13
Intake / Scheduling	4.99	4.37	7.90	9.23
LPN	4.99	4.37	6.82	5.87
Manager	*	*	3.54	2.00
Medical Director	+	+	1.69	2.59
MSW	10.39	10.68	16.70	17.32
OT	4.88	4.09	4.18	3.96
Other Administrative	15.98	17.23	15.63	15.07
Other Clinical	18.80	20.48	4.97	4.58
PT	9.16	9.76	9.52	10.17
PTA	9.91	8.80	9.00	8.12
RN	49.89	48.89	46.41	51.41
SLP	1.72	1.37	0.88	1.21
HH&H Total	**156.18**	**150.98**	**145.71**	**152.65**

Source: Applicant

Notes: Row totals in each column may not sum exactly to "Total" row for each column due to rounding. *Manager included in "Other Administrative" during 2020-2021 period. +Medical Director included in "Other Clinical" during 2020-2021 period.

Table 16: MultiCare Home Health and Hospice Staffing, 2024 to 2028

Entire Agency, HH&H Combined	2024	2025	2026	2027	2028
Administrator	1.00	1.00	1.00	1.00	1.00
Clinical Supervisor	5.00	5.38	5.50	5.50	5.50
COTA	4.00	4.00	4.00	4.00	4.00
HHA	11.13	11.54	11.76	12.01	12.26
Intake / Scheduling	9.23	9.60	9.73	9.98	9.98
LPN	5.87	6.08	6.15	6.15	6.20
Manager	2.00	2.00	2.00	2.00	2.00
Medical Director	2.59	2.79	2.86	2.86	2.93
MSW	17.32	17.84	18.46	18.90	19.36
OT	3.96	3.96	3.96	3.96	3.96
Other Administrative	15.07	15.45	15.82	15.82	15.82
Other Clinical	4.58	4.78	4.85	4.89	4.98
PT	10.17	10.17	10.17	10.17	10.17
PTA	8.12	8.12	8.12	8.12	8.12
RN	51.41	52.64	54.14	55.20	56.29
SLP	1.21	1.21	1.21	1.21	1.21

Spokane Hospice Outreach Coordinator	0.00	0.38	0.50	1.00	1.00
Total	**152.65**	**156.92**	**160.23**	**162.77**	**164.78**

Source: Applicant

Notes: Row totals in each column may not sum exactly to "Total" row for each column due to rounding. FTE counts above represent the sum of FTEs in Table 14 with the June 2023 YTD FTE figures in Table 15. The forecast assumption is that non-Spokane staffing in Table 15 remains constant over the forecast period.

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

Standard caseload per discipline and knowledge of the service area assisted in projecting the number and types of FTEs to initially manage patients in Spokane County. In addition, we have added a Hospice Outreach Coordinator FTE to lead the local efforts in increasing hospice use among underserved communities.

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

The clinical staffing plan for the agency is based off historical patient-to-staff ratios for MultiCare Hospice in King, Pierce, and Kitsap counties. These ratios meet or exceed comparable statistics for other hospice agencies in Washington State for which this information is available. Administrative staffing levels are not based on historical patient-to-staff ratios but are based on MultiCare experience.

5. Provide the name and professional license number of the current or proposed medical director. If not already disclosed under 210(1) identify if the medical director is an employee or under contract.

Dr. Jason Heffernan, MD60051097

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

Please see Exhibit 8 for the Medical Director Job Description.

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

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

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

The names and professional license numbers of MultiCare providers who could reasonably be expected to provide services to Spokane hospice patients includes:

HOSPICE PROVIDER	LICENSE NUMBER
Chubbuck, Melissa MD	MD61054939
Dorna, Isam MD	MD60123479
Heffernan, Jason MD	MD60051097
Mullen, Margaret MD	MD60240449
Coville, Lea MD	MD60767737
Mosely, Michael MD	MD60380187
Malynda Gonzales ARNP	AP61119592
David Hutchason ARNP	AP30004263

9. Describe your methods for staff recruitment and retention. If any barriers to staff recruitment exist in the planning area, provide a detailed description of your plan to staff this project.

The ability of a hospice agency to recruit and retain sufficient staff is essential. There exist staffing shortages across Washington, as well as in Spokane County. Furthermore, staffing is especially challenging in hospice programs because the caregivers are in the field (i.e., in the patient's home or other place of residence) and thus must be more independent and self-reliant. Accordingly, greater training and experience are necessary for hospice staff. This can make recruitment more difficult than, for instance, recruiting staff for a skilled nursing facility, hospital, or other inpatient facility, where there is on-site supervision and support.

Staff recruitment will be handled through MultiCare's recruitment department. Recruiters and agency leadership review open requisitions and discuss the various recruitment strategies being used. Virtual hiring events are held every 4-6 weeks. For retention, an employee satisfaction survey is completed annually to help leadership identify opportunities for improvement in the work environment. The employee-run Practice Council operates to discuss any concerns with leadership, develop quality initiatives for increased quality of care, and problem solve any identified issues.

While staffing shortages exist, MultiCare is in a position to respond proactively to these shortages and to recruit and retain sufficient qualified caregivers. Furthermore, due to its established presence and respected reputation in the area, together with its strong local recruitment program and existing network of local and national recruiting resources, it is well-equipped to leverage its relatively generous compensation package to quickly and successfully recruit the new staff that will be required. With these practices, MultiCare surpasses national benchmarks for hospice staff turnover. Presently staff turnover within MultiCare hospice is equal to about 8%, which is superior to the NSI Benchmark of 20%.

If MultiCare did face barriers to staffing, we would ensure quality and timely patient care in a number of ways. We would temporarily devote resources from support departments into recruitment and onboarding departments to increase the speed and power of recruitment and onboarding for as long as the staffing constraint lasted. Another primary tactic would be to increase support for our on-site and current employees through support clinical staff-as well as support administrative staff programs to provide additional incentives to remain with

MultiCare and thereby decrease our attrition rate. All of these could be accomplished in relatively short order in the event of a serious barrier to recruitment and retention of staff.

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

Hours of operation are from 8:00 a.m. to 5:00 p.m. There is a nurse on-call after hours and on weekends for all patients to access for any needs. Calls are originally routed to MultiCare's Consulting Nurses or to an on-call answering service. The on-call nurse for hospice is then contacted and the patient is called to determine what needs the patient may have. A nurse is sent to visit the patient as needed.

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

Press Ganey is the third-party entity that sends out patient satisfaction surveys. They then tabulate the results and have reports that show responses. Strategic Healthcare Programs gives the agency real time data to monitor outcomes and process measures for CMS quality measures. RLSolutions is the platform that is used to document and report all occurrences, infections, and complaints.

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

Press Ganey - Patient satisfaction
Strategic Healthcare Programs - Measuring outcomes and process measures
RLSolutions - Reporting occurrences
Epic - EMR
Corridor - Clinical Coding
Ability Network - ADR and appeals tracking
Status in Demand/AMN Health Care - Language Services
Medline - Medical supplies
Schryver Medical - Mobile imaging

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

There is no expected change to the agreements for the support service vendors.

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

This question is not applicable.

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

MultiCare Home Health, Hospice, and Palliative Care has working relationships with all other MultiCare affiliated hospitals and healthcare facilities listed in Table 1. This includes

MultiCare Deaconess Medical Center in Spokane and MultiCare Valley Hospital in Spokane Valley.

MultiCare has agreements with several skilled nursing and assisted living providing care to Spokane residents. These include:

Skilled Nursing Facilities

- Prestige Care and Rehab Center
- Sunshine Health & Rehab
- Cheney Care Center
- EmpRes Healthcare
- Touchmark on South Hill
- ManorCare of Spokane
- Good Samaritan Society
- Franklin Hills Health & Rehabilitation Center
- Royal Park Health & Rehabilitation
- Regency at Northpointe
- Avalon Care Center at Northpointe
- Alderwood Manor
- Spokane Veteran's Home
- Sullivan Park Care Center
- Columbia Crest Center
- Spokane Valley Health & Rehabilitation
- Good Samaritan Society Mountain View Manor

Assisted Living Facilities

- Rose Point Assisted Living
- Cherrywood Place
- The Cottages of Spokane
- Maplewood Gardens Assisted Living
- Willow Grove
- Mallon Place
- Bethany Place
- Brookdale Nine Mile

The current relationships will be utilized, and new ones created as needed, to allow MultiCare to comprehensively meet the service demands for the project.

In addition to skilled nursing and other senior care facilities, MultiCare has and will expand its working relationships with community organizations to ensure its provision of culturally competent care. These include Spectrum Center, Pride Spokane, Shades of Motherhood, and Nuestras Raices.

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

Existing working relationships would not change as a result of this project.

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

This question is not applicable.

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

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

MultiCare has no history with the actions described above. Therefore, this question is not applicable.

19. Provide a discussion explaining how the proposed project will promote continuity in the provision of health care services in the planning area, and not result in an unwarranted fragmentation of services. WAC 246-310-230.

Without additional hospice services targeted to their specific needs, underserved populations within Spokane County will remain so. This would contribute to a fragmentation of healthcare services, where Spokane families would be forced to either out-migrate or manage and plan the care for their family members without assistance or coordination. Thus, the proposed project will not result in unwarranted fragmentation but rather prevent it.

MultiCare will promote continuity of care and help prevent fragmentation of services within Spokane County. Both Deaconess and Valley hospitals within Spokane County are part of MultiCare, and the proposed project will complement our provision of services across the care continuum.

20. Provide a discussion explaining how the proposed project will have an appropriate relationship to the service area's existing health care system as required in WAC 246-310-230.

There is significant unmet need for hospice services in Spokane County, especially for the underserved populations discussed above. The proposed project will help to address part of this need and provide needed capacity and delivery of services in the planning area to ensure all Spokane County residents have timely access to hospice care. MultiCare has existing relationships with planning area inpatient providers, nursing homes, assisted living facilities, and other providers of facility-based and in-home care.

MultiCare will promote continuity of care and help prevent fragmentation of services within Spokane County. In 2022, MultiCare hospitals accounted for 13,037 discharges to Spokane County residents.[7] This included 5,999 discharges to Spokane residents aged 65 and over. Of these discharges to Spokane residents, 241 were to a hospice organization.[8] However, another 346 died without being discharged to hospice. Relative to persons discharged to hospice agencies, these persons who died without being discharged to hospice were more likely to have a primary payer of Medicaid and more likely to identify as non-White.

Some portion of the 346 persons who died prior to discharge could have been likely candidates for hospice services, although these services were not received. For persons 65+, these include 14 patients who died with a primary diagnosis related to cancer, 39 who died with a primary diagnosis related to circulatory/heart issues, 27 who died with a primary diagnosis related to kidney disease, and 6 who died with a primary diagnosis related to stroke/cerebrovascular accident.

In addition to those persons who died without hospice services, many inpatients in Spokane who were discharged to hospice waited too long. Persons at MultiCare hospitals in Spokane who received a referral for hospice services waited about 13 days on average if they were enrolled on Apple Health or Medicaid. This wait was about six to eight days on average for patients with commercial or Medicare payers. Relative to their commercial and Medicare counterparts, Medicaid patients thus lost nearly a week of access to necessary hospice services.

These numbers are not explicitly allocated as sources of hospice admissions above but represent a potential area of need among patients, especially those among the identified underserved populations, who already receive care within MultiCare's inpatient facilities.

The proposed agency will complement, and add to, MultiCare's provision of services across the care continuum, including inpatient hospital services at its facilities in Puget Sound and Inland Northwest regions, and hospice services in Yakima, Thurston, Pierce, King, and Kitsap counties. Without hospice services targeted towards the underserved groups in Spokane, these residents will go without needed care. In addition to leading to poorer health outcomes, this would continue fragmentation of healthcare services, where families of these individuals would be forced to manage and plan the care for their family members without assistance or coordination.

21. The department will complete a quality of care analysis using publicly available information from CMS. If any facilities or agencies owned or operated by the applicant reflect a pattern of condition-level findings, provide applicable plans of correction identifying the facility's current compliance status.

No facilities owned or operated by the applicant reflect a pattern of condition-level findings.

22. If information provided in response to the question above shows a history of condition-level findings, provide clear, cogent and convincing evidence that the applicant can and will operate the proposed project in a manner that

[7] CHARS 2022.
[8] Ibid.

ensures safe and adequate care, and conforms to applicable federal and state requirements.

This question is not applicable.

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

Projects are evaluated based on the criteria in WAC 246-310-240 in order to identify the best available project for the planning area.

1. Identify all alternatives considered prior to submitting this project. At a minimum include a brief discussion of this project versus no project.

Prior to submitting this application, MultiCare considered doing nothing, or requesting approval to provide hospice services to Spokane County residents (The Project). MultiCare believes the need for additional hospice services exists in Spokane County, and is particularly acute for underserved populations, and so has applied for CN approval to establish an agency there.

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

Table 17: Promoting Access to Healthcare Services

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

Table 18: Promoting Quality of Care

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

Table 19: Cost Efficiency and Capital Impacts

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

Table 20: Legal Restrictions

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

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

   This question is not applicable.

4. **Identify any aspects of the project that will involve appropriate improvements or innovations in the financing and delivery of health services which foster cost containment and which promote quality assurance and cost effectiveness.**

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

V. Hospice Agency Superiority

In the event that two or more applications meet all applicable review criteria and there is not enough need projected for more than one approval, the department uses the criteria in WAC 246-310-290(11) to determine the superior proposal.

VI. Multiple Applications in One Year

In the event you are preparing more than one application for different planning areas under the same parent company – regardless of how the proposed agencies will be operated – the department will require additional financial information to assess conformance with WAC 246-310-220. The type of financial information required from the department will depend on how you propose to operate the proposed projects. Related to this, answer the following questions:

1. **Is the applicant (defined under WAC 246-310-010(6)) submitting any other hospice applications under either of this year's concurrent review cycles? This could include the same parent corporation or group of individuals submitting under separate LLCs under their common ownership.**

   If the answer to this question is no, there is no need to complete further questions under this section.

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

2. **If the answer to the previous question is yes, clarify:**
   - **Are these applications being submitted under separate companies owned by the same applicant(s); or**
   - **Are these applications being submitted under a single company/applicant?**
   - **Will they be operated under some other structure? Describe in detail.**

   This question is not applicable.

3. **Under the financial feasibility section, you should have provided a pro forma balance sheet showing the financial position of this project in the first three full calendar years of operation. Provide pro forma balance sheets for the applicant, assuming approval of this project showing the first three full calendar years of operation. In addition, provide a pro forma balance sheet for the applicant assuming approval of all proposed projects in this year's review cycles showing the first three full calendar years of operation.**

   This question is not applicable.

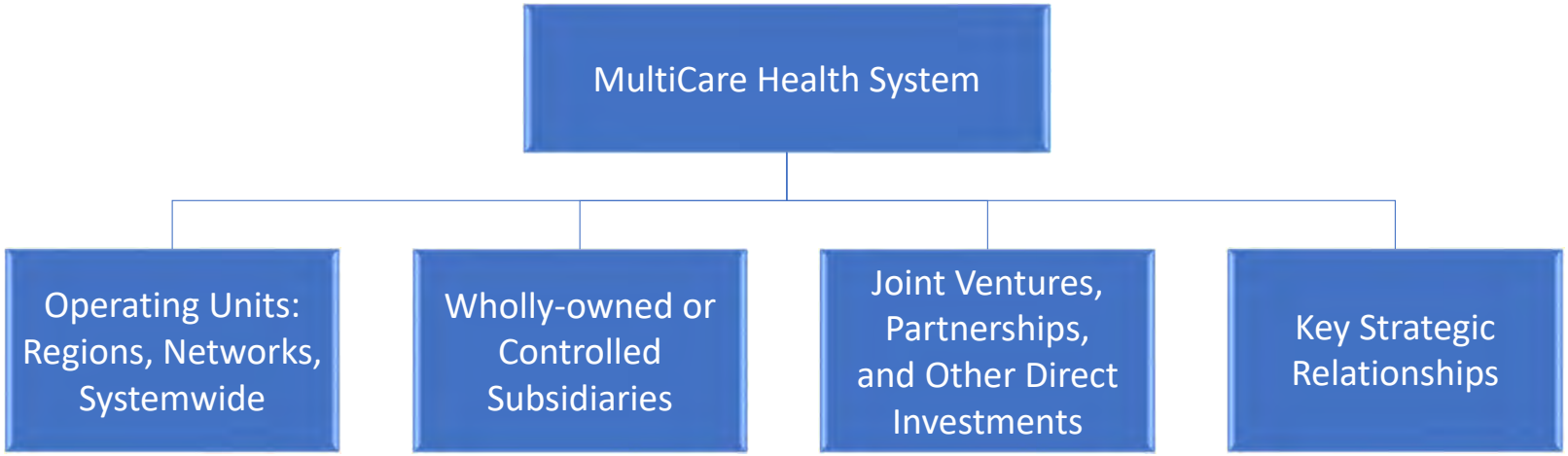
4. **In the event that the department can approve more than one county for the same applicant, further pro forma revenue and expense statements may be required.**

- **If your applications propose operating multiple counties under the same license, provide combined pro forma revenue and expense statements showing the first three full calendar years of operation assuming approval of all proposed counties.**
- **If your applications propose operating multiple counties under separate licenses, there is no need to provide further pro forma revenue and expense statements.**

  This question is not applicable.

Exhibit 1

Organizational Chart


MultiCare Health System
Operating Units: Regions, Networks, Systemwide
Wholly-owned or Controlled Subsidiaries
Joint Ventures, Partnerships, and Other Direct Investments
Key Strategic Relationships

3

Operating Units
Regions, Networks, Systemwide

Regions

South Puget Sound (East Pierce, West Pierce & Kitsap, South King, Capital Pacific Regions)

HOSPITALS

Auburn Medical Center

Covington Medical Center

Good Samaritan Hospital/Off Campus Emergency Depts (OCEDs)

Tacoma General/ Allenmore Hospitals/OCED

Capital Medical Center

CLINICS

Gig Harbor Multi-specialty Medical Center

Primary Care & Specialty Care

MultiCare Medical Associates

OTHER

New Adventures Daycare

Inland Northwest Region

Deaconess Hospital/North Deaconess OCED

Valley Hospital

Rockwood Clinic

Central Washington Region

Yakima Memorial Hospital

Primary Care & Specialty Care Clinics

Systemwide

MultiCare Institute for Research & Innovation (MIRI)
MultiCare Capital Partners

Networks

Retail Health

Indigo Urgent Care
Dispatch Health
Labs Northwest
Virtual Health
Occupational Health
Home Health & Hospice
Adult Day Health
System Pharmacy

Pulse Heart Institute*

Mary Bridge

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

Behavioral Health

Good Samaritan Behavioral Health
Navos*
Greater Lakes Mental Healthcare*

Population Health

MultiCare Connected Care, LLC*
Physicians of Southwest Washington, LLC*
PNW CIN, LLC* d/b/a Embright
NW Momentum Health Partners ACO, LLC*

* Operates through separate legal entity

Exhibit 2
Letter of Intent

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

November 29, 2023

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

RE: Letter of Intent to operate a certificate of need approved hospice agency in Spokane County, Washington

Dear Mr. Hernandez:

In accordance with WAC 246-310-080, MultiCare Health System ("MultiCare") submits this Letter of Intent ("LOI") to establish and operate a certificate of need approved hospice agency in Spokane County, Washington.

1. Description of Proposed Service:
   The establishment and operation of a certificate of need approved hospice agency in Spokane County, Washington

2. Estimated Cost of the Project:
   The estimated capital cost of the project is $66,315

3. Identification of the Service Area:
   The Service Area is Spokane County, Washington

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

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

Frank Fox, PhD
HealthTrends
206.914.8866
frankfox@comcast.net

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

Sincerely,

Erin Kobberstad

Erin Kobberstad, Vice President, Strategic Planning
MultiCare Health System

Exhibit 3

DOH 2023-2024 Hospice Need Methodology

Department of Health
2023-2024 Hospice Numeric Need Methodology
Distributed November 6, 2023

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

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

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

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

Hospice admissions ages 0-64	
Year	Admissions
2020	3,680
2021	3,883
2022	3,377
average:	**3,647**

Deaths ages 0-64	
Year	Deaths
2020	16,663
2021	18,015
2022	17,201
average:	**17,293**

Use Rates	
0-64	21.09%
65+	56.80%

Hospice admissions ages 65+	
Year	Admissions
2020	27,957
2021	27,885
2022	28,832
average:	**28,225**

Deaths ages 65+	
Year	Deaths
2020	46,367
2021	50,717
2022	52,002
average:	**49,695**

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Distributed November 6, 2023

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

0-64				
County	2020	2021	2022	2020-2022 Average Deaths
Adams	20	23	25	**23**
Asotin	56	43	45	**48**
Benton	555	536	566	**552**
Chelan	224	256	225	**235**
Clallam	195	185	179	**186**
Clark	1,043	1,078	1,002	**1,041**
Columbia	7	11	12	**10**
Cowlitz	314	401	311	**342**
Douglas	42	45	45	**44**
Ferry	19	21	22	**21**
Franklin	100	110	79	**96**
Garfield	5	4	2	**4**
Grant	186	208	190	**195**
Grays Harbor	209	236	223	**223**
Island	110	116	117	**114**
Jefferson	68	54	59	**60**
King	4,456	4,892	4,902	**4,750**
Kitsap	454	489	462	**468**
Kittitas	78	88	78	**81**
Klickitat	42	50	50	**47**
Lewis	205	186	191	**194**
Lincoln	15	24	24	**21**
Mason	143	168	152	**154**
Okanogan	88	92	106	**95**
Pacific	55	59	69	**61**
Pend Oreille	41	55	44	**47**
Pierce	2,364	2,574	2,518	**2,485**
San Juan	18	24	12	**18**
Skagit	269	334	258	**287**
Skamania	26	25	20	**24**
Snohomish	1,587	1,563	1,468	**1,539**
Spokane	1,634	1,842	1,603	**1,693**
Stevens	86	114	107	**102**
Thurston	628	763	709	**700**
Wahkiakum	10	7	9	**9**
Walla Walla	150	138	157	**148**
Whatcom	457	443	467	**456**
Whitman	51	59	65	**58**
Yakima	653	699	628	**660**

65+				
County	2020	2021	2022	2020-2022 Average Deaths
Adams	59	92	91	**81**
Asotin	186	188	227	**200**
Benton	1,522	1,610	1,739	**1,624**
Chelan	785	870	873	**843**
Clallam	777	906	935	**873**
Clark	3,205	3,705	3,709	**3,540**
Columbia	43	43	37	**41**
Cowlitz	968	1,100	989	**1,019**
Douglas	160	174	205	**180**
Ferry	58	63	60	**60**
Franklin	263	261	234	**253**
Garfield	11	24	24	**20**
Grant	455	523	533	**504**
Grays Harbor	558	590	683	**610**
Island	505	504	548	**519**
Jefferson	273	295	298	**289**
King	11,186	11,896	12,448	**11,843**
Kitsap	1,714	1,832	1,895	**1,814**
Kittitas	241	241	261	**248**
Klickitat	113	164	130	**136**
Lewis	653	723	753	**710**
Lincoln	75	76	67	**73**
Mason	408	461	414	**428**
Okanogan	277	324	341	**314**
Pacific	177	239	235	**217**
Pend Oreille	101	119	127	**116**
Pierce	5,608	6,264	6,412	**6,095**
San Juan	94	91	78	**88**
Skagit	1,068	1,190	1,215	**1,158**
Skamania	47	56	60	**54**
Snohomish	4,278	4,478	4,833	**4,530**
Spokane	4,322	4,810	4,603	**4,578**
Stevens	248	304	336	**296**
Thurston	2,007	2,285	2,419	**2,237**
Wahkiakum	18	25	24	**22**
Walla Walla	522	595	598	**572**
Whatcom	1,481	1,674	1,653	**1,603**
Whitman	226	278	233	**246**
Yakima	1,675	1,644	1,682	**1,667**

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
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Department of Health
2023-2024 Hospice Numeric Need Methodology
Distributed November 6, 2023

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

0-64		
County	2020-2022 Average Deaths	Projected Patients: 21.09% of Deaths
Adams	23	5
Asotin	48	10
Benton	552	116
Chelan	235	50
Clallam	186	39
Clark	1,041	220
Columbia	10	2
Cowlitz	342	72
Douglas	44	9
Ferry	21	4
Franklin	96	20
Garfield	4	1
Grant	195	41
Grays Harbor	223	47
Island	114	24
Jefferson	60	13
King	4,750	1,002
Kitsap	468	99
Kittitas	81	17
Klickitat	47	10
Lewis	194	41
Lincoln	21	4
Mason	154	33
Okanogan	95	20
Pacific	61	13
Pend Oreille	47	10
Pierce	2,485	524
San Juan	18	4
Skagit	287	61
Skamania	24	5
Snohomish	1,539	325
Spokane	1,693	357
Stevens	102	22
Thurston	700	148
Wahkiakum	9	2
Walla Walla	148	31
Whatcom	456	96
Whitman	58	12
Yakima	660	139

65+		
County	2020-2022 Average Deaths	Projected Patients: 56.80% of Deaths
Adams	81	46
Asotin	200	114
Benton	1,624	922
Chelan	843	479
Clallam	873	496
Clark	3,540	2,010
Columbia	41	23
Cowlitz	1,019	579
Douglas	180	102
Ferry	60	34
Franklin	253	144
Garfield	20	11
Grant	504	286
Grays Harbor	610	347
Island	519	295
Jefferson	289	164
King	11,843	6,726
Kitsap	1,814	1,030
Kittitas	248	141
Klickitat	136	77
Lewis	710	403
Lincoln	73	41
Mason	428	243
Okanogan	314	178
Pacific	217	123
Pend Oreille	116	66
Pierce	6,095	3,461
San Juan	88	50
Skagit	1,158	658
Skamania	54	31
Snohomish	4,530	2,573
Spokane	4,578	2,600
Stevens	296	168
Thurston	2,237	1,271
Wahkiakum	22	13
Walla Walla	572	325
Whatcom	1,603	910
Whitman	246	140
Yakima	1,667	947

Sources:
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2023-2024 Hospice Numeric Need Methodology
Distributed November 6, 2023

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

0-64								
County	Projected Patients	2020-2022 Average Population	2023 projected population	2024 projected population	2025 projected population	2023 potential volume	2024 potential volume	2025 potential volume
Adams	5	18,199	18,565	18,748	18,931	5	5	5
Asotin	10	16,706	16,475	16,360	16,244	10	10	10
Benton	116	175,851	178,935	180,477	182,019	119	120	121
Chelan	50	62,907	63,062	63,139	63,217	50	50	50
Clallam	39	52,247	52,552	52,704	52,857	40	40	40
Clark	220	424,857	433,316	437,545	441,774	224	226	228
Columbia	2	2,763	2,664	2,615	2,566	2	2	2
Cowlitz	72	87,937	88,116	88,206	88,295	72	72	72
Douglas	9	35,378	35,624	35,746	35,869	9	9	9
Ferry	4	5,127	4,967	4,886	4,806	4	4	4
Franklin	20	88,772	91,315	92,587	93,859	21	21	21
Garfield	1	1,570	1,569	1,569	1,569	1	1	1
Grant	41	85,596	86,774	87,363	87,952	42	42	42
Grays Harbor	47	58,092	57,484	57,179	56,875	46	46	46
Island	24	63,840	64,256	64,464	64,672	24	24	24
Jefferson	13	20,269	20,116	20,040	19,964	13	13	13
King	1002	1,974,586	1,993,774	2,003,368	2,012,962	1011	1016	1021
Kitsap	99	222,587	222,681	222,729	222,776	99	99	99
Kittitas	17	38,539	39,282	39,653	40,024	17	18	18
Klickitat	10	17,217	16,988	16,874	16,759	10	10	10
Lewis	41	63,811	64,225	64,432	64,639	41	41	41
Lincoln	4	7,804	7,785	7,775	7,765	4	4	4
Mason	33	49,998	50,395	50,594	50,793	33	33	33
Okanogan	20	31,910	31,564	31,392	31,219	20	20	20
Pacific	13	15,523	15,405	15,346	15,287	13	13	13
Pend Oreille	10	9,660	9,543	9,485	9,427	10	10	10
Pierce	524	790,591	797,852	801,483	805,114	529	531	534
San Juan	4	11,682	11,654	11,640	11,626	4	4	4
Skagit	61	100,574	101,422	101,846	102,270	61	61	62
Skamania	5	9,243	8,998	8,875	8,752	5	5	5
Snohomish	325	712,731	721,470	725,839	730,209	329	331	333
Spokane	357	447,909	450,821	452,277	453,733	359	360	362
Stevens	22	35,790	35,311	35,071	34,832	21	21	21
Thurston	148	242,356	246,365	248,369	250,374	150	151	152
Wahkiakum	2	2,943	2,917	2,903	2,890	2	2	2
Walla Walla	31	50,364	50,376	50,382	50,388	31	31	31
Whatcom	96	185,493	188,095	189,395	190,696	97	98	99
Whitman	12	42,489	42,517	42,531	42,545	12	12	12
Yakima	139	219,628	220,336	220,690	221,044	140	140	140

Sources:
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Department of Health
2023-2024 Hospice Numeric Need Methodology
Distributed November 6, 2023

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

65+								
County	Projected Patients	2020-2022 Average Population	2023 projected population	2024 projected population	2025 projected population	2023 potential volume	2024 potential volume	2025 potential volume
Adams	**46**	**2,605**	2,621	2,629	2,637	46	46	46
Asotin	**114**	**5,673**	6,094	6,305	6,515	122	126	131
Benton	**922**	**33,826**	36,349	37,611	38,872	991	1,025	1,060
Chelan	**479**	**16,903**	18,085	18,677	19,268	512	529	546
Clallam	**496**	**25,369**	25,986	26,295	26,603	508	514	520
Clark	**2,010**	**86,493**	94,113	97,923	101,733	2,187	2,276	2,365
Columbia	**23**	**1,170**	1,229	1,259	1,289	24	25	26
Cowlitz	**579**	**23,471**	24,649	25,237	25,826	608	622	637
Douglas	**102**	**8,039**	8,752	9,109	9,465	111	116	120
Ferry	**34**	**2,058**	2,235	2,323	2,411	37	39	40
Franklin	**144**	**9,795**	10,887	11,433	11,979	160	167	175
Garfield	**11**	**711**	700	695	690	11	11	11
Grant	**286**	**14,729**	15,957	16,571	17,185	310	322	334
Grays Harbor	**347**	**17,700**	18,621	19,082	19,542	365	374	383
Island	**295**	**23,676**	24,579	25,030	25,482	306	312	317
Jefferson	**164**	**13,029**	13,824	14,221	14,618	174	179	184
King	**6,726**	**316,701**	340,737	352,755	364,773	7,237	7,492	7,747
Kitsap	**1,030**	**55,150**	59,307	61,385	63,464	1,108	1,147	1,185
Kittitas	**141**	**8,482**	8,846	9,028	9,210	147	150	153
Klickitat	**77**	**5,695**	6,280	6,572	6,864	85	89	93
Lewis	**403**	**18,899**	19,608	19,962	20,316	418	426	433
Lincoln	**41**	**3,116**	3,223	3,276	3,330	43	43	44
Mason	**243**	**16,436**	17,453	17,962	18,471	258	265	273
Okanogan	**178**	**10,353**	11,017	11,348	11,680	190	195	201
Pacific	**123**	**7,971**	8,347	8,534	8,722	129	132	135
Pend Oreille	**66**	**3,845**	4,170	4,332	4,494	71	74	77
Pierce	**3,461**	**139,235**	150,840	156,642	162,444	3,750	3,894	4,038
San Juan	**50**	**6,326**	6,796	7,030	7,265	53	55	57
Skagit	**658**	**30,250**	32,005	32,882	33,759	696	715	734
Skamania	**31**	**2,455**	2,891	3,108	3,326	36	39	42
Snohomish	**2,573**	**125,852**	138,363	144,618	150,874	2,828	2,956	3,084
Spokane	**2,600**	**96,172**	102,744	106,030	109,316	2,778	2,867	2,956
Stevens	**168**	**11,029**	12,255	12,868	13,481	187	196	205
Thurston	**1,271**	**56,276**	59,944	61,778	63,612	1,353	1,395	1,436
Wahkiakum	**13**	**1,512**	1,604	1,651	1,697	13	14	14
Walla Walla	**325**	**12,446**	12,886	13,106	13,326	336	342	348
Whatcom	**910**	**44,049**	46,838	48,232	49,627	968	997	1,026
Whitman	**140**	**5,619**	5,860	5,980	6,101	146	149	151
Yakima	**947**	**38,467**	40,491	41,504	42,516	997	1,022	1,046

Sources:
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WAC246-310-290(8)(e) Step 5:
Combine the two age cohorts. Subtract the average of the most recent three years hospice capacity in each planning area from the projected volumes calculated in Step 4 to determine the number of projected admissions beyond the planning area capacity.

County	2023 potential volume	2024 potential volume	2025 potential volume	Current Supply of Hospice Providers	2023 Unmet Need Admissions*	2024 Unmet Need Admissions*	2025 Unmet Need Admissions*
Adams	51	51	51	**44.00**	7	7	7
Asotin	132	136	141	**100.33**	32	36	40
Benton	1,109	1,145	1,180	**1,057.33**	52	88	123
Chelan	562	579	595	**769.67**	(208)	(191)	(174)
Clallam	547	553	559	**429.67**	118	124	130
Clark	2,411	2,502	2,593	**2,909.67**	(498)	(408)	(317)
Columbia	27	27	28	**36.33**	(10)	(9)	(9)
Cowlitz	680	695	709	**813.33**	(133)	(119)	(104)
Douglas	120	125	130	**566.00**	(446)	(441)	(436)
Ferry	41	43	44	**36.00**	5	7	8
Franklin	180	189	197	**191.33**	(11)	(3)	6
Garfield	12	12	12	**9.33**	2	2	2
Grant	352	364	376	**270.33**	81	93	106
Grays Harbor	411	420	429	**352.00**	59	68	77
Island	330	336	342	**469.00**	(139)	(133)	(127)
Jefferson	187	192	196	**132.67**	54	59	64
King	8,248	8,508	8,769	**8,624.67**	(376)	(116)	144
Kitsap	1,207	1,245	1,284	**1,141.00**	66	104	143
Kittitas	164	167	171	**151.67**	13	16	19
Klickitat	95	99	103	**99.00**	(4)	(0)	4
Lewis	459	467	475	**453.67**	6	13	21
Lincoln	47	48	49	**21.00**	26	27	28
Mason	291	298	306	**524.67**	(234)	(226)	(219)
Okanogan	210	215	221	**183.00**	27	32	38
Pacific	142	145	148	**65.33**	76	79	82
Pend Oreille	81	84	86	**65.33**	16	18	21
Pierce	4,279	4,426	4,572	**4,244.33**	35	181	328
San Juan	57	59	61	**99.00**	(42)	(40)	(38)
Skagit	757	776	795	**791.33**	(35)	(15)	4
Skamania	41	44	47	**41.67**	(0)	2	5
Snohomish	3,157	3,287	3,417	**4,217.00**	(1,060)	(930)	(800)
Spokane	3,137	3,227	3,317	**3,195.67**	(58)	32	122
Stevens	208	217	226	**148.33**	60	69	78
Thurston	1,503	1,546	1,589	**1,766.33**	(263)	(220)	(178)
Wahkiakum	15	16	16	**14.33**	1	1	2
Walla Walla	367	373	379	**280.33**	87	93	99
Whatcom	1,065	1,095	1,124	**1,718.33**	(653)	(624)	(594)
Whitman	158	161	164	**112.67**	45	48	51
Yakima	1,136	1,161	1,187	**1,087.67**	49	74	99

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

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WAC246-310-290(8)(f) Step 6:
Multiply the unmet need from Step 5 by the statewide average length of stay as determined by CMS to determine unmet need patient days in the projection years.

				Step 6 (Admits * ALOS) = Unmet Patient Days			
County	**2023 Unmet Need Admissions***	**2024 Unmet Need Admissions***	**2025 Unmet Need Admissions***	**Statewide ALOS**	**2023 Unmet Need Patient Days***	**2024 Unmet Need Patient Days***	**2025 Unmet Need Patient Days***
Adams	7	7	7	**61.11**	426	437	449
Asotin	32	36	40	**61.11**	1,947	2,201	2,455
Benton	52	88	123	**61.11**	3,186	5,350	7,514
Chelan	(208)	(191)	(174)	**61.11**	(12,705)	(11,678)	(10,652)
Clallam	118	124	130	**61.11**	7,183	7,558	7,934
Clark	(498)	(408)	(317)	**61.11**	(30,451)	(24,906)	(19,360)
Columbia	(10)	(9)	(9)	**61.11**	(601)	(567)	(533)
Cowlitz	(133)	(119)	(104)	**61.11**	(8,145)	(7,254)	(6,362)
Douglas	(446)	(441)	(436)	**61.11**	(27,229)	(26,950)	(26,672)
Ferry	5	7	8	**61.11**	331	417	502
Franklin	(11)	(3)	6	**61.11**	(668)	(162)	345
Garfield	2	2	2	**61.11**	149	144	139
Grant	81	93	106	**61.11**	4,961	5,707	6,453
Grays Harbor	59	68	77	**61.11**	3,614	4,150	4,686
Island	(139)	(133)	(127)	**61.11**	(8,477)	(8,129)	(7,781)
Jefferson	54	59	64	**61.11**	3,294	3,597	3,899
King	(376)	(116)	144	**61.11**	(22,996)	(7,100)	8,796
Kitsap	66	104	143	**61.11**	4,004	6,378	8,752
Kittitas	13	16	19	**61.11**	765	959	1,154
Klickitat	(4)	(0)	4	**61.11**	(256)	(19)	219
Lewis	6	13	21	**61.11**	347	817	1,286
Lincoln	26	27	28	**61.11**	1,595	1,639	1,682
Mason	(234)	(226)	(219)	**61.11**	(14,296)	(13,828)	(13,361)
Okanogan	27	32	38	**61.11**	1,629	1,971	2,313
Pacific	76	79	82	**61.11**	4,674	4,848	5,023
Pend Oreille	16	18	21	**61.11**	955	1,121	1,286
Pierce	35	181	328	**61.11**	2,112	11,074	20,036
San Juan	(42)	(40)	(38)	**61.11**	(2,550)	(2,437)	(2,325)
Skagit	(35)	(15)	4	**61.11**	(2,119)	(938)	243
Skamania	(0)	2	5	**61.11**	(29)	134	297
Snohomish	(1,060)	(930)	(800)	**61.11**	(64,778)	(56,842)	(48,905)
Spokane	(58)	32	122	**61.11**	(3,566)	1,934	7,435
Stevens	60	69	78	**61.11**	3,652	4,214	4,777
Thurston	(263)	(220)	(178)	**61.11**	(16,069)	(13,464)	(10,859)
Wahkiakum	1	1	2	**61.11**	57	81	104
Walla Walla	87	93	99	**61.11**	5,323	5,674	6,025
Whatcom	(653)	(624)	(594)	**61.11**	(39,906)	(38,104)	(36,302)
Whitman	45	48	51	**61.11**	2,759	2,943	3,126
Yakima	49	74	99	**61.11**	2,968	4,505	6,041

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

Sources:
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WAC246-310-290(8)(g) Step 7:
Divide the unmet patient days from Step 6 by 365 to determine the unmet need ADC.

				Step 7 (Patient Days / 365) = Unmet ADC		
County	**2023 Unmet Need Patient Days***	**2024 Unmet Need Patient Days***	**2025 Unmet Need Patient Days***	**2023 Unmet Need ADC***	**2024 Unmet Need ADC*†**	**2025 Unmet Need ADC***
Adams	426	437	449	1	1	1
Asotin	1,947	2,201	2,455	5	6	7
Benton	3,186	5,350	7,514	9	15	21
Chelan	(12,705)	(11,678)	(10,652)	(35)	(32)	(29)
Clallam	7,183	7,558	7,934	20	21	22
Clark	(30,451)	(24,906)	(19,360)	(83)	(68)	(53)
Columbia	(601)	(567)	(533)	(2)	(2)	(1)
Cowlitz	(8,145)	(7,254)	(6,362)	(22)	(20)	(17)
Douglas	(27,229)	(26,950)	(26,672)	(75)	(74)	(73)
Ferry	331	417	502	1	1	1
Franklin	(668)	(162)	345	(2)	(0)	1
Garfield	149	144	139	0	0	0
Grant	4,961	5,707	6,453	14	16	18
Grays Harbor	3,614	4,150	4,686	10	11	13
Island	(8,477)	(8,129)	(7,781)	(23)	(22)	(21)
Jefferson	3,294	3,597	3,899	9	10	11
King	(22,996)	(7,100)	8,796	(63)	(19)	24
Kitsap	4,004	6,378	8,752	11	17	24
Kittitas	765	959	1,154	2	3	3
Klickitat	(256)	(19)	219	(1)	(0)	1
Lewis	347	817	1,286	1	2	4
Lincoln	1,595	1,639	1,682	4	4	5
Mason	(14,296)	(13,828)	(13,361)	(39)	(38)	(37)
Okanogan	1,629	1,971	2,313	4	5	6
Pacific	4,674	4,848	5,023	13	13	14
Pend Oreille	955	1,121	1,286	3	3	4
Pierce	2,112	11,074	20,036	6	30	55
San Juan	(2,550)	(2,437)	(2,325)	(7)	(7)	(6)
Skagit	(2,119)	(938)	243	(6)	(3)	1
Skamania	(29)	134	297	(0)	0	1
Snohomish	(64,778)	(56,842)	(48,905)	(177)	(155)	(134)
Spokane	(3,566)	1,934	7,435	(10)	5	20
Stevens	3,652	4,214	4,777	10	12	13
Thurston	(16,069)	(13,464)	(10,859)	(44)	(37)	(30)
Wahkiakum	57	81	104	0	0	0
Walla Walla	5,323	5,674	6,025	15	16	17
Whatcom	(39,906)	(38,104)	(36,302)	(109)	(104)	(99)
Whitman	2,759	2,943	3,126	8	8	9
Yakima	2,968	4,505	6,041	8	12	17

*a negative number indicates existing hospice service capacity exceeds the projected utilization based on the statewide use rate.
†unmet need for 2024 is calculated by dividing by 366 days due to it being a leap year.

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2023-2024 Hospice Numeric Need Methodology
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WAC246-310-290(8)(h) Step 8:
Determine the number of hospice agencies in the planning area that could support the unmet need with an ADC of thirty-five.

Application Year

Step 7 (Patient Days / 365) = Unmet ADC				Step 8 - Numeric Need	
County	**2023 Unmet Need ADC***	**2024 Unmet Need ADC*†**	**2025 Unmet Need ADC***	**Numeric Need?**	**Number of New Agencies Needed?****
Adams	1	1	1	FALSE	FALSE
Asotin	5	6	7	FALSE	FALSE
Benton	9	15	21	FALSE	FALSE
Chelan	(35)	(32)	(29)	FALSE	FALSE
Clallam	20	21	22	FALSE	FALSE
Clark	(83)	(68)	(53)	FALSE	FALSE
Columbia	(2)	(2)	(1)	FALSE	FALSE
Cowlitz	(22)	(20)	(17)	FALSE	FALSE
Douglas	(75)	(74)	(73)	FALSE	FALSE
Ferry	1	1	1	FALSE	FALSE
Franklin	(2)	(0)	1	FALSE	FALSE
Garfield	0	0	0	FALSE	FALSE
Grant	14	16	18	FALSE	FALSE
Grays Harbor	10	11	13	FALSE	FALSE
Island	(23)	(22)	(21)	FALSE	FALSE
Jefferson	9	10	11	FALSE	FALSE
King	(63)	(19)	24	FALSE	FALSE
Kitsap	11	17	24	FALSE	FALSE
Kittitas	2	3	3	FALSE	FALSE
Klickitat	(1)	(0)	1	FALSE	FALSE
Lewis	1	2	4	FALSE	FALSE
Lincoln	4	4	5	FALSE	FALSE
Mason	(39)	(38)	(37)	FALSE	FALSE
Okanogan	4	5	6	FALSE	FALSE
Pacific	13	13	14	FALSE	FALSE
Pend Oreille	3	3	4	FALSE	FALSE
Pierce	6	30	55	***TRUE***	***1***
San Juan	(7)	(7)	(6)	FALSE	FALSE
Skagit	(6)	(3)	1	FALSE	FALSE
Skamania	(0)	0	1	FALSE	FALSE
Snohomish	(177)	(155)	(134)	FALSE	FALSE
Spokane	(10)	5	20	FALSE	FALSE
Stevens	10	12	13	FALSE	FALSE
Thurston	(44)	(37)	(30)	FALSE	FALSE
Wahkiakum	0	0	0	FALSE	FALSE
Walla Walla	15	16	17	FALSE	FALSE
Whatcom	(109)	(104)	(99)	FALSE	FALSE
Whitman	8	8	9	FALSE	FALSE
Yakima	8	12	17	FALSE	FALSE

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

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

†unmet need for 2024 is calculated by dividing by 366 days due to it being a leap year.

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
290(7)(b) Agencies

Release Year	2023
Supply year 1	2020
Supply year 3	2022
Statewide ALOS	61.11
Default Admits = 35 ADC	209.0

			Supply Years									
			2020			2021			2022			
Provider	**County**	**Certificate Year**	**Survey**	**CN Yet?**	**# Used**	**Survey**	**CN Yet?**	**# Used**	**Survey**	**CN Yet?**	**# Used**	**Notes**
Stride Health Care	Chelan	2022	none	no CN yet	0.0	none	no CN yet	0.0	none	209.0	209.0	Third year 2024
Olympic Medical Center	Clallam	2019	none	209.0	209.0	none	209.0	209.0				Third year 2021
Providence Health & Services	Clark	2019	none	209.0	209.0	18	209.0	209.0				Third year 2021
Stride Health Care	Douglas	2023	none	no CN yet	0.0	none	no CN yet	0.0	none	209.0	209.0	Third year 2025 adjustment in 2022 as proxy
The Pennant Group (Puget Sound Hospice)	Grays Harbor	2021	none	no CN yet	0.0	6	209.0	209.0	31	209.0	209.0	Third year 2023
Envision Hospice	King	2019	77	209.0	209.0	74	209.0	209.0				Third year 2021
Continuum Care of King	King	2020	none	209.0	209.0	none	209.0	209.0	none	209.0	209.0	Third year 2022
EmpRes Healthcare Group	King	2021	none	no CN yet	0.0	none	209.0	209.0	none	209.0	209.0	Third year 2023
Seasons	King	2021	none	no CN yet	0.0	none	209.0	209.0	none	209.0	209.0	Third year 2023
The Pennant Group	King	2022	none	no CN yet	0.0	none	no CN yet	0.0	none	209.0	209.0	Third year 2024
Y.B.G. Healthcare	King	2022	none	no CN yet	0.0	none	no CN yet	0.0	none	209.0	209.0	Third year 2024
Envision Hospice	Kitsap	2020	none	209.0	209.0	61	209.0	209.0	120	209.0	209.0	Third year 2022
The Pennant Group (Puget Sound Hospice)	Mason	2021	none	no CN yet	0.0	none	209.0	209.0	100	209.0	209.0	Third year 2023
Providence Health & Services	Pierce	2021	none	no CN yet	0.0	2	209.0	209.0	98	209.0	209.0	Third year 2023
Envision Hospice	Pierce	2021	21	no CN yet	21.0	121	209.0	209.0	85	209.0	209.0	Third year 2023
Continuum Care of Snohomish	Pierce	2022	none	no CN yet	0.0	none	no CN yet	0.0	none	209.0	209.0	Third year 2024
The Pennant Group	Pierce	2022	none	no CN yet	0.0	none	no CN yet	0.0	none	209.0	209.0	Third year 2024
Seasons	Pierce	2022	none	no CN yet	0.0	none	no CN yet	0.0	none	209.0	209.0	Third year 2024
Wesley Homes Hospice	Pierce	2023	17	no CN yet	17.0	50	no CN yet	50.0	41	209.0	209.0	Third year 2025 adjustment in 2022 as proxy
Continuum Care of Snohomish	Snohomish	2019	143	209.0	209.0	342	209.0	342.0				Third year 2021
Envision Hospice	Snohomish	2019	none	209.0	209.0	1	209.0	209.0				Third year 2021
Glacier Peak Healthcare (Alpha)	Snohomish	2019	31	209.0	209.0	117	209.0	209.0				Third year 2021
Heart of Hospice	Snohomish	2019	none	209.0	209.0	none	209.0	209.0				Third year 2021
EmpRes Healthcare Group	Snohomish	2021	none	no CN yet	0.0	none	209.0	209.0	none	209.0	209.0	Third year 2023
Seasons	Snohomish	2021	none	no CN yet	0.0	none	209.0	209.0	none	209.0	209.0	Third year 2023
Providence Health & Services	Spokane	2023	none	no CN yet	0.0	none	no CN yet	0.0	none	209.0	209.0	Third year 2025 adjustment in 2022 as proxy
Envision Hospice	Thurston	2018	25	209.0	209.0							Third year 2020
Symbol Healthcare (Puget Sound Hospice)	Thurston	2019	6	209.0	209.0	19	209.0	209.0				Third year 2021
MultiCare Health	Thurston	2021	none	no CN yet	0.0	none	209.0	209.0	none	209.0	209.0	Third year 2023
Bristol Hospice	Thurston	2021	none	no CN yet	0.0	none	209.0	209.0	none	209.0	209.0	Third year 2023
EmpRes Healthcare Group	Whatcom	2020	none	209.0	209.0	26	209.0	209.0	65	209.0	209.0	Third year 2022

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Hospice Capacity Admission Calculations

0-64 Total Admissions by County				65+ Total Admissions by County				Actual Survey Admits Not Adjusted For Newly Approved All Agencies				Actual Survey Admits Only Under Default 290(7)(b) Newly Approved Only				Count of Newly Approved Agencies Only Under Default 290(7)(b) Newly Approved Only				Default Adjustments Only Under Default 290(7)(b) Newly Approved Only				Adjusted Admits Includes Adjustment for 290(7)(b) Agencies All Agencies				
	Sum of 0-64				Sum of 65+																							
County	2020	2021	2022	County	2020	2021	2022	County	2020	2021	2022	County	2020	2021	2022	2020	2021	2022	County	2020	2021	2022	County	2020	2021	2022	Average
Adams	4	4	4	Adams	48	36	36	Adams	52	40	40	Adams							Adams	-	-	-	Adams	52.00	40.00	40.00	**44.00**
Asotin	24	9	6	Asotin	84	92	86	Asotin	108	101	92	Asotin							Asotin	-	-	-	Asotin	108.00	101.00	92.00	**100.33**
Benton	132	107	137	Benton	973	830	993	Benton	1105	937	1130	Benton							Benton	-	-	-	Benton	1,105.00	937.00	1,130.00	**1057.33**
Chelan	32	53	0	Chelan	421	686	490	Chelan	453	739	490	Chelan	0	0	0	1	1	1	Chelan	209.0	209.0	209.0	Chelan	662.00	948.00	699.00	**769.67**
Clallam	24	24	18	Clallam	283	271	251	Clallam	307	295	269	Clallam	0	0	0	1	1	-	Clallam	209.0	209.0	-	Clallam	516.00	504.00	269.00	**429.67**
Clark	297	308	313	Clark	2238	2464	2709	Clark	2535	2772	3022	Clark	0	18	0	1	1	-	Clark	209.0	209.0	-	Clark	2,744.00	2,963.00	3,022.00	**2909.67**
Columbia	3	3	4	Columbia	50	31	18	Columbia	53	34	22	Columbia							Columbia	-	-	-	Columbia	53.00	34.00	22.00	**36.33**
Cowlitz	94	116	75	Cowlitz	707	793	655	Cowlitz	801	909	730	Cowlitz							Cowlitz	-	-	-	Cowlitz	801.00	909.00	730.00	**813.33**
Douglas	17	23	1	Douglas	170	227	633	Douglas	187	250	634	Douglas	0	0	0	1	1	1	Douglas	209.0	209.0	209.0	Douglas	396.00	459.00	843.00	**566.00**
Ferry	3	6	4	Ferry	28	32	35	Ferry	31	38	39	Ferry							Ferry	-	-	-	Ferry	31.00	38.00	39.00	**36.00**
Franklin	34	17	38	Franklin	194	134	157	Franklin	228	151	195	Franklin							Franklin	-	-	-	Franklin	228.00	151.00	195.00	**191.33**
Garfield	3	0	1	Garfield	7	6	11	Garfield	10	6	12	Garfield							Garfield	-	-	-	Garfield	10.00	6.00	12.00	**9.33**
Grant	40	27	30	Grant	254	230	230	Grant	294	257	260	Grant							Grant	-	-	-	Grant	294.00	257.00	260.00	**270.33**
Grays Harbor	27	2	40	Grays Harbor	186	8	203	Grays Harbor	213	10	243	Grays Harbor	0	6	31	1	1	1	Grays Harbor	209.0	209.0	209.0	Grays Harbor	422.00	213.00	421.00	**352.00**
Island	54	68	41	Island	375	450	419	Island	429	518	460	Island							Island	-	-	-	Island	429.00	518.00	460.00	**469.00**
Jefferson	17	15	0	Jefferson	194	171	1	Jefferson	211	186	1	Jefferson							Jefferson	-	-	-	Jefferson	211.00	186.00	1.00	**132.67**
King	889	812	796	King	7131	6592	6252	King	8020	7404	7048	King	77	74	0	6	6	5	King	1,254.0	1,254.0	1,045.0	King	9,197.00	8,584.00	8,093.00	**8624.67**
Kitsap	96	389	57	Kitsap	921	704	690	Kitsap	1017	1093	747	Kitsap	0	61	0	1	1	1	Kitsap	209.0	209.0	209.0	Kitsap	1,226.00	1,241.00	956.00	**1141.00**
Kittitas	12	15	8	Kittitas	157	115	148	Kittitas	169	130	156	Kittitas							Kittitas	-	-	-	Kittitas	169.00	130.00	156.00	**151.67**
Klickitat	12	13	13	Klickitat	87	82	90	Klickitat	99	95	103	Klickitat							Klickitat	-	-	-	Klickitat	99.00	95.00	103.00	**99.00**
Lewis	47	38	52	Lewis	401	421	402	Lewis	448	459	454	Lewis							Lewis	-	-	-	Lewis	448.00	459.00	454.00	**453.67**
Lincoln	6	5	1	Lincoln	22	12	17	Lincoln	28	17	18	Lincoln							Lincoln	-	-	-	Lincoln	28.00	17.00	18.00	**21.00**
Mason	43	37	28	Mason	263	347	329	Mason	306	384	357	Mason	0	0	100	1	1	1	Mason	209.0	209.0	209.0	Mason	515.00	593.00	466.00	**524.67**
Okanogan	31	19	20	Okanogan	167	183	129	Okanogan	198	202	149	Okanogan							Okanogan	-	-	-	Okanogan	198.00	202.00	149.00	**183.00**
Pacific	12	2	12	Pacific	69	2	99	Pacific	81	4	111	Pacific							Pacific	-	-	-	Pacific	81.00	4.00	111.00	**65.33**
Pend Oreille	17	12	8	Pend Oreille	49	55	55	Pend Oreille	66	67	63	Pend Oreille							Pend Oreille	-	-	-	Pend Oreille	66.00	67.00	63.00	**65.33**
Pierce	425	322	325	Pierce	2714	2310	3127	Pierce	3139	2632	3452	Pierce	38	173	41	6	6	6	Pierce	1,254.0	1,254.0	1,254.0	Pierce	4,355.00	3,713.00	4,665.00	**4244.33**
San Juan	8	5	9	San Juan	89	95	91	San Juan	97	100	100	San Juan							San Juan	-	-	-	San Juan	97.00	100.00	100.00	**99.00**
Skagit	70	85	67	Skagit	607	750	795	Skagit	677	835	862	Skagit							Skagit	-	-	-	Skagit	677.00	835.00	862.00	**791.33**
Skamania	3	4	1	Skamania	37	38	42	Skamania	40	42	43	Skamania							Skamania	-	-	-	Skamania	40.00	42.00	43.00	**41.67**
Snohomish	361	514	341	Snohomish	2636	3580	2794	Snohomish	2997	4094	3135	Snohomish	174	118	0	6	5	2	Snohomish	1,254.0	1,045.0	418.0	Snohomish	4,077.00	5,021.00	3,553.00	**4217.00**
Spokane	362	368	388	Spokane	2648	2690	2504	Spokane	3010	3058	2892	Spokane	0	0	0	1	1	1	Spokane	209.0	209.0	209.0	Spokane	3,219.00	3,267.00	3,101.00	**3195.67**
Stevens	21	31	16	Stevens	128	111	138	Stevens	149	142	154	Stevens							Stevens	-	-	-	Stevens	149.00	142.00	154.00	**148.33**
Thurston	129	107	102	Thurston	1070	923	1137	Thurston	1199	1030	1239	Thurston	31	19	0	4	3	2	Thurston	836.0	627.0	418.0	Thurston	2,004.00	1,638.00	1,657.00	**1766.33**
Wahkiakum	3	3	1	Wahkiakum	11	17	8	Wahkiakum	14	20	9	Wahkiakum							Wahkiakum	-	-	-	Wahkiakum	14.00	20.00	9.00	**14.33**
Walla Walla	41	31	28	Walla Walla	242	243	256	Walla Walla	283	274	284	Walla Walla							Walla Walla	-	-	-	Walla Walla	283.00	274.00	284.00	**280.33**
Whatcom	80	113	276	Whatcom	978	1054	2118	Whatcom	1058	1167	2394	Whatcom	0	26	65	1	1	1	Whatcom	209.0	209.0	209.0	Whatcom	1,267.00	1,350.00	2,538.00	**1718.33**
Whitman	12	15	0	Whitman	128	175	8	Whitman	140	190	8	Whitman							Whitman	-	-	-	Whitman	140.00	190.00	8.00	**112.67**
Yakima	195	161	116	Yakima	1190	925	676	Yakima	1385	1086	792	Yakima							Yakima	-	-	-	Yakima	1,385.00	1,086.00	792.00	**1087.67**

35 ADC * 365 days per year = 12,775 default patient days
12,775 patient days/61.11 ALOS = 209.0 default admissions
209.0 Default
For affected counties, the actual volumes from these recently approved agnecies will be subtracted, and default values will be added.

blue = proxy for new agencies issued a CN in 2022, since no 2022 for historical

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Survey Data

Agency Name	License Number	County	Year	0-64	65+
Washington HomeCare and Hospice of Central Basin, LLC	IHS.FS.60092413	Adams	2022	4	36
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Adams	2020	4	48
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Adams	2021	4	36
Alpowa Healthcare Inc dba Elite Home Health and Hospice	IHS.FS.60384078	Asotin	2022	6	86
Alpowa Healthcare, Inc. d/b/a Elite Home Health & Hospice	IHS.FS.60384078	Asotin	2020	24	84
Alpowa Healthcare, Inc. d/b/a Elite Home Health & Hospice	IHS.FS.60384078	Asotin	2021	9	92
Chaplaincy Health Care	IHS.FS.00000456	Benton	2020	118	821
Heartlinks	IHS.FS.00000369	Benton	2020	14	152
Heartlinks	IHS.FS.00000369	Benton	2021	17	205
Heartlinks	IHS.FS.00000369	Benton	2022	14	198
Tri Cities Chaplaincy	IHS.FS.00000456	Benton	2021	90	625
Tri Cities Chaplaincy	IHS.FS.00000456	Benton	2022	123	795
Central Washington Home Care Service	IHS.FS.00000250	Chelan	2020	32	421
Central Washington Home Care Services	IHS.FS.00000250	Chelan	2021	53	686
Central Washington Home Care Services	IHS.FS.00000250	Chelan	2022	0	490
Enhabit Hospice	IHS.FS.61165576	Chelan	2021	0	0
Northwest Healthcare Alliance, Inc	IHS.FS.00000229	Clallam	2022	18	251
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Clallam	2020	24	283
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Clallam	2021	24	271
Olympic Medical Hospice	IHS.FS.00000393	Clallam	2020	0	0
Olympic Medical Hospice	IHS.FS.00000393	Clallam	2021	0	0
Community Health & Hospice	IHS.FS.60547198	Clark	2022	46	329
Community Home Health & Hospice	IHS.FS.00000262	Clark	2022	46	329
Community Home Health/Hospice	IHS.FS.60547198	Clark	2020	61	430
Community Home Health/Hospice	IHS.FS.60547198	Clark	2021	57	425
HEART OF HOSPICE	IHS.FS.60741443	Clark	2020	0	3
HEART OF HOSPICE	IHS.FS.60741443	Clark	2021	0	0
Kaiser Permanente	IHS.FS.00000353	Clark	2021	37	408
Kaiser Permanente Continuing Care Services	IHS.FS.00000353	Clark	2020	42	433
Kaiser Permanente Continuing Care Services	IHS.FS.00000353	Clark	2022	27	271
PeaceHealth Hospice Southwest	IHS.FS.60331226	Clark	2020	194	1372
PeaceHealth Hospice Southwest	IHS.FS.60331226	Clark	2022	167	1524
PeaceHealth Southwest Hospice	IHS.FS.60331226	Clark	2021	213	1614
Providence Hospice	IHS.FS.60201476	Clark	2020	0	0
Providence Hospice	IHS.FS.60201476	Clark	2021	1	17
Providence Hospice	IHS.FS.60201476	Clark	2022	27	256
Walla Walla Community Hospice	IHS.FS.60480441	Columbia	2020	3	50
Walla Walla Community Hospice	IHS.FS.60480441	Columbia	2021	3	31
Walla Walla Community Hospice	IHS.FS.60480441	Columbia	2022	4	18
Community Home Health & Hospice	IHS.FS.00000262	Cowlitz	2022	42	411
Community Home Health/Hospice	IHS.FS.00000262	Cowlitz	2020	78	616
Community Home Health/Hospice	IHS.FS.00000262	Cowlitz	2021	73	558
Kaiser Permanente	IHS.FS.00000353	Cowlitz	2021	4	7
Kaiser Permanente Continuing Care Services	IHS.FS.00000353	Cowlitz	2022	2	17
PeaceHealth Hospice Southwest	IHS.FS.60331226	Cowlitz	2020	16	91
PeaceHealth Hospice Southwest	IHS.FS.60331226	Cowlitz	2022	31	227
PeaceHealth Southwest Hospice	IHS.FS.60331226	Cowlitz	2021	39	228
Central Washington Home Care Service	IHS.FS.00000250	Douglas	2020	13	159
Central Washington Home Care Services	IHS.FS.00000250	Douglas	2021	19	209
Central Washington Home Care Services	IHS.FS.00000250	Douglas	2022	0	630
Enhabit Hospice	IHS.FS.61165576	Douglas	2021	4	18
Enhabit Hospice	IHS.FS.61165576	Douglas	2022	1	3
Frontier Home Health & Hospice	IHS.FS.60379608	Douglas	2020	4	11
Enhabit Hospice	IHS.FS.61165576	Ferry	2021	0	0
Hospice of Spokane	IHS.FS.00000337	Ferry	2020	3	28
Hospice of Spokane	IHS.FS.00000337	Ferry	2021	6	32
Hospice of Spokane	IHS.FS.00000337	Ferry	2022	4	35
Chaplaincy Health Care	IHS.FS.00000456	Franklin	2020	30	192
Heartlinks	IHS.FS.00000369	Franklin	2020	4	2
Heartlinks	IHS.FS.00000369	Franklin	2021	1	9
Heartlinks	IHS.FS.00000369	Franklin	2022	0	6
Tri Cities Chaplaincy	IHS.FS.00000456	Franklin	2021	16	125
Tri Cities Chaplaincy	IHS.FS.00000456	Franklin	2022	38	151
Alpowa Healthcare Inc dba Elite Home Health and Hospice	IHS.FS.60384078	Garfield	2022	1	11
Alpowa Healthcare, Inc. d/b/a Elite Home Health & Hospice	IHS.FS.60384078	Garfield	2020	3	7
Alpowa Healthcare, Inc. d/b/a Elite Home Health & Hospice	IHS.FS.60384078	Garfield	2021	0	6
Enhabit Hospice	IHS.FS.61165576	Grant	2021	2	5
Enhabit Hospice	IHS.FS.61165576	Grant	2022	1	10
Frontier Home Health & Hospice	IHS.FS.60379608	Grant	2020	0	3
Washington HomeCare and Hospice of Central Basin, LLC	IHS.FS.60092413	Grant	2022	29	220
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Grant	2020	40	251

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Survey Data

Agency Name	License Number	County	Year	0-64	65+
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Grant	2021	25	225
Harbors Home Health & Hospice	IHS.FS.00000306	Grays Harbor	2021	2	2
Harbors Home Health & Hospice	IHS.FS.00000306	Grays Harbor	2022	40	172
Harbors Home Health and Hospice	IHS.FS.00000306	Grays Harbor	2020	27	186
Puget Sound Hospice	IHS.FS.61032138	Grays Harbor	2021	0	6
Puget Sound Hospice	IHS.FS.61032138	Grays Harbor	2022	0	31
EvergreenHealth	IHS.FS.00000278	Island	2020	0	6
EvergreenHealth	IHS.FS.00000278	Island	2021	0	4
EvergreenHealth	IHS.FS.00000278	Island	2022	0	4
Providence Hospice & Homecare of Snohomish County	IHS.FS.00000418	Island	2022	3	29
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Island	2020	5	36
Providence Hospice Snohomish	IHS.FS.00000418	Island	2021	7	36
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	Island	2020	20	81
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	Island	2021	22	111
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	Island	2022	16	132
WhidbeyHealth Hospice	IHS.FS.00000323	Island	2020	29	252
WhidbeyHealth Hospice	IHS.FS.00000323	Island	2021	39	299
WhidbeyHealth Hospice	IHS.FS.00000323	Island	2022	22	254
Hospice of Jefferson County	IHS.FS.00000349	Jefferson	2020	17	178
Hospice of Jefferson County	IHS.FS.00000349	Jefferson	2021	14	162
Northwest Healthcare Alliance, Inc	IHS.FS.00000229	Jefferson	2022	0	1
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Jefferson	2020	0	16
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Jefferson	2021	1	9
Caroline Kline Galland	IHS.FS.60103742	King	2022	39	472
Continuum Care of King LLC	IHS.FS.61058934	King	2020	0	0
Continuum Care of King LLC	IHS.FS.61058934	King	2021	0	0
Continuum Care of Snohomish	IHS.FS.61010090	King	2020	2	40
Continuum Care of Snohomish	IHS.FS.61010090	King	2022	17	452
Continuum Care of Snohomish, LLC	IHS.FS.61010090	King	2021	9	309
Envision Hospice of Washington LLC	IHS.FS.60952486	King	2020	1	76
Envision Hospice of Washington, LLC	IHS.FS.60952486	King	2021	1	73
Envision Hospice of Washington, LLC	IHS.FS.60952486	King	2022	3	69
EvergreenHealth	IHS.FS.00000278	King	2020	316	2451
EvergreenHealth	IHS.FS.00000278	King	2021	259	2082
EvergreenHealth	IHS.FS.00000278	King	2022	320	2379
Franciscan Hospice and Palliative Care	IHS.FS.00000287	King	2021	31	387
Franciscan Hospice and Palliative Care	IHS.FS.00000287	King	2022	30	405
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	King	2020	49	446
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	King	2021	42	281
Kindred Hospice	IHS.FS.60330209	King	2020	9	200
Kline Galland Hospice	IHS.FS.60103742	King	2020	83	896
Kline Galland Hospice	IHS.FS.60103742	King	2021	42	410
Multicare Home Health, Hospice	IHS.FS.60639376	King	2020	36	137
Multicare Hospice	IHS.FS.60639376	King	2021	21	141
Multicare Hospice	IHS.FS.60639376	King	2022	23	100
Odyssey HealthCare Operating B, LP	IHS.FS.60330209	King	2021	1	116
Odyssey HealthCare Operating B, LP	IHS.FS.60330209	King	2022	1	67
Providence Hospice of Seattle	IHS.FS.00000336	King	2020	338	2059
Providence Hospice of Seattle	IHS.FS.00000336	King	2021	402	2664
Providence Hospice of Seattle	IHS.FS.00000336	King	2022	361	2215
Virginia Mason Franciscan Hospice & Palliative Care	IHS.FS.00000287	King	2020	52	716
Wesley Homes Hospice, LLC	IHS.FS.60276500	King	2020	3	110
Wesley Homes Hospice, LLC	IHS.FS.60276500	King	2021	4	129
Wesley Homes Hospice, LLC	IHS.FS.60276500	King	2022	2	93
Y.B.G. Healthcare LLC DBA Heart and Soul Hospice	IHS.FS.61379202	King	2022	0	0
Envision Hospice of Washington LLC	IHS.FS.60952486	Kitsap	2020	0	0
Envision Hospice of Washington, LLC	IHS.FS.60952486	Kitsap	2021	6	55
Envision Hospice of Washington, LLC	IHS.FS.60952486	Kitsap	2022	3	117
Franciscan Hospice and Palliative Care	IHS.FS.00000287	Kitsap	2021	356	371
Franciscan Hospice and Palliative Care	IHS.FS.00000287	Kitsap	2022	30	405
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	Kitsap	2020	13	114
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	Kitsap	2021	11	138
Multicare Home Health, Hospice	IHS.FS.60639376	Kitsap	2020	12	126
Multicare Hospice	IHS.FS.60639376	Kitsap	2021	16	140
Multicare Hospice	IHS.FS.60639376	Kitsap	2022	24	168
Virginia Mason Franciscan Hospice & Palliative Care	IHS.FS.00000287	Kitsap	2020	71	681
Kittitas Valley Healthcare Hospice	IHS.FS.00000320	Kittitas	2021	15	115
Kittitas Valley Home Health and Hospice	IHS.FS.00000320	Kittitas	2020	12	157
Kittitas Valley Home Health and Hospice	IHS.FS.00000320	Kittitas	2022	8	148
HEART OF HOSPICE	IHS.FS.60741443	Klickitat	2020	2	21
HEART OF HOSPICE	IHS.FS.60741443	Klickitat	2021	3	20
Inspiring Hospice Partners of Oregon, LLC	IHS.FS.60741443	Klickitat	2022	5	20

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Survey Data

Agency Name	License Number	County	Year	0-64	65+
Klickitat Valley Health - Hospice	IHS.FS.00000361	Klickitat	2021	3	28
Klickitat Valley Health Home Health & Hospice	IHS.FS.00000361	Klickitat	2020	4	38
Klickitat Valley Health Home Health & Hospice	IHS.FS.00000361	Klickitat	2022	5	44
Providence Hospice	IHS.FS.60201476	Klickitat	2020	6	28
Providence Hospice	IHS.FS.60201476	Klickitat	2021	7	34
Providence Hospice	IHS.FS.60201476	Klickitat	2022	3	26
Northwest Healthcare Alliance, Inc	IHS.FS.00000229	Lewis	2022	21	247
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Lewis	2020	15	226
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Lewis	2021	19	221
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Lewis	2020	32	175
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Lewis	2021	19	200
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Lewis	2022	31	155
Enhabit Hospice	IHS.FS.61165576	Lincoln	2021	0	0
Hospice of Spokane	IHS.FS.00000337	Lincoln	2020	1	1
Hospice of Spokane	IHS.FS.00000337	Lincoln	2021	1	2
Hospice of Spokane	IHS.FS.00000337	Lincoln	2022	0	1
Washington HomeCare and Hospice of Central Basin, LLC	IHS.FS.60092413	Lincoln	2022	1	16
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Lincoln	2020	5	21
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Lincoln	2021	4	10
Northwest Healthcare Alliance, Inc	IHS.FS.00000229	Mason	2022	5	53
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Mason	2020	8	70
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Mason	2021	12	47
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Mason	2020	35	193
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Mason	2021	25	300
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Mason	2022	23	176
Puget Sound Hospice	IHS.FS.61032138	Mason	2021	0	0
Puget Sound Hospice	IHS.FS.61032138	Mason	2022	0	100
Enhabit Hospice	IHS.FS.61165576	Okanogan	2021	19	183
Enhabit Hospice	IHS.FS.61165576	Okanogan	2022	20	129
Frontier Home Health & Hospice	IHS.FS.60379608	Okanogan	2020	30	167
Hospice of Spokane	IHS.FS.00000337	Okanogan	2020	1	0
Community Home Health/Hospice	IHS.FS.00000262	Pacific	2020	1	3
Harbors Home Health & Hospice	IHS.FS.00000306	Pacific	2021	2	2
Harbors Home Health & Hospice	IHS.FS.00000306	Pacific	2022	12	99
Harbors Home Health and Hospice	IHS.FS.00000306	Pacific	2020	11	66
Hospice of Spokane	IHS.FS.00000337	Pend Oreille	2022	8	55
Hospice of Spokane	IHS.FS.00000337	Pend Oreille	2020	17	49
Hospice of Spokane	IHS.FS.00000337	Pend Oreille	2021	12	55
Continuum Care of Snohomish	IHS.FS.61010090	Pierce	2022	0	0
Envision Hospice of Washington LLC	IHS.FS.60952486	Pierce	2020	1	20
Envision Hospice of Washington, LLC	IHS.FS.60952486	Pierce	2021	8	113
Envision Hospice of Washington, LLC	IHS.FS.60952486	Pierce	2022	1	84
Franciscan Hospice and Palliative Care	IHS.FS.00000287	Pierce	2021	141	1081
Franciscan Hospice and Palliative Care	IHS.FS.00000287	Pierce	2022	136	2118
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	Pierce	2020	30	181
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	Pierce	2021	21	156
Multicare Home Health, Hospice	IHS.FS.60639376	Pierce	2020	161	866
Multicare Hospice	IHS.FS.60639376	Pierce	2021	145	914
Multicare Hospice	IHS.FS.60639376	Pierce	2022	156	818
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Pierce	2020	0	1
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Pierce	2021	0	1
Providence Hospice of Seattle	IHS.FS.00000336	Pierce	2021	1	1
Providence Hospice of Seattle	IHS.FS.00000336	Pierce	2022	31	67
Puget Sound Hospice	IHS.FS.61032138	Pierce	2021	0	0
Virginia Mason Franciscan Hospice & Palliative Care	IHS.FS.00000287	Pierce	2020	232	1630
Wesley Homes Hospice, LLC	IHS.FS.60276500	Pierce	2020	1	16
Wesley Homes Hospice, LLC	IHS.FS.60276500	Pierce	2021	6	44
Wesley Homes Hospice, LLC	IHS.FS.60276500	Pierce	2022	1	40
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	San Juan	2020	8	89
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	San Juan	2021	5	95
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	San Juan	2022	9	91
Eden Hospice at Whatcom County	IHS.FS.61117985	Skagit	2021	0	1
Eden Hospice at Whatcom County, LLC	IHS.FS.61117985	Skagit	2022	1	42
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	Skagit	2020	70	607
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	Skagit	2021	85	749
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	Skagit	2022	66	753
HEART OF HOSPICE	IHS.FS.60741443	Skamania	2020	2	18
HEART OF HOSPICE	IHS.FS.60741443	Skamania	2021	2	22
Inspiring Hospice Partners of Oregon, LLC	IHS.FS.60741443	Skamania	2022	0	21
PeaceHealth Hospice Southwest	IHS.FS.60331226	Skamania	2020	0	3
PeaceHealth Hospice Southwest	IHS.FS.60331226	Skamania	2022	0	3
PeaceHealth Southwest Hospice	IHS.FS.60331226	Skamania	2021	0	1

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Survey Data

Agency Name	License Number	County	Year	0-64	65+
Providence Hospice	IHS.FS.60201476	Skamania	2020	1	16
Providence Hospice	IHS.FS.60201476	Skamania	2021	2	15
Providence Hospice	IHS.FS.60201476	Skamania	2022	1	18
Alpha Hospice	IHS.FS.61032013	Snohomish	2020	1	30
Alpha Hospice	IHS.FS.61032013	Snohomish	2021	6	111
Alpha Hospice	IHS.FS.61032013	Snohomish	2022	7	162
Continuum Care of Snohomish	IHS.FS.61010090	Snohomish	2020	12	131
Continuum Care of Snohomish	IHS.FS.61010090	Snohomish	2022	30	406
Continuum Care of Snohomish, LLC	IHS.FS.61010090	Snohomish	2021	36	306
Envision Hospice of Washington LLC	IHS.FS.60952486	Snohomish	2020	0	0
Envision Hospice of Washington LLC	IHS.FS.60952486	Snohomish	2021	0	1
EvergreenHealth	IHS.FS.00000278	Snohomish	2020	70	672
EvergreenHealth	IHS.FS.00000278	Snohomish	2021	67	627
EvergreenHealth	IHS.FS.00000278	Snohomish	2022	68	642
HEART OF HOSPICE	IHS.FS.60741443	Snohomish	2020	0	0
HEART OF HOSPICE	IHS.FS.60741443	Snohomish	2021	0	0
Inspiring Hospice Partners of Oregon, LLC	IHS.FS.60741443	Snohomish	2022	1	42
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	Snohomish	2020	3	84
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	Snohomish	2021	5	63
Providence Hospice & Homecare of Snohomish County	IHS.FS.00000418	Snohomish	2022	220	1396
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Snohomish	2020	267	1645
Providence Hospice of Seattle	IHS.FS.00000336	Snohomish	2020	0	0
Providence Hospice Snohomish	IHS.FS.00000418	Snohomish	2021	387	2378
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	Snohomish	2020	8	74
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	Snohomish	2021	13	94
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	Snohomish	2022	15	146
Gentiva Hospice	IHS.FS.60308060	Spokane	2022	106	198
Horizon Hospice	IHS.FS.00000332	Spokane	2021	36	520
Horizon Hospice & Palliative Care	IHS.FS.00000332	Spokane	2020	28	456
Horizon Hospice & Palliative Care	IHS.FS.00000332	Spokane	2022	46	633
Hospice of Spokane	IHS.FS.00000337	Spokane	2020	302	1895
Hospice of Spokane	IHS.FS.00000337	Spokane	2021	317	1899
Hospice of Spokane	IHS.FS.00000337	Spokane	2022	236	1673
Kindred Hospice	IHS.FS.60308060	Spokane	2020	32	297
Odyssey HealthCare Operating B, LP	IHS.FS.60308060	Spokane	2021	15	271
Hospice of Spokane	IHS.FS.00000337	Stevens	2020	21	128
Hospice of Spokane	IHS.FS.00000337	Stevens	2021	31	111
Hospice of Spokane	IHS.FS.00000337	Stevens	2022	16	138
Bristol Hospice - Thurston, LLC	IHS.FS.61211200	Thurston	2021	0	0
Envision Hospice of Washington LLC	IHS.FS.60952486	Thurston	2020	1	24
Envision Hospice of Washington, LLC	IHS.FS.60952486	Thurston	2021	1	22
Envision Hospice of Washington, LLC	IHS.FS.60952486	Thurston	2022	2	39
Northwest Healthcare Alliance, Inc	IHS.FS.00000229	Thurston	2022	24	363
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Thurston	2020	22	268
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Thurston	2021	31	282
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Thurston	2020	106	772
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Thurston	2021	75	600
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Thurston	2022	76	725
Puget Sound Hospice	IHS.FS.61032138	Thurston	2020	0	6
Puget Sound Hospice	IHS.FS.61032138	Thurston	2021	0	19
Puget Sound Hospice	IHS.FS.61032138	Thurston	2022	0	10
Community Home Health & Hospice	IHS.FS.00000262	Wahkiakum	2022	1	2
Community Home Health/Hospice	IHS.FS.00000262	Wahkiakum	2020	3	11
Community Home Health/Hospice	IHS.FS.00000262	Wahkiakum	2021	1	14
PeaceHealth Hospice Southwest	IHS.FS.60331226	Wahkiakum	2022	0	6
PeaceHealth Southwest Hospice	IHS.FS.60331226	Wahkiakum	2021	2	3
Tri Cities Chaplaincy	IHS.FS.00000456	Walla Walla	2022	0	8
Walla Walla Community Hospice	IHS.FS.60480441	Walla Walla	2020	41	242
Walla Walla Community Hospice	IHS.FS.60480441	Walla Walla	2021	31	243
Walla Walla Community Hospice	IHS.FS.60480441	Walla Walla	2022	28	248
Eden Hospice at Whatcom County	IHS.FS.61117985	Whatcom	2021	2	24
Eden Hospice at Whatcom County, LLC	IHS.FS.61117985	Whatcom	2020	0	0
Whatcom Hospice	IHS.FS.00000471	Whatcom	2021	111	1030
Whatcom Hospice	IHS.FS.00000471	Whatcom	2022	139	1025
Whatcom Hospice	IHS.FS.00000471	Whatcom	2020	80	978
Eden Hospice at Whatcom County, LLC	IHS.FS.61117985	Whatcom	2022	3	62
PeaceHealth Whatcom Hospice	IHS.FS.61214897	Whatcom	2022	134	1031
Alpowa Healthcare Inc dba Elite Home Health and Hospice	IHS.FS.60384078	Whitman	2022	0	8
Hospice of Spokane	IHS.FS.00000337	Whitman	2020	0	1
Kindred Hospice	IHS.FS.60308060	Whitman	2020	12	127
Odyssey HealthCare Operating B, LP	IHS.FS.60308060	Whitman	2021	15	175
Astria Hospice	IHS.FS.60097245	Yakima	2021	3	52

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Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Survey Data

Agency Name	License Number	County	Year	0-64	65+
Astria Hospice	IHS.FS.60097245	Yakima	2020	0	56
Heartlinks	IHS.FS.00000369	Yakima	2020	20	181
Heartlinks	IHS.FS.00000369	Yakima	2021	15	224
Heartlinks	IHS.FS.00000369	Yakima	2022	25	204
Memorial Home Care Services	IHS.FS.00000376	Yakima	2020	175	953
Memorial Home Care Services	IHS.FS.00000376	Yakima	2021	143	649

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Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Preliminary Death Data Updated September 22, 2023

	0-64			65+	
County	**2020**	**2021**	**2022**	**2020**	**2021**
ADAMS	20	23	25	59	92
ASOTIN	56	43	45	186	188
BENTON	555	536	566	1522	1610
CHELAN	224	256	225	785	870
CLALLAM	195	185	179	777	906
CLARK	1043	1078	1002	3205	3705
COLUMBIA	7	11	12	43	43
COWLITZ	314	401	311	968	1100
DOUGLAS	42	45	45	160	174
FERRY	19	21	22	58	63
FRANKLIN	100	110	79	263	261
GARFIELD	5	4	2	11	24
GRANT	186	208	190	455	523
GRAYS HARBOR	209	236	223	558	590
ISLAND	110	116	117	505	504
JEFFERSON	68	54	59	273	295
KING	4456	4892	4902	11186	11896
KITSAP	454	489	462	1714	1832
KITTITAS	78	88	78	241	241
KLICKITAT	42	50	50	113	164
LEWIS	205	186	191	653	723
LINCOLN	15	24	24	75	76
MASON	143	168	152	408	461
OKANOGAN	88	92	106	277	324
PACIFIC	55	59	69	177	239
PEND OREILLE	41	55	44	101	119
PIERCE	2364	2574	2518	5608	6264
SAN JUAN	18	24	12	94	91
SKAGIT	269	334	258	1068	1190
SKAMANIA	26	25	20	47	56
SNOHOMISH	1587	1563	1468	4278	4478
SPOKANE	1634	1842	1603	4322	4810
STEVENS	86	114	107	248	304
THURSTON	628	763	709	2007	2285
WAHKIAKUM	10	7	9	18	25
WALLA WALLA	150	138	157	522	595
WHATCOM	457	443	467	1481	1674
WHITMAN	51	59	65	226	278
YAKIMA	653	699	628	1675	1644

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Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
0-64 Population Projection

County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2020-2022 Average Population
Adams	17,637	17,768	17,899	18,029	18,160	18,015	18,199	18,382	18,565	18,748	18,931	18,199
Asotin	16,969	16,906	16,842	16,779	16,715	16,822	16,706	16,591	16,475	16,360	16,244	16,706
Benton	162,262	163,693	165,123	166,554	167,984	174,308	175,851	177,393	178,935	180,477	182,019	175,851
Chelan	61,284	61,520	61,755	61,991	62,227	62,829	62,907	62,984	63,062	63,139	63,217	62,907
Clallam	52,716	52,661	52,605	52,550	52,494	52,094	52,247	52,399	52,552	52,704	52,857	52,247
Clark	387,296	393,291	399,287	405,282	411,278	420,628	424,857	429,086	433,316	437,545	441,774	424,857
Columbia	2,988	2,947	2,905	2,863	2,822	2,812	2,763	2,713	2,664	2,615	2,566	2,763
Cowlitz	85,417	85,517	85,617	85,717	85,817	87,848	87,937	88,027	88,116	88,206	88,295	87,937
Douglas	33,540	33,938	34,335	34,732	35,130	35,255	35,378	35,501	35,624	35,746	35,869	35,378
Ferry	5,834	5,782	5,731	5,680	5,628	5,208	5,127	5,047	4,967	4,886	4,806	5,127
Franklin	79,651	81,742	83,832	85,922	88,012	87,500	88,772	90,044	91,315	92,587	93,859	88,772
Garfield	1,665	1,644	1,623	1,602	1,581	1,570	1,570	1,570	1,569	1,569	1,569	1,570
Grant	81,535	82,660	83,784	84,909	86,033	85,007	85,596	86,185	86,774	87,363	87,952	85,596
Grays Harb	59,105	58,675	58,246	57,817	57,387	58,396	58,092	57,788	57,484	57,179	56,875	58,092
Island	62,514	62,664	62,814	62,964	63,114	63,633	63,840	64,048	64,256	64,464	64,672	63,840
Jefferson	20,636	20,653	20,670	20,688	20,705	20,345	20,269	20,192	20,116	20,040	19,964	20,269
King	1,798,581	1,820,215	1,841,848	1,863,482	1,885,115	1,964,992	1,974,586	1,984,180	1,993,774	2,003,368	2,012,962	1,974,586
Kitsap	212,548	214,045	215,543	217,040	218,538	222,540	222,587	222,634	222,681	222,729	222,776	222,587
Kittitas	36,206	36,768	37,330	37,892	38,453	38,168	38,539	38,910	39,282	39,653	40,024	38,539
Klickitat	16,208	16,082	15,955	15,828	15,702	17,332	17,217	17,103	16,988	16,874	16,759	17,217
Lewis	61,494	61,796	62,097	62,398	62,700	63,604	63,811	64,018	64,225	64,432	64,639	63,811
Lincoln	8,101	8,042	7,982	7,923	7,864	7,814	7,804	7,794	7,785	7,775	7,765	7,804
Mason	48,672	49,162	49,652	50,142	50,632	49,799	49,998	50,196	50,395	50,594	50,793	49,998
Okanogan	33,087	32,906	32,726	32,545	32,364	32,082	31,910	31,737	31,564	31,392	31,219	31,910
Pacific	15,115	14,972	14,830	14,688	14,545	15,581	15,523	15,464	15,405	15,346	15,287	15,523
Pend Oreill	10,045	9,998	9,952	9,905	9,859	9,718	9,660	9,602	9,543	9,485	9,427	9,660
Pierce	721,137	729,937	738,738	747,538	756,339	786,960	790,591	794,221	797,852	801,483	805,114	790,591
San Juan	11,305	11,194	11,084	10,974	10,863	11,697	11,682	11,668	11,654	11,640	11,626	11,682
Skagit	97,885	98,616	99,346	100,076	100,807	100,150	100,574	100,998	101,422	101,846	102,270	100,574
Skamania	9,272	9,266	9,260	9,254	9,248	9,366	9,243	9,121	8,998	8,875	8,752	9,243
Snohomish	661,812	672,806	683,800	694,793	705,787	708,361	712,731	717,100	721,470	725,839	730,209	712,731
Spokane	414,493	416,684	418,875	421,066	423,256	446,453	447,909	449,365	450,821	452,277	453,733	447,909
Stevens	34,576	34,459	34,343	34,226	34,109	36,029	35,790	35,550	35,311	35,071	34,832	35,790
Thurston	224,951	228,261	231,571	234,880	238,190	240,351	242,356	244,360	246,365	248,369	250,374	242,356
Wahkiakur	2,726	2,669	2,612	2,555	2,498	2,957	2,943	2,930	2,917	2,903	2,890	2,943
Walla Wall	49,893	50,111	50,328	50,546	50,763	50,358	50,364	50,370	50,376	50,382	50,388	50,364
Whatcom	175,840	178,234	180,629	183,023	185,418	184,193	185,493	186,794	188,095	189,395	190,696	185,493
Whitman	42,880	42,965	43,051	43,137	43,222	42,475	42,489	42,503	42,517	42,531	42,545	42,489
Yakima	215,882	217,605	219,328	221,051	222,774	219,274	219,628	219,982	220,336	220,690	221,044	219,628

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
65+ Population Projection

County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2020-2022 Average Population
Adams	1,773	1,887	2,000	2,114	2,227	2,598	2,605	2,613	2,621	2,629	2,637	2,605
Asotin	5,041	5,233	5,426	5,619	5,812	5,463	5,673	5,884	6,094	6,305	6,515	5,673
Benton	26,328	27,492	28,657	29,821	30,986	32,565	33,826	35,088	36,349	37,611	38,872	33,826
Chelan	13,746	14,279	14,811	15,343	15,876	16,312	16,903	17,494	18,085	18,677	19,268	16,903
Clallam	19,934	20,401	20,867	21,334	21,800	25,061	25,369	25,678	25,986	26,295	26,603	25,369
Clark	64,524	68,044	71,564	75,085	78,605	82,683	86,493	90,303	94,113	97,923	101,733	86,493
Columbia	1,102	1,135	1,169	1,202	1,236	1,140	1,170	1,200	1,229	1,259	1,289	1,170
Cowlitz	18,863	19,684	20,505	21,326	22,148	22,882	23,471	24,060	24,649	25,237	25,826	23,471
Douglas	6,450	6,831	7,213	7,595	7,976	7,683	8,039	8,396	8,752	9,109	9,465	8,039
Ferry	1,876	1,949	2,022	2,095	2,168	1,970	2,058	2,147	2,235	2,323	2,411	2,058
Franklin	7,499	7,921	8,343	8,765	9,188	9,249	9,795	10,341	10,887	11,433	11,979	9,795
Garfield	595	607	620	633	645	716	711	706	700	695	690	711
Grant	12,395	13,011	13,628	14,244	14,861	14,116	14,729	15,343	15,957	16,571	17,185	14,729
Grays Harb	14,005	14,535	15,064	15,594	16,123	17,240	17,700	18,161	18,621	19,082	19,542	17,700
Island	18,086	18,625	19,163	19,701	20,239	23,224	23,676	24,127	24,579	25,030	25,482	23,676
Jefferson	10,244	10,580	10,916	11,252	11,588	12,632	13,029	13,427	13,824	14,221	14,618	13,029
King	254,219	268,307	282,395	296,484	310,572	304,683	316,701	328,719	340,737	352,755	364,773	316,701
Kitsap	45,652	47,697	49,743	51,788	53,833	53,071	55,150	57,228	59,307	61,385	63,464	55,150
Kittitas	6,464	6,760	7,055	7,351	7,647	8,300	8,482	8,664	8,846	9,028	9,210	8,482
Klickitat	4,792	5,051	5,310	5,570	5,829	5,403	5,695	5,987	6,280	6,572	6,864	5,695
Lewis	15,166	15,576	15,987	16,398	16,808	18,545	18,899	19,253	19,608	19,962	20,316	18,899
Lincoln	2,619	2,687	2,755	2,823	2,891	3,062	3,116	3,169	3,223	3,276	3,330	3,116
Mason	13,528	14,123	14,717	15,311	15,905	15,927	16,436	16,945	17,453	17,962	18,471	16,436
Okanogan	8,773	9,198	9,624	10,050	10,475	10,022	10,353	10,685	11,017	11,348	11,680	10,353
Pacific	6,095	6,258	6,421	6,584	6,747	7,784	7,971	8,159	8,347	8,534	8,722	7,971
Pend Oreill	3,195	3,378	3,560	3,742	3,925	3,683	3,845	4,007	4,170	4,332	4,494	3,845
Pierce	108,983	114,409	119,836	125,262	130,688	133,433	139,235	145,038	150,840	156,642	162,444	139,235
San Juan	4,876	5,099	5,322	5,545	5,768	6,091	6,326	6,561	6,796	7,030	7,265	6,326
Skagit	22,735	24,021	25,308	26,595	27,881	29,373	30,250	31,128	32,005	32,882	33,759	30,250
Skamania	2,158	2,286	2,414	2,542	2,670	2,238	2,455	2,673	2,891	3,108	3,326	2,455
Snohomish	95,788	101,674	107,560	113,447	119,333	119,596	125,852	132,107	138,363	144,618	150,874	125,852
Spokane	73,817	77,325	80,834	84,343	87,852	92,886	96,172	99,458	102,744	106,030	109,316	96,172
Stevens	9,454	9,930	10,407	10,884	11,360	10,416	11,029	11,642	12,255	12,868	13,481	11,029
Thurston	42,459	44,534	46,608	48,683	50,757	54,442	56,276	58,110	59,944	61,778	63,612	56,276
Wahkiakur	1,254	1,316	1,379	1,441	1,503	1,465	1,512	1,558	1,604	1,651	1,697	1,512
Walla Wall	10,757	10,819	10,881	10,944	11,006	12,226	12,446	12,666	12,886	13,106	13,326	12,446
Whatcom	33,950	35,688	37,426	39,164	40,902	42,654	44,049	45,443	46,838	48,232	49,627	44,049
Whitman	4,370	4,659	4,948	5,237	5,526	5,498	5,619	5,739	5,860	5,980	6,101	5,619
Yakima	34,088	34,949	35,809	36,670	37,530	37,454	38,467	39,479	40,491	41,504	42,516	38,467

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Adams** ***Select from drop down menu***

Adams County Only													
Population information (OFM)													
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
0 - 64	Adams	17,768	17,899	18,029	18,160	18,015	18,199	18,382	18,565	18,748	18,931		18,199
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
65 +	Adams	1,887	2,000	2,114	2,227	2,598	2,605	2,613	2,621	2,629	2,637		2,605

WAC 246-310-290(8)(a) Step 1:						
		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:										
Ages 0-64	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Planning area historical resident deaths (OFM)	**2**		20	23	25					**Ages 0 - 64**
Average deaths (2020-2022)	**2**	23								
Projected patient deaths: 21.09%	**3**	5								
Average population (OFM)	**4**	18,199								
Projected population	**N/A**		18,015	18,199	18,382	18,565	18,748	18,931		**Steps 2-4**
Potential volume	**N/A**		5	5	5	5	5	5		

Ages 65+	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
PA historical resident deaths (OFM)	**2**		59	92	91					**Ages 65+**
Average deaths (2020-2022)	**2**	81								
Projected patient deaths: 56.80%	**3**	46								
Average population (OFM)	**4**	2,605								
Projected population	**N/A**		2,598	2,605	2,613	2,621	2,629	2,637		**Steps 2-4**
Potential volume	**N/A**		46	46	46	46	46	46		

All Ages	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Combined age cohorts	**5**		50	51	51	51	51	51		**All Ages**
Current capacity (DOH survey)	**N/A**	44								
Unmet need	**5**		**6**	**7**	**7**	**7**	**7**	**7**		
Unmet need patient days (statewide ALOS)	**6**	61.11	392	403	414	426	437	449		**Steps 5-8**
Unmet Average Daily Census (ADC)	**7**		1	1	1	1	1	1		
Agency needed (ADC > 35)	**8**	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Asotin** ***Select from drop down menu***

Asotin County Only													
Population information (OFM)													
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
0 - 64	Asotin	16,906	16,842	16,779	16,715	16,822	16,706	16,591	16,475	16,360	16,244		16,706
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
65 +	Asotin	5,233	5,426	5,619	5,812	5,463	5,673	5,884	6,094	6,305	6,515		5,673

WAC 246-310-290(8)(a) Step 1:						
		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:										
Ages 0-64	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Planning area historical resident deaths (OFM)	**2**		56	43	45					**Ages 0 - 64**
Average deaths (2020-2022)	**2**	48								
Projected patient deaths: 21.09%	**3**	10								
Average population (OFM)	**4**	16,706								
Projected population	**N/A**		16,822	16,706	16,591	16,475	16,360	16,244		**Steps 2-4**
Potential volume	**N/A**		10	10	10	10	10	10		

Ages 65+	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
PA historical resident deaths (OFM)	**2**		186	188	227					**Ages 65+**
Average deaths (2020-2022)	**2**	200								
Projected patient deaths: 56.80%	**3**	114								
Average population (OFM)	**4**	5,673								
Projected population	**N/A**		5,463	5,673	5,884	6,094	6,305	6,515		**Steps 2-4**
Potential volume	**N/A**		110	114	118	122	126	131		

All Ages	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Combined age cohorts	**5**		120	124	128	132	136	141		**All Ages**
Current capacity (DOH survey)	**N/A**	100								
Unmet need	**5**		**19**	**24**	**28**	**32**	**36**	**40**		**Steps 5-8**
Unmet need patient days (statewide ALOS)	**6**	61.11	1,187	1,440	1,694	1,947	2,201	2,455		
Unmet Average Daily Census (ADC)	**7**		3	4	5	5	6	7		
Agency needed (ADC > 35)	**8**	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
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Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Benton** ***Select from drop down menu***

Benton County Only													
Population information (OFM)													
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
0 - 64	Benton	163,693	165,123	166,554	167,984	174,308	175,851	177,393	178,935	180,477	182,019		175,851
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
65 +	Benton	27,492	28,657	29,821	30,986	32,565	33,826	35,088	36,349	37,611	38,872		33,826

WAC 246-310-290(8)(a) Step 1:						
		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:										
Ages 0-64	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Planning area historical resident deaths (OFM)	**2**		555	536	566					**Ages 0 - 64**
Average deaths (2020-2022)	**2**	552								
Projected patient deaths: 21.09%	**3**	116								
Average population (OFM)	**4**	175,851								
Projected population	**N/A**		174,308	175,851	177,393	178,935	180,477	182,019		**Steps 2-4**
Potential volume	**N/A**		115	116	117	119	120	121		

Ages 65+	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
PA historical resident deaths (OFM)	**2**		1,522	1,610	1,739					**Ages 65+**
Average deaths (2020-2022)	**2**	1,624								
Projected patient deaths: 56.80%	**3**	922								
Average population (OFM)	**4**	33,826								
Projected population	**N/A**		32,565	33,826	35,088	36,349	37,611	38,872		**Steps 2-4**
Potential volume	**N/A**		888	922	957	991	1,025	1,060		

All Ages	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Combined age cohorts	**5**		1,003	1,039	1,074	1,109	1,145	1,180		**All Ages**
Current capacity (DOH survey)	**N/A**	1,057								
Unmet need	**5**		**(54)**	**(19)**	**17**	**52**	**88**	**123**		
Unmet need patient days (statewide ALOS)	**6**	61.11	(3,306)	(1,142)	1,022	3,186	5,350	7,514		**Steps 5-8**
Unmet Average Daily Census (ADC)	**7**		(9)	(3)	3	9	15	21		
Agency needed (ADC > 35)	**8**	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Chelan** ***Select from drop down menu***

Chelan County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Chelan	61,520	61,755	61,991	62,227	62,829	62,907	62,984	63,062	63,139	63,217		62,907
Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
65 +	Chelan	14,279	14,811	15,343	15,876	16,312	16,903	17,494	18,085	18,677	19,268		16,903

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025	
Planning area historical resident deaths (OFM)	2		224	256	225				Ages 0 - 64 Steps 2-4
Average deaths (2020-2022)	2	235							
Projected patient deaths: 21.09%	3	50							
Average population (OFM)	4	62,907							
Projected population	N/A		62,829	62,907	62,984	63,062	63,139	63,217	
Potential volume	N/A		49	50	50	50	50	50	

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025	
PA historical resident deaths (OFM)	2		785	870	873				Ages 65+ Steps 2-4
Average deaths (2020-2022)	2	843							
Projected patient deaths: 56.80%	3	479							
Average population (OFM)	4	16,903							
Projected population	N/A		16,312	16,903	17,494	18,085	18,677	19,268	
Potential volume	N/A		462	479	495	512	529	546	

All Ages	Step	Result	2020	2021	2022	2023	2024	2025	
Combined age cohorts	5		511	528	545	562	579	595	All Ages Steps 5-8
Current capacity (DOH survey)	N/A	770							
Unmet need	5		**(258)**	**(242)**	**(225)**	**(208)**	**(191)**	**(174)**	
Unmet need patient days (statewide ALOS)	6	61.11	(15,786)	(14,759)	(13,732)	(12,705)	(11,678)	(10,652)	
Unmet Average Daily Census (ADC)	7		(43)	(40)	(38)	(35)	(32)	(29)	
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Clallam** ***Select from drop down menu***

Clallam County Only													
Population information (OFM)													
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
0 - 64	Clallam	52,661	52,605	52,550	52,494	52,094	52,247	52,399	52,552	52,704	52,857		52,247
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
65 +	Clallam	20,401	20,867	21,334	21,800	25,061	25,369	25,678	25,986	26,295	26,603		25,369

WAC 246-310-290(8)(a) Step 1:						
		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:										
Ages 0-64	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Planning area historical resident deaths (OFM)	**2**		195	185	179					**Ages 0 - 64**
Average deaths (2020-2022)	**2**	186								
Projected patient deaths: 21.09%	**3**	39								
Average population (OFM)	**4**	52,247								
Projected population	**N/A**		52,094	52,247	52,399	52,552	52,704	52,857		**Steps 2-4**
Potential volume	**N/A**		39	39	39	40	40	40		

Ages 65+	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
PA historical resident deaths (OFM)	**2**		777	906	935					**Ages 65+**
Average deaths (2020-2022)	**2**	873								
Projected patient deaths: 56.80%	**3**	496								
Average population (OFM)	**4**	25,369								
Projected population	**N/A**		25,061	25,369	25,678	25,986	26,295	26,603		**Steps 2-4**
Potential volume	**N/A**		490	496	502	508	514	520		

All Ages	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Combined age cohorts	**5**		529	535	541	547	553	559		**All Ages**
Current capacity (DOH survey)	**N/A**	430								
Unmet need	**5**		**99**	**105**	**111**	**118**	**124**	**130**		
Unmet need patient days (statewide ALOS)	**6**	61.11	6,057	6,433	6,808	7,183	7,558	7,934		**Steps 5-8**
Unmet Average Daily Census (ADC)	**7**		17	18	19	20	21	22		
Agency needed (ADC > 35)	**8**	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Clark** ***Select from drop down menu***

Clark County Only													
Population information (OFM)													
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
0 - 64	Clark	393,291	399,287	405,282	411,278	420,628	424,857	429,086	433,316	437,545	441,774		424,857
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
65 +	Clark	68,044	71,564	75,085	78,605	82,683	86,493	90,303	94,113	97,923	101,733		86,493

WAC 246-310-290(8)(a) Step 1:						
		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:										
Ages 0-64	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Planning area historical resident deaths (OFM)	**2**		1,043	1,078	1,002					**Ages 0 - 64**
Average deaths (2020-2022)	**2**	1,041								
Projected patient deaths: 21.09%	**3**	220								
Average population (OFM)	**4**	424,857								
Projected population	**N/A**		420,628	424,857	429,086	433,316	437,545	441,774		**Steps 2-4**
Potential volume	**N/A**		217	220	222	224	226	228		

Ages 65+	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
PA historical resident deaths (OFM)	**2**		3,205	3,705	3,709					**Ages 65+**
Average deaths (2020-2022)	**2**	3,540								
Projected patient deaths: 56.80%	**3**	2,010								
Average population (OFM)	**4**	86,493								
Projected population	**N/A**		82,683	86,493	90,303	94,113	97,923	101,733		**Steps 2-4**
Potential volume	**N/A**		1,922	2,010	2,099	2,187	2,276	2,365		

All Ages	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Combined age cohorts	**5**		2,139	2,230	2,321	2,411	2,502	2,593		**All Ages**
Current capacity (DOH survey)	**N/A**	2,910								
Unmet need	**5**		**(771)**	**(680)**	**(589)**	**(498)**	**(408)**	**(317)**		
Unmet need patient days (statewide ALOS)	**6**	61.11	(47,086)	(41,541)	(35,996)	(30,451)	(24,906)	(19,360)		**Steps 5-8**
Unmet Average Daily Census (ADC)	**7**		(129)	(114)	(99)	(83)	(68)	(53)		
Agency needed (ADC > 35)	**8**	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Columbia** ***Select from drop down menu***

Columbia County Only													
Population information (OFM)													
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
0 - 64	Columbia	2,947	2,905	2,863	2,822	2,812	2,763	2,713	2,664	2,615	2,566		2,763
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
65 +	Columbia	1,135	1,169	1,202	1,236	1,140	1,170	1,200	1,229	1,259	1,289		1,170

WAC 246-310-290(8)(a) Step 1:						
		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:										
Ages 0-64	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Planning area historical resident deaths (OFM)	**2**		7	11	12					**Ages 0 - 64**
Average deaths (2020-2022)	**2**	10								
Projected patient deaths: 21.09%	**3**	2								
Average population (OFM)	**4**	2,763								
Projected population	**N/A**		2,812	2,763	2,713	2,664	2,615	2,566		**Steps 2-4**
Potential volume	**N/A**		2	2	2	2	2	2		

Ages 65+	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
PA historical resident deaths (OFM)	**2**		43	43	37					**Ages 65+**
Average deaths (2020-2022)	**2**	41								
Projected patient deaths: 56.80%	**3**	23								
Average population (OFM)	**4**	1,170								
Projected population	**N/A**		1,140	1,170	1,200	1,229	1,259	1,289		**Steps 2-4**
Potential volume	**N/A**		23	23	24	24	25	26		

All Ages	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Combined age cohorts	**5**		25	25	26	27	27	28		**All Ages**
Current capacity (DOH survey)	**N/A**	36								
Unmet need	**5**		**(11)**	**(11)**	**(10)**	**(10)**	**(9)**	**(9)**		
Unmet need patient days (statewide ALOS)	**6**	61.11	(702)	(668)	(635)	(601)	(567)	(533)		**Steps 5-8**
Unmet Average Daily Census (ADC)	**7**		(2)	(2)	(2)	(2)	(2)	(1)		
Agency needed (ADC > 35)	**8**	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Cowlitz** ***Select from drop down menu***

Cowlitz County Only													
Population information (OFM)													
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
0 - 64	Cowlitz	85,517	85,617	85,717	85,817	87,848	87,937	88,027	88,116	88,206	88,295		87,937
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
65 +	Cowlitz	19,684	20,505	21,326	22,148	22,882	23,471	24,060	24,649	25,237	25,826		23,471

WAC 246-310-290(8)(a) Step 1:						
		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:										
Ages 0-64	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Planning area historical resident deaths (OFM)	**2**		314	401	311					**Ages 0 - 64**
Average deaths (2020-2022)	**2**	342								
Projected patient deaths: 21.09%	**3**	72								
Average population (OFM)	**4**	87,937								
Projected population	**N/A**		87,848	87,937	88,027	88,116	88,206	88,295		**Steps 2-4**
Potential volume	**N/A**		72	72	72	72	72	72		

Ages 65+	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
PA historical resident deaths (OFM)	**2**		968	1,100	989					**Ages 65+**
Average deaths (2020-2022)	**2**	1,019								
Projected patient deaths: 56.80%	**3**	579								
Average population (OFM)	**4**	23,471								
Projected population	**N/A**		22,882	23,471	24,060	24,649	25,237	25,826		**Steps 2-4**
Potential volume	**N/A**		564	579	593	608	622	637		

All Ages	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Combined age cohorts	**5**		636	651	665	680	695	709		**All Ages**
Current capacity (DOH survey)	**N/A**	813								
Unmet need	**5**		**(177)**	**(162)**	**(148)**	**(133)**	**(119)**	**(104)**		
Unmet need patient days (statewide ALOS)	**6**	61.11	(10,820)	(9,928)	(9,037)	(8,145)	(7,254)	(6,362)		**Steps 5-8**
Unmet Average Daily Census (ADC)	**7**		(30)	(27)	(25)	(22)	(20)	(17)		
Agency needed (ADC > 35)	**8**	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
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Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Douglas** ***Select from drop down menu***

Douglas County Only													
Population information (OFM)													
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
0 - 64	Douglas	33,938	34,335	34,732	35,130	35,255	35,378	35,501	35,624	35,746	35,869		35,378
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
65 +	Douglas	6,831	7,213	7,595	7,976	7,683	8,039	8,396	8,752	9,109	9,465		8,039

WAC 246-310-290(8)(a) Step 1:						
		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025	
Planning area historical resident deaths (OFM)	2		42	45	45				Ages 0 - 64 Steps 2-4
Average deaths (2020-2022)	2	44							
Projected patient deaths: 21.09%	3	9							
Average population (OFM)	4	35,378							
Projected population	N/A		35,255	35,378	35,501	35,624	35,746	35,869	
Potential volume	N/A		9	9	9	9	9	9	

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025	
PA historical resident deaths (OFM)	2		160	174	205				Ages 65+ Steps 2-4
Average deaths (2020-2022)	2	180							
Projected patient deaths: 56.80%	3	102							
Average population (OFM)	4	8,039							
Projected population	N/A		7,683	8,039	8,396	8,752	9,109	9,465	
Potential volume	N/A		98	102	107	111	116	120	

All Ages	Step	Result	2020	2021	2022	2023	2024	2025	
Combined age cohorts	5		107	111	116	120	125	130	All Ages Steps 5-8
Current capacity (DOH survey)	N/A	566							
Unmet need	5		**(459)**	**(455)**	**(450)**	**(446)**	**(441)**	**(436)**	
Unmet need patient days (statewide ALOS)	6	61.11	(28,064)	(27,785)	(27,507)	(27,229)	(26,950)	(26,672)	
Unmet Average Daily Census (ADC)	7		(77)	(76)	(75)	(75)	(74)	(73)	
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Ferry** ***Select from drop down menu***

Ferry County Only													
Population information (OFM)													
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
0 - 64	Ferry	5,782	5,731	5,680	5,628	5,208	5,127	5,047	4,967	4,886	4,806		5,127
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
65 +	Ferry	1,949	2,022	2,095	2,168	1,970	2,058	2,147	2,235	2,323	2,411		2,058

WAC 246-310-290(8)(a) Step 1:						
		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:										
Ages 0-64	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Planning area historical resident deaths (OFM)	**2**		19	21	22					**Ages 0 - 64**
Average deaths (2020-2022)	**2**	21								
Projected patient deaths: 21.09%	**3**	4								
Average population (OFM)	**4**	5,127								
Projected population	**N/A**		5,208	5,127	5,047	4,967	4,886	4,806		**Steps 2-4**
Potential volume	**N/A**		4	4	4	4	4	4		

Ages 65+	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
PA historical resident deaths (OFM)	**2**		58	63	60					**Ages 65+**
Average deaths (2020-2022)	**2**	60								
Projected patient deaths: 56.80%	**3**	34								
Average population (OFM)	**4**	2,058								
Projected population	**N/A**		1,970	2,058	2,147	2,235	2,323	2,411		**Steps 2-4**
Potential volume	**N/A**		33	34	36	37	39	40		

All Ages	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Combined age cohorts	**5**		37	39	40	41	43	44		**All Ages**
Current capacity (DOH survey)	**N/A**	36								
Unmet need	**5**		**1**	**3**	**4**	**5**	**7**	**8**		
Unmet need patient days (statewide ALOS)	**6**	61.11	75	160	246	331	417	502		**Steps 5-8**
Unmet Average Daily Census (ADC)	**7**		0	0	1	1	1	1		
Agency needed (ADC > 35)	**8**	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Franklin** ***Select from drop down menu***

Franklin County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Franklin	81,742	83,832	85,922	88,012	87,500	88,772	90,044	91,315	92,587	93,859		88,772
Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
65 +	Franklin	7,921	8,343	8,765	9,188	9,249	9,795	10,341	10,887	11,433	11,979		9,795

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025	
Planning area historical resident deaths (OFM)	2		100	110	79				Ages 0 - 64 Steps 2-4
Average deaths (2020-2022)	2	96							
Projected patient deaths: 21.09%	3	20							
Average population (OFM)	4	88,772							
Projected population	N/A		87,500	88,772	90,044	91,315	92,587	93,859	
Potential volume	N/A		20	20	21	21	21	21	

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025	
PA historical resident deaths (OFM)	2		263	261	234				Ages 65+ Steps 2-4
Average deaths (2020-2022)	2	253							
Projected patient deaths: 56.80%	3	144							
Average population (OFM)	4	9,795							
Projected population	N/A		9,249	9,795	10,341	10,887	11,433	11,979	
Potential volume	N/A		136	144	152	160	167	175	

All Ages	Step	Result	2020	2021	2022	2023	2024	2025	
Combined age cohorts	5		156	164	172	180	189	197	All Ages Steps 5-8
Current capacity (DOH survey)	N/A	191							
Unmet need	5		**(36)**	**(28)**	**(19)**	**(11)**	**(3)**	**6**	
Unmet need patient days (statewide ALOS)	6	61.11	(2,188)	(1,681)	(1,175)	(668)	(162)	345	
Unmet Average Daily Census (ADC)	7		(6)	(5)	(3)	(2)	(0)	1	
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Garfield** ***Select from drop down menu***

Garfield County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Garfield	1,644	1,623	1,602	1,581	1,570	1,570	1,570	1,569	1,569	1,569		1,570
Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
65 +	Garfield	607	620	633	645	716	711	706	700	695	690		711

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025	
Planning area historical resident deaths (OFM)	2		5	4	2				Ages 0 - 64 Steps 2-4
Average deaths (2020-2022)	2	4							
Projected patient deaths: 21.09%	3	1							
Average population (OFM)	4	1,570							
Projected population	N/A		1,570	1,570	1,570	1,569	1,569	1,569	
Potential volume	N/A		1	1	1	1	1	1	

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025	
PA historical resident deaths (OFM)	2		11	24	24				Ages 65+ Steps 2-4
Average deaths (2020-2022)	2	20							
Projected patient deaths: 56.80%	3	11							
Average population (OFM)	4	711							
Projected population	N/A		716	711	706	700	695	690	
Potential volume	N/A		11	11	11	11	11	11	

All Ages	Step	Result	2020	2021	2022	2023	2024	2025	
Combined age cohorts	5		12	12	12	12	12	12	All Ages Steps 5-8
Current capacity (DOH survey)	N/A	9							
Unmet need	5		**3**	**3**	**3**	**2**	**2**	**2**	
Unmet need patient days (statewide ALOS)	6	61.11	164	159	154	149	144	139	
Unmet Average Daily Census (ADC)	7		0	0	0	0	0	0	
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Grant** ***Select from drop down menu***

Grant County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Grant	82,660	83,784	84,909	86,033	85,007	85,596	86,185	86,774	87,363	87,952		85,596
Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
65 +	Grant	13,011	13,628	14,244	14,861	14,116	14,729	15,343	15,957	16,571	17,185		14,729

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025	
Planning area historical resident deaths (OFM)	2		186	208	190				Ages 0 - 64 Steps 2-4
Average deaths (2020-2022)	2	195							
Projected patient deaths: 21.09%	3	41							
Average population (OFM)	4	85,596							
Projected population	N/A		85,007	85,596	86,185	86,774	87,363	87,952	
Potential volume	N/A		41	41	41	42	42	42	

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025	
PA historical resident deaths (OFM)	2		455	523	533				Ages 65+ Steps 2-4
Average deaths (2020-2022)	2	504							
Projected patient deaths: 56.80%	3	286							
Average population (OFM)	4	14,729							
Projected population	N/A		14,116	14,729	15,343	15,957	16,571	17,185	
Potential volume	N/A		274	286	298	310	322	334	

All Ages	Step	Result	2020	2021	2022	2023	2024	2025	
Combined age cohorts	5		315	327	339	352	364	376	All Ages Steps 5-8
Current capacity (DOH survey)	N/A	270							
Unmet need	5		**45**	**57**	**69**	**81**	**93**	**106**	
Unmet need patient days (statewide ALOS)	6	61.11	2,724	3,470	4,215	4,961	5,707	6,453	
Unmet Average Daily Census (ADC)	7		7	9	12	14	16	18	
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
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Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: Grays Harbor **Select from drop down menu*

Grays Harbor County Only													
Population information (OFM)													
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
0 - 64	Grays Harbor	58,675	58,246	57,817	57,387	58,396	58,092	57,788	57,484	57,179	56,875		58,092
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
65 +	Grays Harbor	14,535	15,064	15,594	16,123	17,240	17,700	18,161	18,621	19,082	19,542		17,700

WAC 246-310-290(8)(a) Step 1:						
		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025	
Planning area historical resident deaths (OFM)	2		209	236	223				Ages 0 - 64 Steps 2-4
Average deaths (2020-2022)	2	223							
Projected patient deaths: 21.09%	3	47							
Average population (OFM)	4	58,092							
Projected population	N/A		58,396	58,092	57,788	57,484	57,179	56,875	
Potential volume	N/A		47	47	47	46	46	46	

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025	
PA historical resident deaths (OFM)	2		558	590	683				Ages 65+ Steps 2-4
Average deaths (2020-2022)	2	610							
Projected patient deaths: 56.80%	3	347							
Average population (OFM)	4	17,700							
Projected population	N/A		17,240	17,700	18,161	18,621	19,082	19,542	
Potential volume	N/A		338	347	356	365	374	383	

All Ages	Step	Result	2020	2021	2022	2023	2024	2025	
Combined age cohorts	5		385	394	402	411	420	429	All Ages Steps 5-8
Current capacity (DOH survey)	N/A	352							
Unmet need	5		**33**	**42**	**50**	**59**	**68**	**77**	
Unmet need patient days (statewide ALOS)	6	61.11	2,006	2,542	3,078	3,614	4,150	4,686	
Unmet Average Daily Census (ADC)	7		5	7	8	10	11	13	
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Island** ***Select from drop down menu***

Island County Only													
Population information (OFM)													
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
0 - 64	Island	62,664	62,814	62,964	63,114	63,633	63,840	64,048	64,256	64,464	64,672		63,840
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
65 +	Island	18,625	19,163	19,701	20,239	23,224	23,676	24,127	24,579	25,030	25,482		23,676

WAC 246-310-290(8)(a) Step 1:						
		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:										
Ages 0-64	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Planning area historical resident deaths (OFM)	**2**		110	116	117					**Ages 0 - 64**
Average deaths (2020-2022)	**2**	114								
Projected patient deaths: 21.09%	**3**	24								
Average population (OFM)	**4**	63,840								
Projected population	**N/A**		63,633	63,840	64,048	64,256	64,464	64,672		**Steps 2-4**
Potential volume	**N/A**		24	24	24	24	24	24		

Ages 65+	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
PA historical resident deaths (OFM)	**2**		505	504	548					**Ages 65+**
Average deaths (2020-2022)	**2**	519								
Projected patient deaths: 56.80%	**3**	295								
Average population (OFM)	**4**	23,676								
Projected population	**N/A**		23,224	23,676	24,127	24,579	25,030	25,482		**Steps 2-4**
Potential volume	**N/A**		289	295	300	306	312	317		

All Ages	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Combined age cohorts	**5**		313	319	325	330	336	342		**All Ages**
Current capacity (DOH survey)	**N/A**	469								
Unmet need	**5**		**(156)**	**(150)**	**(144)**	**(139)**	**(133)**	**(127)**		
Unmet need patient days (statewide ALOS)	**6**	61.11	(9,522)	(9,174)	(8,826)	(8,477)	(8,129)	(7,781)		**Steps 5-8**
Unmet Average Daily Census (ADC)	**7**		(26)	(25)	(24)	(23)	(22)	(21)		
Agency needed (ADC > 35)	**8**	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
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Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Jefferson** ***Select from drop down menu***

Jefferson County Only													
Population information (OFM)													
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
0 - 64	Jefferson	20,653	20,670	20,688	20,705	20,345	20,269	20,192	20,116	20,040	19,964		20,269
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
65 +	Jefferson	10,580	10,916	11,252	11,588	12,632	13,029	13,427	13,824	14,221	14,618		13,029

WAC 246-310-290(8)(a) Step 1:						
		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:										
Ages 0-64	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Planning area historical resident deaths (OFM)	**2**		68	54	59					**Ages 0 - 64**
Average deaths (2020-2022)	**2**	60								
Projected patient deaths: 21.09%	**3**	13								
Average population (OFM)	**4**	20,269								
Projected population	**N/A**		20,345	20,269	20,192	20,116	20,040	19,964		**Steps 2-4**
Potential volume	**N/A**		13	13	13	13	13	13		

Ages 65+	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
PA historical resident deaths (OFM)	**2**		273	295	298					**Ages 65+**
Average deaths (2020-2022)	**2**	289								
Projected patient deaths: 56.80%	**3**	164								
Average population (OFM)	**4**	13,029								
Projected population	**N/A**		12,632	13,029	13,427	13,824	14,221	14,618		**Steps 2-4**
Potential volume	**N/A**		159	164	169	174	179	184		

All Ages	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Combined age cohorts	**5**		172	177	182	187	192	196		**All Ages**
Current capacity (DOH survey)	**N/A**	133								
Unmet need	**5**		**39**	**44**	**49**	**54**	**59**	**64**		
Unmet need patient days (statewide ALOS)	**6**	61.11	2,387	2,689	2,992	3,294	3,597	3,899		**Steps 5-8**
Unmet Average Daily Census (ADC)	**7**		7	7	8	9	10	11		
Agency needed (ADC > 35)	**8**	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
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Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **King** ***Select from drop down menu***

King County Only													
Population information (OFM)													
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
0 - 64	King	1,820,215	1,841,848	1,863,482	1,885,115	1,964,992	1,974,586	1,984,180	1,993,774	2,003,368	2,012,962		1,974,586
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
65 +	King	268,307	282,395	296,484	310,572	304,683	316,701	328,719	340,737	352,755	364,773		316,701

WAC 246-310-290(8)(a) Step 1:						
		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:										
Ages 0-64	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Planning area historical resident deaths (OFM)	**2**		4,456	4,892	4,902					**Ages 0 - 64**
Average deaths (2020-2022)	**2**	4,750								
Projected patient deaths: 21.09%	**3**	1,002								
Average population (OFM)	**4**	1,974,586								
Projected population	**N/A**		1,964,992	1,974,586	1,984,180	1,993,774	2,003,368	2,012,962		**Steps 2-4**
Potential volume	**N/A**		997	1002	1007	1011	1016	1021		

Ages 65+	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
PA historical resident deaths (OFM)	**2**		11,186	11,896	12,448					**Ages 65+**
Average deaths (2020-2022)	**2**	11,843								
Projected patient deaths: 56.80%	**3**	6,726								
Average population (OFM)	**4**	316,701								
Projected population	**N/A**		304,683	316,701	328,719	340,737	352,755	364,773		**Steps 2-4**
Potential volume	**N/A**		6,471	6,726	6,982	7,237	7,492	7,747		

All Ages	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Combined age cohorts	**5**		7,468	7,728	7,988	8,248	8,508	8,769		**All Ages**
Current capacity (DOH survey)	**N/A**	8,625								
Unmet need	**5**		**(1,157)**	**(897)**	**(636)**	**(376)**	**(116)**	**144**		
Unmet need patient days (statewide ALOS)	**6**	61.11	(70,683)	(54,788)	(38,892)	(22,996)	(7,100)	8,796		**Steps 5-8**
Unmet Average Daily Census (ADC)	**7**		(194)	(150)	(107)	(63)	(19)	24		
Agency needed (ADC > 35)	**8**	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Kitsap** ***Select from drop down menu***

Kitsap County Only													
Population information (OFM)													
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
0 - 64	Kitsap	214,045	215,543	217,040	218,538	222,540	222,587	222,634	222,681	222,729	222,776		222,587
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
65 +	Kitsap	47,697	49,743	51,788	53,833	53,071	55,150	57,228	59,307	61,385	63,464		55,150

WAC 246-310-290(8)(a) Step 1:						
		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:										
Ages 0-64	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Planning area historical resident deaths (OFM)	**2**		454	489	462					**Ages 0 - 64**
Average deaths (2020-2022)	**2**	468								
Projected patient deaths: 21.09%	**3**	99								
Average population (OFM)	**4**	222,587								
Projected population	**N/A**		222,540	222,587	222,634	222,681	222,729	222,776		**Steps 2-4**
Potential volume	**N/A**		99	99	99	99	99	99		

Ages 65+	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
PA historical resident deaths (OFM)	**2**		1,714	1,832	1,895					**Ages 65+**
Average deaths (2020-2022)	**2**	1,814								
Projected patient deaths: 56.80%	**3**	1,030								
Average population (OFM)	**4**	55,150								
Projected population	**N/A**		53,071	55,150	57,228	59,307	61,385	63,464		**Steps 2-4**
Potential volume	**N/A**		991	1,030	1,069	1,108	1,147	1,185		

All Ages	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Combined age cohorts	**5**		1,090	1,129	1,168	1,207	1,245	1,284		**All Ages**
Current capacity (DOH survey)	**N/A**	1,141								
Unmet need	**5**		**(51)**	**(12)**	**27**	**66**	**104**	**143**		
Unmet need patient days (statewide ALOS)	**6**	61.11	(3,117)	(743)	1,631	4,004	6,378	8,752		**Steps 5-8**
Unmet Average Daily Census (ADC)	**7**		(9)	(2)	4	11	17	24		
Agency needed (ADC > 35)	**8**	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Kittitas** ***Select from drop down menu***

Kittitas County Only													
Population information (OFM)													
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
0 - 64	Kittitas	36,768	37,330	37,892	38,453	38,168	38,539	38,910	39,282	39,653	40,024		38,539
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
65 +	Kittitas	6,760	7,055	7,351	7,647	8,300	8,482	8,664	8,846	9,028	9,210		8,482

WAC 246-310-290(8)(a) Step 1:						
		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:										
Ages 0-64	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Planning area historical resident deaths (OFM)	**2**		78	88	78					**Ages 0 - 64**
Average deaths (2020-2022)	**2**	81								
Projected patient deaths: 21.09%	**3**	17								
Average population (OFM)	**4**	38,539								
Projected population	**N/A**		38,168	38,539	38,910	39,282	39,653	40,024		**Steps 2-4**
Potential volume	**N/A**		17	17	17	17	18	18		

Ages 65+	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
PA historical resident deaths (OFM)	**2**		241	241	261					**Ages 65+**
Average deaths (2020-2022)	**2**	248								
Projected patient deaths: 56.80%	**3**	141								
Average population (OFM)	**4**	8,482								
Projected population	**N/A**		8,300	8,482	8,664	8,846	9,028	9,210		**Steps 2-4**
Potential volume	**N/A**		138	141	144	147	150	153		

All Ages	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Combined age cohorts	**5**		155	158	161	164	167	171		**All Ages**
Current capacity (DOH survey)	**N/A**	152								
Unmet need	**5**		**3**	**6**	**9**	**13**	**16**	**19**		
Unmet need patient days (statewide ALOS)	**6**	61.11	181	376	570	765	959	1,154		**Steps 5-8**
Unmet Average Daily Census (ADC)	**7**		0	1	2	2	3	3		
Agency needed (ADC > 35)	**8**	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Klickitat** ***Select from drop down menu***

Klickitat County Only													
Population information (OFM)													
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
0 - 64	Klickitat	16,082	15,955	15,828	15,702	17,332	17,217	17,103	16,988	16,874	16,759		17,217
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
65 +	Klickitat	5,051	5,310	5,570	5,829	5,403	5,695	5,987	6,280	6,572	6,864		5,695

WAC 246-310-290(8)(a) Step 1:						
		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:										
Ages 0-64	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Planning area historical resident deaths (OFM)	**2**		42	50	50					**Ages 0 - 64**
Average deaths (2020-2022)	**2**	47								
Projected patient deaths: 21.09%	**3**	10								
Average population (OFM)	**4**	17,217								
Projected population	**N/A**		17,332	17,217	17,103	16,988	16,874	16,759		**Steps 2-4**
Potential volume	**N/A**		10	10	10	10	10	10		

Ages 65+	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
PA historical resident deaths (OFM)	**2**		113	164	130					**Ages 65+**
Average deaths (2020-2022)	**2**	136								
Projected patient deaths: 56.80%	**3**	77								
Average population (OFM)	**4**	5,695								
Projected population	**N/A**		5,403	5,695	5,987	6,280	6,572	6,864		**Steps 2-4**
Potential volume	**N/A**		73	77	81	85	89	93		

All Ages	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Combined age cohorts	**5**		83	87	91	95	99	103		**All Ages**
Current capacity (DOH survey)	**N/A**	99								
Unmet need	**5**		**(16)**	**(12)**	**(8)**	**(4)**	**(0)**	**4**		
Unmet need patient days (statewide ALOS)	**6**	61.11	(969)	(731)	(494)	(256)	(19)	219		**Steps 5-8**
Unmet Average Daily Census (ADC)	**7**		(3)	(2)	(1)	(1)	(0)	1		
Agency needed (ADC > 35)	**8**	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Lewis** ***Select from drop down menu***

Lewis County Only													
Population information (OFM)													
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
0 - 64	Lewis	61,796	62,097	62,398	62,700	63,604	63,811	64,018	64,225	64,432	64,639		63,811
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
65 +	Lewis	15,576	15,987	16,398	16,808	18,545	18,899	19,253	19,608	19,962	20,316		18,899

WAC 246-310-290(8)(a) Step 1:						
		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:										
Ages 0-64	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Planning area historical resident deaths (OFM)	**2**		205	186	191					**Ages 0 - 64**
Average deaths (2020-2022)	**2**	194								
Projected patient deaths: 21.09%	**3**	41								
Average population (OFM)	**4**	63,811								
Projected population	**N/A**		63,604	63,811	64,018	64,225	64,432	64,639		**Steps 2-4**
Potential volume	**N/A**		41	41	41	41	41	41		

Ages 65+	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
PA historical resident deaths (OFM)	**2**		653	723	753					**Ages 65+**
Average deaths (2020-2022)	**2**	710								
Projected patient deaths: 56.80%	**3**	403								
Average population (OFM)	**4**	18,899								
Projected population	**N/A**		18,545	18,899	19,253	19,608	19,962	20,316		**Steps 2-4**
Potential volume	**N/A**		396	403	411	418	426	433		

All Ages	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Combined age cohorts	**5**		436	444	452	459	467	475		**All Ages**
Current capacity (DOH survey)	**N/A**	454								
Unmet need	**5**		**(17)**	**(10)**	**(2)**	**6**	**13**	**21**		
Unmet need patient days (statewide ALOS)	**6**	61.11	(1,062)	(593)	(123)	347	817	1,286		**Steps 5-8**
Unmet Average Daily Census (ADC)	**7**		(3)	(2)	(0)	1	2	4		
Agency needed (ADC > 35)	**8**	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
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Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Lincoln** ***Select from drop down menu***

Lincoln County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Lincoln	8,042	7,982	7,923	7,864	7,814	7,804	7,794	7,785	7,775	7,765		7,804
Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
65 +	Lincoln	2,687	2,755	2,823	2,891	3,062	3,116	3,169	3,223	3,276	3,330		3,116

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025	
Planning area historical resident deaths (OFM)	2		15	24	24				Ages 0 - 64 Steps 2-4
Average deaths (2020-2022)	2	21							
Projected patient deaths: 21.09%	3	4							
Average population (OFM)	4	7,804							
Projected population	N/A		7,814	7,804	7,794	7,785	7,775	7,765	
Potential volume	N/A		4	4	4	4	4	4	

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025	
PA historical resident deaths (OFM)	2		75	76	67				Ages 65+ Steps 2-4
Average deaths (2020-2022)	2	73							
Projected patient deaths: 56.80%	3	41							
Average population (OFM)	4	3,116							
Projected population	N/A		3,062	3,116	3,169	3,223	3,276	3,330	
Potential volume	N/A		41	41	42	43	43	44	

All Ages	Step	Result	2020	2021	2022	2023	2024	2025	
Combined age cohorts	5		45	46	46	47	48	49	All Ages Steps 5-8
Current capacity (DOH survey)	N/A	21							
Unmet need	5		**24**	**25**	**25**	**26**	**27**	**28**	
Unmet need patient days (statewide ALOS)	6	61.11	1,466	1,509	1,552	1,595	1,639	1,682	
Unmet Average Daily Census (ADC)	7		4	4	4	4	4	5	
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Mason** ***Select from drop down menu***

Mason County Only													
Population information (OFM)													
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
0 - 64	Mason	49,162	49,652	50,142	50,632	49,799	49,998	50,196	50,395	50,594	50,793		49,998
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
65 +	Mason	14,123	14,717	15,311	15,905	15,927	16,436	16,945	17,453	17,962	18,471		16,436

WAC 246-310-290(8)(a) Step 1:						
		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:										
Ages 0-64	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Planning area historical resident deaths (OFM)	**2**		143	168	152					**Ages 0 - 64**
Average deaths (2020-2022)	**2**	154								
Projected patient deaths: 21.09%	**3**	33								
Average population (OFM)	**4**	49,998								
Projected population	**N/A**		49,799	49,998	50,196	50,395	50,594	50,793		**Steps 2-4**
Potential volume	**N/A**		32	33	33	33	33	33		

Ages 65+	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
PA historical resident deaths (OFM)	**2**		408	461	414					**Ages 65+**
Average deaths (2020-2022)	**2**	428								
Projected patient deaths: 56.80%	**3**	243								
Average population (OFM)	**4**	16,436								
Projected population	**N/A**		15,927	16,436	16,945	17,453	17,962	18,471		**Steps 2-4**
Potential volume	**N/A**		235	243	250	258	265	273		

All Ages	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Combined age cohorts	**5**		268	275	283	291	298	306		**All Ages**
Current capacity (DOH survey)	**N/A**	525								
Unmet need	**5**		**(257)**	**(249)**	**(242)**	**(234)**	**(226)**	**(219)**		
Unmet need patient days (statewide ALOS)	**6**	61.11	(15,698)	(15,230)	(14,763)	(14,296)	(13,828)	(13,361)		**Steps 5-8**
Unmet Average Daily Census (ADC)	**7**		(43)	(42)	(40)	(39)	(38)	(37)		
Agency needed (ADC > 35)	**8**	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
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Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Okanogan** ***Select from drop down menu***

Okanogan County Only													
Population information (OFM)													
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
0 - 64	Okanogan	32,906	32,726	32,545	32,364	32,082	31,910	31,737	31,564	31,392	31,219		31,910
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
65 +	Okanogan	9,198	9,624	10,050	10,475	10,022	10,353	10,685	11,017	11,348	11,680		10,353

WAC 246-310-290(8)(a) Step 1:						
		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:										
Ages 0-64	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Planning area historical resident deaths (OFM)	**2**		88	92	106					**Ages 0 - 64** **Steps 2-4**
Average deaths (2020-2022)	**2**	95								
Projected patient deaths: 21.09%	**3**	20								
Average population (OFM)	**4**	31,910								
Projected population	**N/A**		32,082	31,910	31,737	31,564	31,392	31,219		
Potential volume	**N/A**		20	20	20	20	20	20		

Ages 65+	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
PA historical resident deaths (OFM)	**2**		277	324	341					**Ages 65+** **Steps 2-4**
Average deaths (2020-2022)	**2**	314								
Projected patient deaths: 56.80%	**3**	178								
Average population (OFM)	**4**	10,353								
Projected population	**N/A**		10,022	10,353	10,685	11,017	11,348	11,680		
Potential volume	**N/A**		173	178	184	190	195	201		

All Ages	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Combined age cohorts	**5**		193	198	204	210	215	221		**All Ages** **Steps 5-8**
Current capacity (DOH survey)	**N/A**	183								
Unmet need	**5**		**10**	**15**	**21**	**27**	**32**	**38**		
Unmet need patient days (statewide ALOS)	**6**	61.11	601	944	1,286	1,629	1,971	2,313		
Unmet Average Daily Census (ADC)	**7**		2	3	4	4	5	6		
Agency needed (ADC > 35)	**8**	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
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Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Pacific** ***Select from drop down menu***

Pacific County Only													
Population information (OFM)													
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
0 - 64	Pacific	14,972	14,830	14,688	14,545	15,581	15,523	15,464	15,405	15,346	15,287		15,523
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
65 +	Pacific	6,258	6,421	6,584	6,747	7,784	7,971	8,159	8,347	8,534	8,722		7,971

WAC 246-310-290(8)(a) Step 1:						
		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:										
Ages 0-64	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Planning area historical resident deaths (OFM)	**2**		55	59	69					**Ages 0 - 64**
Average deaths (2020-2022)	**2**	61								
Projected patient deaths: 21.09%	**3**	13								
Average population (OFM)	**4**	15,523								
Projected population	**N/A**		15,581	15,523	15,464	15,405	15,346	15,287		**Steps 2-4**
Potential volume	**N/A**		13	13	13	13	13	13		

Ages 65+	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
PA historical resident deaths (OFM)	**2**		177	239	235					**Ages 65+**
Average deaths (2020-2022)	**2**	217								
Projected patient deaths: 56.80%	**3**	123								
Average population (OFM)	**4**	7,971								
Projected population	**N/A**		7,784	7,971	8,159	8,347	8,534	8,722		**Steps 2-4**
Potential volume	**N/A**		120	123	126	129	132	135		

All Ages	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Combined age cohorts	**5**		133	136	139	142	145	148		**All Ages**
Current capacity (DOH survey)	**N/A**	65								
Unmet need	**5**		**68**	**71**	**74**	**76**	**79**	**82**		
Unmet need patient days (statewide ALOS)	**6**	61.11	4,151	4,325	4,499	4,674	4,848	5,023		**Steps 5-8**
Unmet Average Daily Census (ADC)	**7**		11	12	12	13	13	14		
Agency needed (ADC > 35)	**8**	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Pend Oreille** ***Select from drop down menu***

Pend Oreille County Only													
Population information (OFM)													
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
0 - 64	Pend Oreille	9,998	9,952	9,905	9,859	9,718	9,660	9,602	9,543	9,485	9,427		9,660
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
65 +	Pend Oreille	3,378	3,560	3,742	3,925	3,683	3,845	4,007	4,170	4,332	4,494		3,845

WAC 246-310-290(8)(a) Step 1:						
		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:										
Ages 0-64	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Planning area historical resident deaths (OFM)	**2**		41	55	44					**Ages 0 - 64**
Average deaths (2020-2022)	**2**	47								
Projected patient deaths: 21.09%	**3**	10								
Average population (OFM)	**4**	9,660								
Projected population	**N/A**		9,718	9,660	9,602	9,543	9,485	9,427		**Steps 2-4**
Potential volume	**N/A**		10	10	10	10	10	10		

Ages 65+	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
PA historical resident deaths (OFM)	**2**		101	119	127					**Ages 65+**
Average deaths (2020-2022)	**2**	116								
Projected patient deaths: 56.80%	**3**	66								
Average population (OFM)	**4**	3,845								
Projected population	**N/A**		3,683	3,845	4,007	4,170	4,332	4,494		**Steps 2-4**
Potential volume	**N/A**		63	66	68	71	74	77		

All Ages	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Combined age cohorts	**5**		73	76	78	81	84	86		**All Ages**
Current capacity (DOH survey)	**N/A**	65								
Unmet need	**5**		**7**	**10**	**13**	**16**	**18**	**21**		
Unmet need patient days (statewide ALOS)	**6**	61.11	458	623	789	955	1,121	1,286		**Steps 5-8**
Unmet Average Daily Census (ADC)	**7**		1	2	2	3	3	4		
Agency needed (ADC > 35)	**8**	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Pierce** ***Select from drop down menu***

Pierce County Only													
Population information (OFM)													
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
0 - 64	Pierce	729,937	738,738	747,538	756,339	786,960	790,591	794,221	797,852	801,483	805,114		790,591
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
65 +	Pierce	114,409	119,836	125,262	130,688	133,433	139,235	145,038	150,840	156,642	162,444		139,235

WAC 246-310-290(8)(a) Step 1:						
		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:										
Ages 0-64	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Planning area historical resident deaths (OFM)	**2**		2,364	2,574	2,518					**Ages 0 - 64**
Average deaths (2020-2022)	**2**	2,485								
Projected patient deaths: 21.09%	**3**	524								
Average population (OFM)	**4**	790,591								
Projected population	**N/A**		786,960	790,591	794,221	797,852	801,483	805,114		**Steps 2-4**
Potential volume	**N/A**		522	524	527	529	531	534		

Ages 65+	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
PA historical resident deaths (OFM)	**2**		5,608	6,264	6,412					**Ages 65+**
Average deaths (2020-2022)	**2**	6,095								
Projected patient deaths: 56.80%	**3**	3,461								
Average population (OFM)	**4**	139,235								
Projected population	**N/A**		133,433	139,235	145,038	150,840	156,642	162,444		**Steps 2-4**
Potential volume	**N/A**		3,317	3,461	3,606	3,750	3,894	4,038		

All Ages	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Combined age cohorts	**5**		3,839	3,986	4,132	4,279	4,426	4,572		**All Ages**
Current capacity (DOH survey)	**N/A**	4,244								
Unmet need	**5**		**(405)**	**(259)**	**(112)**	**35**	**181**	**328**		
Unmet need patient days (statewide ALOS)	**6**	61.11	(24,774)	(15,812)	(6,850)	2,112	11,074	20,036		**Steps 5-8**
Unmet Average Daily Census (ADC)	**7**		(68)	(43)	(19)	6	30	55		
Agency needed (ADC > 35)	**8**	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**1**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **San Juan** ***Select from drop down menu***

San Juan County Only													
Population information (OFM)													
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
0 - 64	San Juan	11,194	11,084	10,974	10,863	11,697	11,682	11,668	11,654	11,640	11,626		11,682
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
65 +	San Juan	5,099	5,322	5,545	5,768	6,091	6,326	6,561	6,796	7,030	7,265		6,326

WAC 246-310-290(8)(a) Step 1:						
		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:										
Ages 0-64	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Planning area historical resident deaths (OFM)	**2**		18	24	12					**Ages 0 - 64**
Average deaths (2020-2022)	**2**	18								
Projected patient deaths: 21.09%	**3**	4								
Average population (OFM)	**4**	11,682								
Projected population	**N/A**		11,697	11,682	11,668	11,654	11,640	11,626		**Steps 2-4**
Potential volume	**N/A**		4	4	4	4	4	4		

Ages 65+	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
PA historical resident deaths (OFM)	**2**		94	91	78					**Ages 65+**
Average deaths (2020-2022)	**2**	88								
Projected patient deaths: 56.80%	**3**	50								
Average population (OFM)	**4**	6,326								
Projected population	**N/A**		6,091	6,326	6,561	6,796	7,030	7,265		**Steps 2-4**
Potential volume	**N/A**		48	50	52	53	55	57		

All Ages	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Combined age cohorts	**5**		52	54	55	57	59	61		**All Ages**
Current capacity (DOH survey)	**N/A**	99								
Unmet need	**5**		**(47)**	**(45)**	**(44)**	**(42)**	**(40)**	**(38)**		
Unmet need patient days (statewide ALOS)	**6**	61.11	(2,888)	(2,775)	(2,663)	(2,550)	(2,437)	(2,325)		**Steps 5-8**
Unmet Average Daily Census (ADC)	**7**		(8)	(8)	(7)	(7)	(7)	(6)		
Agency needed (ADC > 35)	**8**	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
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Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Skagit** ***Select from drop down menu***

Skagit County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Skagit	98,616	99,346	100,076	100,807	100,150	100,574	100,998	101,422	101,846	102,270		100,574
Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
65 +	Skagit	24,021	25,308	26,595	27,881	29,373	30,250	31,128	32,005	32,882	33,759		30,250

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025	
Planning area historical resident deaths (OFM)	2		269	334	258				Ages 0 - 64 Steps 2-4
Average deaths (2020-2022)	2	287							
Projected patient deaths: 21.09%	3	61							
Average population (OFM)	4	100,574							
Projected population	N/A		100,150	100,574	100,998	101,422	101,846	102,270	
Potential volume	N/A		60	61	61	61	61	62	

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025	
PA historical resident deaths (OFM)	2		1,068	1,190	1,215				Ages 65+ Steps 2-4
Average deaths (2020-2022)	2	1,158							
Projected patient deaths: 56.80%	3	658							
Average population (OFM)	4	30,250							
Projected population	N/A		29,373	30,250	31,128	32,005	32,882	33,759	
Potential volume	N/A		638	658	677	696	715	734	

All Ages	Step	Result	2020	2021	2022	2023	2024	2025	
Combined age cohorts	5		699	718	737	757	776	795	All Ages Steps 5-8
Current capacity (DOH survey)	N/A	791							
Unmet need	5		**(93)**	**(73)**	**(54)**	**(35)**	**(15)**	**4**	
Unmet need patient days (statewide ALOS)	6	61.11	(5,661)	(4,480)	(3,299)	(2,119)	(938)	243	
Unmet Average Daily Census (ADC)	7		(16)	(12)	(9)	(6)	(3)	1	
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Skamania** ***Select from drop down menu***

Skamania County Only													
Population information (OFM)													
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
0 - 64	Skamania	9,266	9,260	9,254	9,248	9,366	9,243	9,121	8,998	8,875	8,752		9,243
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
65 +	Skamania	2,286	2,414	2,542	2,670	2,238	2,455	2,673	2,891	3,108	3,326		2,455

WAC 246-310-290(8)(a) Step 1:						
		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:										
Ages 0-64	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Planning area historical resident deaths (OFM)	**2**		26	25	20					**Ages 0 - 64**
Average deaths (2020-2022)	**2**	24								
Projected patient deaths: 21.09%	**3**	5								
Average population (OFM)	**4**	9,243								
Projected population	**N/A**		9,366	9,243	9,121	8,998	8,875	8,752		**Steps 2-4**
Potential volume	**N/A**		5	5	5	5	5	5		

Ages 65+	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
PA historical resident deaths (OFM)	**2**		47	56	60					**Ages 65+**
Average deaths (2020-2022)	**2**	54								
Projected patient deaths: 56.80%	**3**	31								
Average population (OFM)	**4**	2,455								
Projected population	**N/A**		2,238	2,455	2,673	2,891	3,108	3,326		**Steps 2-4**
Potential volume	**N/A**		28	31	34	36	39	42		

All Ages	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Combined age cohorts	**5**		33	36	39	41	44	47		**All Ages**
Current capacity (DOH survey)	**N/A**	42								
Unmet need	**5**		**(8)**	**(6)**	**(3)**	**(0)**	**2**	**5**		
Unmet need patient days (statewide ALOS)	**6**	61.11	(519)	(355)	(192)	(29)	134	297		**Steps 5-8**
Unmet Average Daily Census (ADC)	**7**		(1)	(1)	(1)	(0)	0	1		
Agency needed (ADC > 35)	**8**	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Snohomish** ***Select from drop down menu***

Snohomish County Only													
Population information (OFM)													
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
0 - 64	Snohomish	672,806	683,800	694,793	705,787	708,361	712,731	717,100	721,470	725,839	730,209		712,731
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
65 +	Snohomish	101,674	107,560	113,447	119,333	119,596	125,852	132,107	138,363	144,618	150,874		125,852

WAC 246-310-290(8)(a) Step 1:						
		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:										
Ages 0-64	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Planning area historical resident deaths (OFM)	**2**		1,587	1,563	1,468					**Ages 0 - 64**
Average deaths (2020-2022)	**2**	1,539								
Projected patient deaths: 21.09%	**3**	325								
Average population (OFM)	**4**	712,731								
Projected population	**N/A**		708,361	712,731	717,100	721,470	725,839	730,209		**Steps 2-4**
Potential volume	**N/A**		323	325	327	329	331	333		

Ages 65+	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
PA historical resident deaths (OFM)	**2**		4,278	4,478	4,833					**Ages 65+**
Average deaths (2020-2022)	**2**	4,530								
Projected patient deaths: 56.80%	**3**	2,573								
Average population (OFM)	**4**	125,852								
Projected population	**N/A**		119,596	125,852	132,107	138,363	144,618	150,874		**Steps 2-4**
Potential volume	**N/A**		2,445	2,573	2,701	2,828	2,956	3,084		

All Ages	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Combined age cohorts	**5**		2,767	2,897	3,027	3,157	3,287	3,417		**All Ages**
Current capacity (DOH survey)	**N/A**	4,217								
Unmet need	**5**		**(1,450)**	**(1,320)**	**(1,190)**	**(1,060)**	**(930)**	**(800)**		
Unmet need patient days (statewide ALOS)	**6**	61.11	(88,586)	(80,650)	(72,714)	(64,778)	(56,842)	(48,905)		**Steps 5-8**
Unmet Average Daily Census (ADC)	**7**		(243)	(220)	(199)	(177)	(156)	(134)		
Agency needed (ADC > 35)	**8**	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Spokane** ***Select from drop down menu***

Spokane County Only													
Population information (OFM)													
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
0 - 64	Spokane	416,684	418,875	421,066	423,256	446,453	447,909	449,365	450,821	452,277	453,733		447,909
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
65 +	Spokane	77,325	80,834	84,343	87,852	92,886	96,172	99,458	102,744	106,030	109,316		96,172

WAC 246-310-290(8)(a) Step 1:						
		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:										
Ages 0-64	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Planning area historical resident deaths (OFM)	**2**		1,634	1,842	1,603					**Ages 0 - 64**
Average deaths (2020-2022)	**2**	1,693								
Projected patient deaths: 21.09%	**3**	357								
Average population (OFM)	**4**	447,909								
Projected population	**N/A**		446,453	447,909	449,365	450,821	452,277	453,733		**Steps 2-4**
Potential volume	**N/A**		356	357	358	359	360	362		

Ages 65+	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
PA historical resident deaths (OFM)	**2**		4,322	4,810	4,603					**Ages 65+**
Average deaths (2020-2022)	**2**	4,578								
Projected patient deaths: 56.80%	**3**	2,600								
Average population (OFM)	**4**	96,172								
Projected population	**N/A**		92,886	96,172	99,458	102,744	106,030	109,316		**Steps 2-4**
Potential volume	**N/A**		2,511	2,600	2,689	2,778	2,867	2,956		

All Ages	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Combined age cohorts	**5**		2,867	2,957	3,047	3,137	3,227	3,317		**All Ages**
Current capacity (DOH survey)	**N/A**	3,196								
Unmet need	**5**		**(328)**	**(238)**	**(148)**	**(58)**	**32**	**122**		
Unmet need patient days (statewide ALOS)	**6**	61.11	(20,067)	(14,567)	(9,067)	(3,566)	1,934	7,435		**Steps 5-8**
Unmet Average Daily Census (ADC)	**7**		(55)	(40)	(25)	(10)	5	20		
Agency needed (ADC > 35)	**8**	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Stevens** ***Select from drop down menu***

Stevens County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Stevens	34,459	34,343	34,226	34,109	36,029	35,790	35,550	35,311	35,071	34,832		35,790
Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
65 +	Stevens	9,930	10,407	10,884	11,360	10,416	11,029	11,642	12,255	12,868	13,481		11,029

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025	
Planning area historical resident deaths (OFM)	2		86	114	107				Ages 0 - 64 Steps 2-4
Average deaths (2020-2022)	2	102							
Projected patient deaths: 21.09%	3	22							
Average population (OFM)	4	35,790							
Projected population	N/A		36,029	35,790	35,550	35,311	35,071	34,832	
Potential volume	N/A		22	22	21	21	21	21	

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025	
PA historical resident deaths (OFM)	2		248	304	336				Ages 65+ Steps 2-4
Average deaths (2020-2022)	2	296							
Projected patient deaths: 56.80%	3	168							
Average population (OFM)	4	11,029							
Projected population	N/A		10,416	11,029	11,642	12,255	12,868	13,481	
Potential volume	N/A		159	168	177	187	196	205	

All Ages	Step	Result	2020	2021	2022	2023	2024	2025	
Combined age cohorts	5		180	190	199	208	217	226	All Ages Steps 5-8
Current capacity (DOH survey)	N/A	148							
Unmet need	5		**32**	**41**	**51**	**60**	**69**	**78**	
Unmet need patient days (statewide ALOS)	6	61.11	1,965	2,528	3,090	3,652	4,214	4,777	
Unmet Average Daily Census (ADC)	7		5	7	8	10	12	13	
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Thurston** ***Select from drop down menu***

Thurston County Only													
Population information (OFM)													
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
0 - 64	Thurston	228,261	231,571	234,880	238,190	240,351	242,356	244,360	246,365	248,369	250,374		242,356
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
65 +	Thurston	44,534	46,608	48,683	50,757	54,442	56,276	58,110	59,944	61,778	63,612		56,276

WAC 246-310-290(8)(a) Step 1:						
		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:										
Ages 0-64	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Planning area historical resident deaths (OFM)	**2**		628	763	709					**Ages 0 - 64**
Average deaths (2020-2022)	**2**	700								
Projected patient deaths: 21.09%	**3**	148								
Average population (OFM)	**4**	242,356								
Projected population	**N/A**		240,351	242,356	244,360	246,365	248,369	250,374		**Steps 2-4**
Potential volume	**N/A**		146	148	149	150	151	152		

Ages 65+	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
PA historical resident deaths (OFM)	**2**		2,007	2,285	2,419					**Ages 65+**
Average deaths (2020-2022)	**2**	2,237								
Projected patient deaths: 56.80%	**3**	1,271								
Average population (OFM)	**4**	56,276								
Projected population	**N/A**		54,442	56,276	58,110	59,944	61,778	63,612		**Steps 2-4**
Potential volume	**N/A**		1,229	1,271	1,312	1,353	1,395	1,436		

All Ages	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Combined age cohorts	**5**		1,375	1,418	1,461	1,503	1,546	1,589		**All Ages**
Current capacity (DOH survey)	**N/A**	1,766								
Unmet need	**5**		**(391)**	**(348)**	**(306)**	**(263)**	**(220)**	**(178)**		
Unmet need patient days (statewide ALOS)	**6**	61.11	(23,884)	(21,279)	(18,674)	(16,069)	(13,464)	(10,859)		**Steps 5-8**
Unmet Average Daily Census (ADC)	**7**		(65)	(58)	(51)	(44)	(37)	(30)		
Agency needed (ADC > 35)	**8**	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
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Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Wahkiakum** ***Select from drop down menu***

Wahkiakum County Only													
Population information (OFM)													
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
0 - 64	Wahkiakum	2,669	2,612	2,555	2,498	2,957	2,943	2,930	2,917	2,903	2,890		2,943
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
65 +	Wahkiakum	1,316	1,379	1,441	1,503	1,465	1,512	1,558	1,604	1,651	1,697		1,512

WAC 246-310-290(8)(a) Step 1:						
		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:										
Ages 0-64	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Planning area historical resident deaths (OFM)	**2**		10	7	9					**Ages 0 - 64**
Average deaths (2020-2022)	**2**	9								
Projected patient deaths: 21.09%	**3**	2								
Average population (OFM)	**4**	2,943								
Projected population	**N/A**		2,957	2,943	2,930	2,917	2,903	2,890		**Steps 2-4**
Potential volume	**N/A**		2	2	2	2	2	2		

Ages 65+	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
PA historical resident deaths (OFM)	**2**		18	25	24					**Ages 65+**
Average deaths (2020-2022)	**2**	22								
Projected patient deaths: 56.80%	**3**	13								
Average population (OFM)	**4**	1,512								
Projected population	**N/A**		1,465	1,512	1,558	1,604	1,651	1,697		**Steps 2-4**
Potential volume	**N/A**		12	13	13	13	14	14		

All Ages	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Combined age cohorts	**5**		14	15	15	15	16	16		**All Ages**
Current capacity (DOH survey)	**N/A**	14								
Unmet need	**5**		**(0)**	**0**	**1**	**1**	**1**	**2**		
Unmet need patient days (statewide ALOS)	**6**	61.11	(12)	11	34	57	81	104		**Steps 5-8**
Unmet Average Daily Census (ADC)	**7**		(0)	0	0	0	0	0		
Agency needed (ADC > 35)	**8**	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
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Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Walla Walla** ***Select from drop down menu***

Walla Walla County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Walla Walla	50,111	50,328	50,546	50,763	50,358	50,364	50,370	50,376	50,382	50,388		50,364
Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
65 +	Walla Walla	10,819	10,881	10,944	11,006	12,226	12,446	12,666	12,886	13,106	13,326		12,446

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	21.09%
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	56.80%
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025	
Planning area historical resident deaths (OFM)	2		150	138	157				Ages 0 - 64 Steps 2-4
Average deaths (2020-2022)	2	148							
Projected patient deaths: 21.09%	3	31							
Average population (OFM)	4	50,364							
Projected population	N/A		50,358	50,364	50,370	50,376	50,382	50,388	
Potential volume	N/A		31	31	31	31	31	31	

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025	
PA historical resident deaths (OFM)	2		522	595	598				Ages 65+ Steps 2-4
Average deaths (2020-2022)	2	572							
Projected patient deaths: 56.80%	3	325							
Average population (OFM)	4	12,446							
Projected population	N/A		12,226	12,446	12,666	12,886	13,106	13,326	
Potential volume	N/A		319	325	330	336	342	348	

All Ages	Step	Result	2020	2021	2022	2023	2024	2025	
Combined age cohorts	5		350	356	362	367	373	379	All Ages Steps 5-8
Current capacity (DOH survey)	N/A	280							
Unmet need	5		**70**	**76**	**81**	**87**	**93**	**99**	
Unmet need patient days (statewide ALOS)	6	61.11	4,271	4,622	4,972	5,323	5,674	6,025	
Unmet Average Daily Census (ADC)	7		12	13	14	15	16	16	
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Whatcom** ***Select from drop down menu***

Whatcom County Only													
Population information (OFM)													
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
0 - 64	Whatcom	178,234	180,629	183,023	185,418	184,193	185,493	186,794	188,095	189,395	190,696		185,493
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
65 +	Whatcom	35,688	37,426	39,164	40,902	42,654	44,049	45,443	46,838	48,232	49,627		44,049

WAC 246-310-290(8)(a) Step 1:						
		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:										
Ages 0-64	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Planning area historical resident deaths (OFM)	**2**		457	443	467					**Ages 0 - 64 Steps 2-4**
Average deaths (2020-2022)	**2**	456								
Projected patient deaths: 21.09%	**3**	96								
Average population (OFM)	**4**	185,493								
Projected population	**N/A**		184,193	185,493	186,794	188,095	189,395	190,696		
Potential volume	**N/A**		95	96	97	97	98	99		

Ages 65+	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
PA historical resident deaths (OFM)	**2**		1,481	1,674	1,653					**Ages 65+ Steps 2-4**
Average deaths (2020-2022)	**2**	1,603								
Projected patient deaths: 56.80%	**3**	910								
Average population (OFM)	**4**	44,049								
Projected population	**N/A**		42,654	44,049	45,443	46,838	48,232	49,627		
Potential volume	**N/A**		881	910	939	968	997	1,026		

All Ages	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Combined age cohorts	**5**		977	1,006	1,036	1,065	1,095	1,124		**All Ages Steps 5-8**
Current capacity (DOH survey)	**N/A**	1,718								
Unmet need	**5**		**(741)**	**(712)**	**(683)**	**(653)**	**(624)**	**(594)**		
Unmet need patient days (statewide ALOS)	**6**	61.11	(45,313)	(43,511)	(41,708)	(39,906)	(38,104)	(36,302)		
Unmet Average Daily Census (ADC)	**7**		(124)	(119)	(114)	(109)	(104)	(99)		
Agency needed (ADC > 35)	**8**	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
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Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Whitman** ***Select from drop down menu***

Whitman County Only													
Population information (OFM)													
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
0 - 64	Whitman	42,965	43,051	43,137	43,222	42,475	42,489	42,503	42,517	42,531	42,545		42,489
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
65 +	Whitman	4,659	4,948	5,237	5,526	5,498	5,619	5,739	5,860	5,980	6,101		5,619

WAC 246-310-290(8)(a) Step 1:						
		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:										
Ages 0-64	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Planning area historical resident deaths (OFM)	**2**		51	59	65					**Ages 0 - 64**
Average deaths (2020-2022)	**2**	58								
Projected patient deaths: 21.09%	**3**	12								
Average population (OFM)	**4**	42,489								
Projected population	**N/A**		42,475	42,489	42,503	42,517	42,531	42,545		**Steps 2-4**
Potential volume	**N/A**		12	12	12	12	12	12		

Ages 65+	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
PA historical resident deaths (OFM)	**2**		226	278	233					**Ages 65+**
Average deaths (2020-2022)	**2**	246								
Projected patient deaths: 56.80%	**3**	140								
Average population (OFM)	**4**	5,619								
Projected population	**N/A**		5,498	5,619	5,739	5,860	5,980	6,101		**Steps 2-4**
Potential volume	**N/A**		137	140	143	146	149	151		

All Ages	**Step**	**Result**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Combined age cohorts	**5**		149	152	155	158	161	164		**All Ages**
Current capacity (DOH survey)	**N/A**	113								
Unmet need	**5**		**36**	**39**	**42**	**45**	**48**	**51**		**Steps 5-8**
Unmet need patient days (statewide ALOS)	**6**	61.11	2,210	2,393	2,576	2,759	2,943	3,126		
Unmet Average Daily Census (ADC)	**7**		6	7	7	8	8	9		
Agency needed (ADC > 35)	**8**	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
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Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Yakima** ***Select from drop down menu***

Yakima County Only													
Population information (OFM)													
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
0 - 64	Yakima	217,605	219,328	221,051	222,774	219,274	219,628	219,982	220,336	220,690	221,044		219,628
Ages	**County**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		**2020-2022 Avgerage**
65 +	Yakima	34,949	35,809	36,670	37,530	37,454	38,467	39,479	40,491	41,504	42,516		38,467

WAC 246-310-290(8)(a) Step 1:						
		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	**2021**	**2022**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025	
Planning area historical resident deaths (OFM)	2		653	699	628				**Ages 0 - 64**
Average deaths (2020-2022)	2	660							
Projected patient deaths: 21.09%	3	139							
Average population (OFM)	4	219,628							
Projected population	N/A		219,274	219,628	219,982	220,336	220,690	221,044	**Steps 2-4**
Potential volume	N/A		139	139	139	140	140	140	

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025	
PA historical resident deaths (OFM)	2		1,675	1,644	1,682				**Ages 65+**
Average deaths (2020-2022)	2	1,667							
Projected patient deaths: 56.80%	3	947							
Average population (OFM)	4	38,467							
Projected population	N/A		37,454	38,467	39,479	40,491	41,504	42,516	**Steps 2-4**
Potential volume	N/A		922	947	972	997	1,022	1,046	

All Ages	Step	Result	2020	2021	2022	2023	2024	2025	
Combined age cohorts	5		1,061	1,086	1,111	1,136	1,161	1,187	**All Ages**
Current capacity (DOH survey)	N/A	1,088							
Unmet need	5		**(27)**	**(2)**	**23**	**49**	**74**	**99**	
Unmet need patient days (statewide ALOS)	6	61.11	(1,641)	(104)	1,432	2,968	4,505	6,041	**Steps 5-8**
Unmet Average Daily Census (ADC)	7		(4)	(0)	4	8	12	17	
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Exhibit 4
Financial Assistance Policy

MultiCare	*Administrative*

Document Title: Financial Assistance – Hospital Based Services

Scope:

This policy applies to patients who qualify for Charity Care or Financial Assistance for the services received within the Hospital facilities of MultiCare Health System ("MHS") as provided by MHS.

Locations include: Tacoma General/Allenmore Hospital, Mary Bridge Children's Hospital, Good Samaritan Hospital, Auburn Medical Center, Covington Medical Center, Deaconess Hospital, Valley Hospital, Home Health and Hospice, Navos Behavioral Health Center and Capital Medical Center.

Policy Statement:

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

Definitions:

1. **Collection Efforts** and **Extraordinary Collections Actions** (ECA) are defined by the MHS Collection Guidelines policy.
2. **Charity Care** and/or **Financial Assistance** means medically necessary hospital health care rendered to Eligible Persons when Third-Party Coverage, if any, has been exhausted, to the extent that the persons are unable to pay for the care or to pay deductible or coinsurance amounts required by a third-party payer based on the criteria in this policy. When communicating with patients, the phrase "Financial Assistance" will be used in lieu of "Charity Care." Both terms are synonymous with one another for the purposes of this policy and MHS billing statements.
3. **Eligible Person(s)** is defined as those patients who have exhausted any third-party sources and whose income is equal to or below 400% the federal poverty standards adjusted for family size.
4. **Emergency Medical Conditions** (EMC) are defined by the MHS Emergency Medical Treatment and Active Labor Act (EMTALA), Compliance With policy, which is consistent with WAC 246-453-010.
5. **Family** is defined per WAC 246-453-010 (18) as a group of two or more persons related by birth, marriage or adoption that live together; all such related persons are considered as members of one family.
6. **Income** is defined per WAC 246-453-010(17) as total cash receipts before taxes derived from wages and salaries, welfare payments, Social Security payments, strike benefits, unemployment or disability benefits, child support, alimony and net earnings from business and investment activities.

7. **Medically Necessary** is defined per WAC 246-453-010 (7) as appropriate hospital-based medical services.
8. **Responsible Party** means that individual who is responsible for the payment of any hospital charges not otherwise covered by a funding source as described below.

Policy Guidelines:

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

Emergency care will be provided to patients with Emergent Medical Conditions regardless of their ability to pay. MHS shall allocate resources to identify charity cases and provide uncompensated care per RCW 70.170 and WAC 246- 453. *See* MHS Policy: Emergency Medical Treatment and Active Labor (EMTALA), Compliance With.

MHS supports the state-wide voluntary pledge of hospitals to provide Financial Assistance to Eligible Persons in accordance with the methodology provided and updated annually by the Washington State Hospital Association.

Consideration for Financial Assistance will be given equally to all Eligible Persons, regardless of race, color, sex, religion, age, national origin, veteran's status, marital status, sexual orientation, immigration status or other legally protected status. *See* MHS Policy: Patient Nondiscrimination

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

Lists of providers accepting and not accepting Financial Assistance are available at https://www.multicare.org/financial-assistance/ .

This policy describes the processes for evaluating applications and awarding Financial Assistance for free and discounted care at the following levels based on the Federal Poverty Limit (FPL) adjusted for family size:

1. 100% Financial Assistance - Income levels at or below 300% of the (FPL); or
2. Sliding Scale Financial Assistance - Income levels between 300.5% and 400% of the FPL.

Procedure:

I. Eligibility Criteria

In order for a Responsible Party to be considered eligible for Financial Assistance, the following criteria must be met:

A. *Exhaustion of All Funding Sources*

1. Any of the following sources must first be exhausted before a Responsible Party will be considered for Financial Assistance:
   a. Group or individual medical plans
   b. Workers compensation programs

c. Medicaid programs

d. Other state, federal or military programs

e. Third party liability situations (e.g., auto accidents or personal injuries)

f. Tribal health benefit programs

g. Health care sharing ministry programs

h. Any other persons or entities having a legal responsibility to pay

i. Health saving account (HSA) funds. MHS may require a Responsible Party to fully utilize any available funds from HSA to satisfy outstanding balances.

j. MHS will pursue payment from any available Funding Source. The remaining patient liability will be eligible for Financial Assistance based on the criteria in this policy.

B. *Accurate Completion of Financial Assistance application*.

1. Incomplete applications will be denied. Patients may appeal the denial and provide the missing information per the guidelines set forth below.

2. If the application places an unreasonable burden, taking into account any physical, mental, intellectual, or sensory deficiencies or language barriers which may hinder the Responsible Party's capability of complying with the application procedures on the Responsible Party, then the application process will not be imposed.

C. *Medicaid Eligibility Within 90 Days of Services in Lieu of Application*

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

D. *Presumptive determination or Extraordinary Circumstances*

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

E. *Medically Necessary Health Care Services Rendered*

1. The services provided to the patient must be medically necessary and not elective.

2. Scheduled services that appear to not be medically necessary will be reviewed by Utilization Management prior to the date of service to determine medical necessity.

F. *International Patients*

1. Eligibility determinations for International Patients for non-emergent services will be considered on a case-by-case basis by a committee representing Physician Leadership, Revenue Cycle and Finance.

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

A. *Income Verification*

1. Any of the following types of documentation will be acceptable for purposes of verifying income:
    a. W2 withholding statements
    b. Payroll check stubs
    c. Most recent filed IRS tax returns
    d. Determination of Medicaid and/or state-funded medical assistance
    e. Determination of eligibility for unemployment compensation
    f. Written statements from employers or welfare agencies
2. For Social Security and Pension benefits, bank statements may be used to demonstrate the consistent monthly deposit.
3. In the event the Responsible Party is unable to provide the documentation described above, MHS must rely upon the written and signed statements from the Responsible Party for making a final determination of eligibility.
4. MHS may also use third party verification of ability to make a presumptive determination and apply a charity discount without receiving a financial assistance application.

B. *Calculation of Income*

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

C. *Timing of Determination*

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

III. Process for Determination of Eligibility

A. At the time of registration or as soon as possible following the initiation of services, MultiCare will make an initial determination of eligibility following the patient's review of the FPL grid. If a patient is determined to likely fall below 300% of the FPL, they will not be asked for payment and will be referred to a Patient Financial Navigator (PFN), who will provide additional information about Financial Assistance and other programs that may be available to the patient.

B. Collection activity will cease for 30 calendar days for patients believed to be under 300% of the FPL and the Responsible Party will be asked to complete a Financial Assistance application. If no application is received within 30 days, collection activity will resume.

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

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

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

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

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

IV. Appeals

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

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

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

D. If an appeal is denied, it will be presented to the AVP, Financial Clearance, Vice President of Revenue Cycle or Chief Financial Officer (CFO) for final determination. If this determination affirms the previous denial of Financial Assistance, written notification will be sent to the Responsible Party and the Department of Health in accordance with state law.

E. Collection efforts will be suspended during the thirty (30) calendar day appeal period and the fourteen (14) calendar day appeal review period.

V. Application of Financial Assistance Discount Levels

A. Financial Assistance applies to combined balances for all open accounts for the Responsible Party at time of application submission. The amount owed by an Eligible Person qualifying under this Financial Assistance policy will not exceed amounts generally billed to a Responsible Party not receiving assistance. The method used to calculate the discount to an Eligible Person's balance will be based on an annual retrospective analysis. A rate will be determined for each hospital. This will be calculated using a Look-Back Method pulling a year of claims that have paid in full for Medicare and private/commercial health insurance Responsible Party to determine the "Amount Generally Billed". Patients may obtain information about the Amounts Generally Billed calculations free of charge by calling 800-919-1936.

1. Balances will be considered for Financial Assistance based on the FPL guidelines in Appendix A.
2. If an Eligible Person's residence is in Hawaii or Alaska, the associated FPL guidelines for those states will be utilized to make the determination of assistance.

B. Financial Assistance adjustments will be considered on an individual account balance basis. Approvals on adjustments will be authorized as follows:

1. Patient Financial Navigators: $0.01 - $4,999
2. Supervisor: $5,000 - $49,999
3. Manager/Director: $50,000 - $99,999
4. AVP: $100,000 - $499,999
5. Vice President: $500,000 - $999,999
6. SVP, CFO: $1,000,000 - $2,999,999

C. The volume of applications and adherence to this policy will be tracked and audited on a monthly basis. This report will be reviewed and signed by the Vice President of Revenue Cycle or AVP, Financial Clearance.

VI. Presumptive Eligibility

A. Eligibility may be determined presumptively.

1. MHS may utilize third party vendor software or software applications to determine an account's collectability. This is a "soft" credit check and will not impact the Responsible Party's credit standing.
2. If these reviews determine the patient may be at 300% or below of the FPL, an adjustment will be taken automatically assuming the account otherwise qualifies for Financial Assistance.

VII. Extraordinary Life Circumstances

A. Extraordinary Life Circumstances may also warrant Financial Assistance. Examples of such circumstances may include:

1. **Homeless Persons:** A Homeless person is an individual who has no home or place of residence and depends on charity or public assistance. Such individuals will be eligible for Financial Assistance, even if they are unable to provide the documentation required for the Financial Assistance application.
2. **Deceased Patients:** The charges incurred by a patient who expires may still be considered eligible for Financial Assistance. For the Financial Assistance application, the deceased patient will count as a family member. Accounts in an "Estate" status or situations where the estate has not been opened are not eligible for Financial Assistance until the Estate is settled.
3. **Inmates:** Responsible Party who is incarcerated may be considered eligible in the event the State or County has made a determination that the State or County is not responsible for charges and the inmate/patient is responsible for the bill. Charges incurred while in custody are usually paid through the Law Enforcement Agency and would not qualify for Financial Assistance.
4. **Catastrophic Determinations:** Responsible Party may qualify for a Catastrophic Discount. Only medically necessary services are eligible for a Catastrophic Discount. A Catastrophic event will be determined on a case-by-case basis. Catastrophic cases may include extraordinary medical expenses or hardship situations. All income and non-income resources are considered in the determination, to include the Responsible Party's future income earning

potential, especially where his or her ability to work may be limited as a result of illness and/or their ability to make payments over an extended period of time. All of the debt or a portion of the debt may qualify for Financial Assistance. The Director or Manager of Patient Financial Navigation will assist in making a catastrophic event application determination.

B. Requests for Financial Assistance may originate from other sources including a physician, community or religious groups, social services, financial services personnel, and/or the Responsible Party.

VIII. Individuals that Qualify for Medical Assistance Programs

A. MHS takes the following steps to identify patients or guarantors that may qualify for medical assistance programs under RCW 74.09:

1. Patient Financial Navigators review completed financial assistance applications and will follow up with patients or guarantors that appear to qualify for medical assistance programs.
2. Navigators are available on site at MHS hospital facilities, including our off-campus emergency departments, to identify and screen patients and their guarantors.
3. All self-pay patients admitted to an MHS hospital facility are screened to determine if they qualify for any medical assistance programs.
4. Patients may be referred for screening for coverage or medical assistance programs by Care Managers, Registration staff, and providers.
5. Certified Navigators are located throughout MHS and are available at no cost to help customers sign up for coverage through Washington Healthplanfinder. This service is available to anyone searching for a health plan—not only MHS patients.

B. Once a patient or guarantor is identified as potentially being eligible for a medical assistance program:

1. The patient is screened by a Navigator, who helps determine eligibility for public health care coverage based on household size and income.
2. If the patient's eligibility is confirmed, then a Navigator will partner with the patient and assist the patient in applying for the appropriate health plan.
3. The patient account is flagged to ensure no billing occurs while the application is pending.

C. MHS is not obligated to provide financial assistance if a patient or their guarantor qualifies for retroactive health care coverage under RCW 74.09 and the patient or their guarantor fails to make reasonable efforts to cooperate with a Navigator's attempts to assist them in applying for such coverage.(RCW 70.170.060(5)).

IX. Collection Efforts for Outstanding Patient Accounts

A. MHS will not initiate collection efforts or requests for deposits, provided that the Responsible Party within a reasonable time is cooperative with the system's efforts to reach a determination of Financial Assistance eligibility status. ECA may only be initiated after the Notification Period, in accordance with the MHS Policy: Collection

Guidelines, Patient Accounts.

B. The Responsible Party's financial obligation remaining after application of the sliding fee schedule will follow regular collection procedures to obtain payment, pursuant to Policy.

C. In the event that a Responsible Party pays a portion or all of the charges related to medically necessary health care services, and is subsequently found to have met the Financial Assistance criteria, any payments for services above the qualified amount will be refunded to the Responsible Party within 30 days of the eligibility determination.

X. Staff Training

A. All relevant and appropriate staff supporting Hospital based locations who perform registration, admission, billing, or other related functions shall participate in standardized training based on this Financial Assistance Policy and the use of interpreter services to assist persons with limited English proficiency and non-English-speaking persons in understanding information about the availability of Financial Assistance.

B. The training shall help ensure staff can answer Financial Assistance questions effectively, obtain any necessary interpreter services, and direct inquiries to the appropriate department in a timely manner.

XI. Dissemination of MHS Financial Assistance Policy

A. All patients are provided with information about the availability of Financial Assistance upon registration. Additional copies can be requested from the Hospital Financial Navigators or Patient Access Techs within the hospital facilities.

B. Notices in all languages spoken by more than 10 percent of the population advising patients of the availability of Financial Assistance will be posted in key public areas of the hospital, including Admissions and/or Registration, the Emergency Department, Billing and Financial Services.

C. This policy, the application, and a plain language summary are available to patients free of charge by contacting 800-919-1936.

D. Financial counselors are available to discuss Financial Assistance options in person at all hospital locations or over the phone for other areas of the health system.

E. Billing Statements sent to Responsible Parties will contain information regarding the availability of Financial Assistance in both English and Spanish.

F. Written materials are available in English, Spanish, Russian and Vietnamese. .

G. Wide-reaching community notifications will occur in the following ways:

1. Available at registration areas of all hospital facilities,
2. On MHS website www.multicare.org
3. Communications provided to our community partners for distribution, and
4. Upon request, by calling 800-919-1936

Related Forms:

	Proof of Income for Financial Assistance Instruction Sheet Financial Assistance Application Financial Assistance Letter to Patients Patient Brochure Containing Plain Language Summary
	Appendix A: Financial Assistance
	References: RCW 70.170 WAC 246-453 Federal Register Vol 79, December 31, 2014 Final Rule
	Point of Contact: AVP, Financial Clearance, rcardenas@multicare.org

Approval By:	***Date of Approval:***
Finance Leadership	***12/18, 4/21, 10/21, 4/22***
Corporate Compliance Leadership	***12/18, 4/21, 10/21, 4/22***
System Policy Council	***4/22***
MHS Quality Safety Steering Council	***7/12, 8/13, 7/14, 4/15, 9/19, 5/21, 12/21***
MHS Corporate Board	***10/22***
Original Date:	*5/97*
Revision Dates:	*11/00, 8/03, 2/05, 2/06, 9/08, 11/09, 4/11, 6/12, 8/13, 7/14, 3/15, 2/17, 2/18, 8/18, 9/18, 4/21, 9/21, 4/22, 10/22*
Reviewed with no Changes Dates:	*X/XX; X/XX*

Previously Titled: Charity Care and Financial Assistance (prior to 9/14)

Financial Assistance
Appendix A
2022

FAMILY SIZE	Gross Annual Income	300%	350%	400%
1	$13,590	$40,770	$47,565	$54,360
2	$18,310	$54,930	$64,085	$73,240
3	$23,030	$69,090	$80,605	$92,120
4	$27,750	$83,250	$97,125	$111,000
5	$32,470	$97,410	$113,645	$129,880
6	$37,190	$111,570	$130,165	$148,760
7	$41,910	$125,730	$146,685	$167,640
8	$46,630	$139,890	$163,205	$186,520
9	$51,350	$154,050	$179,725	$205,400
10	$56,070	$168,210	$196,245	$224,280
EACH ADD'L	$4,720			

Poverty Level, Up To		
300%	350%	400%
Charity Discount, %		
100%	75%	60%
Patient Responsibility, %		
0%	25%	40%

Exhibit 5
Admissions Policy

Status **Active** PolicyStat ID **14079952**

Origination	01/2009
Last Approved	08/2023
Effective	08/2023
Last Revised	08/2023
Next Review	08/2026

Owner	Ann Cole: Mgr Home Health Hospice
Area	Home Health and Hospice
Applicability	Multicare Ambulatory

Hospice: Admission

Scope:

Hospice Staff

Policy Statement:

Acceptance of patients to Hospice is based on an initial assessment visit and reasonable expectation that the Hospice program can meet the medical, psychosocial, and spiritual needs of the patient and family. Hospice complies with the Medicare Conditions of Participation.

Procedure:

1. Patients who are identified as having a terminal diagnosis and are being considered for admission to Hospice will be reviewed prior to the admission to determine their appropriateness for Hospice.
    a. The physician must be willing to certify that in his/her best judgment the patient has six months or less to live if the terminal disease continues its "normal" course.
    b. The Local Coverage Determination Guidelines (National Government Services) and/or **Medical Guidelines for Determining Prognosis** are used as a guideline to help determine whether a patient is appropriate for Hospice care and/or eligible for the Medicare/Medicaid Hospice benefit.
2. A request for hospice services may be made by the patient, their family, or the provider.
3. A primary provider must be confirmed to be responsible for the supervision of the mutually established care plan for the patient and their caregivers.
4. Patient meets the following criteria:

a. Has a payor source for Hospice coverage or is applying for uncompensated care.

b. Has a referring physician who will certify a terminal illness with a six-month prognosis and will sign the Plan of Care. The terminal illness must meet the identified guidelines based on diagnosis.

c. Has a home environment safe for the patient, caregivers, and Hospice staff. The Hospice Supervisor or designee screen referrals to determine any safety issues that would place Hospice staff and caregivers at risk. If unacceptable safety risk factors are identified, the referral source and provider will be notified of the decision to not accept the patient for services and alternate resources for the patient's care needs suggested.

d. Desires comfort care that neither hastens nor postpones death, and that the patient no longer desires to pursue curative or life-prolonging treatments.

5. Patients receiving palliative treatment, including but not limited to chemotherapy, radiation therapy, paracentesis, etc., will be reviewed for hospice admission on a case-by-case basis. Admission of patients seeking active interventions requires Hospice approval. Those patients actually admitted to Hospice services must agree to receive palliative treatment through MultiCare or agency-contracted facilities.
6. If using private insurance, the Agency staff will verify the hospice coverage for the patient, including whether palliative treatments can be paid outside of the patient's hospice coverage.
7. Either the signed Certificate of Terminal Illness (CTI) or documented verbal order for admission to Hospice must be received within two (2) calendar days after the beginning of the benefit period (election). The CTI for the first benefit period must be signed, returned, and on file by the plan of care physician and the Medical Director and returned to Medical Records before billing. If a patient has died before a signed CTI has been returned by the plan of care physician, the Medical Director's signature will suffice. For subsequent benefit periods, the CTI must be signed, returned, and on file by either the Medical Director or the plan of care physician prior to billing.
8. An Informed Consent for Patient Care and the Benefit Election Form will be signed by the patient or patient representative.
9. The Hospice Plan of Care will be documented by a nurse within two calendar days of the admission to Hospice.
10. The Hospice Plan of Treatment will be sent to the hospice attending for signature.

References:

CMS 418.20, 418.22
Joint Commission Standard PC.01.01.01
National Hospice and Palliative Care Organization's Medical Guidelines for Determining Prognosis in Selected Non-Cancer Diseases monograph
Local Coverage Determination Guidelines (National Government Services)

Approval Signatures

Step Description	Approver	Date
Council / Committee Approvals	Kimberly Lett: Quality Program Mgr RN	08/2023
Policy Coordinator	Kimberly Lett: Quality Program Mgr RN	08/2023
HH&H Director	Juvy White: Quality Performance Manager-HHHP [MB]	08/2023
	Ann Cole: Mgr Home Health Hospice	07/2023

Standards

No standards are associated with this document

Exhibit 6

Patient Rights and Responsibilities Policy

MultiCare	*Administrative*

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

Scope:

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

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

Policy Statement:

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

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

Procedure:

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

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

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

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

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

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

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

Point of Contact: Executive Director, Patient Access 697.1865

Approval By:	Approval Date:
Patient Registration Leadership	4/19
CapMC Compliance and Ethics Team	7/21
Quality Safety Steering Council	4/14, 1/17, 6/19
Original Date:	*9/90*
Revision Dates:	*3/93, 2/95, 5/96, 11/97, 3/99, 2/01, 2/03, 11/05, 3/09, 4/14, 1/17, 4/19*
Reviewed with no Changes Dates:	*5/12*

Distribution: MSH Intranet

Scope/locations of services updated March, 2017.

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

Approved by QSSC e-vote 8/15/2021 to apply to Capital Medical Center

Exhibit 7
Non-Discrimination Policy

Document Title: Patient Nondiscrimination

Scope:

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

Location Scope:

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

Policy Statement:

MHS does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, creed, religion, age, disability, national origin, language, marital status, sex (including pregnancy), sexual orientation, gender identity or expression, veteran or military status, citizenship or immigration status, or any other basis prohibited by federal or state law in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by MHS directly or through a contractor of any other entity with which MHS arranges to carry out its programs and activities.

This policy applies to MHS Personnel's interactions with patients, vendors, guests, and visitors of MHS. For questions regarding employment discrimination involving MHS, please see the MHS Policy and Procedure "*Equal Employment Opportunity and Employment Law*."

For questions call the Privacy & Civil Rights Office at (253) 459-8300, the Integrity Line at (866) 264-6121 or email compliance@multicare.org.

Special Instructions:

Any person who believes they or any specific class of individuals have been subjected to prohibited discrimination, such person may file a complaint with the MHS Privacy & Civil Rights Office or through the Integrity Line.

All reports will be responded to and investigated by the Privacy & Civil Rights Office. The availability and use of this procedure does not prevent a person from filing a complaint of discrimination with the U.S. Department of Health and Human Services, Office for Civil Rights.

No person will suffer retaliation for reporting discrimination, filing a complaint or cooperating in an investigation of a discrimination complaint.

Procedure:

MHS Personnel will:

1. Treat all patients and visitors receiving services from or participating in other programs of MHS, with equality in a welcoming manner that is free from discrimination based on race, color, creed, religion, age, disability, national origin, marital status, sex (including pregnancy), sexual orientation, gender identity or expression, veteran or military status, or any other basis prohibited by federal or state law.
2. Provide notices to patients regarding this Nondiscrimination Policy and MultiCare Health System's commitment to providing access to and the provision of services in a welcoming, nondiscriminatory manner.
3. Inform patients of the availability of and make reasonable accommodations for patients consistent with federal and state requirements. For example, language interpretation services will be made available for non-English speaking patients and sign language interpretation will be made available for hearing impaired patients.
4. Afford appropriate visitation rights to patients free from discrimination and will ensure that visitors receive equal visitation privileges consistent with patient preferences, safety and other applicable policies. At the time patients are notified of their patient rights, Hospital Personnel will also inform patient, or patient's support person, including the patient's attorney in fact, when appropriate, of the patient's visitation rights, including any clinical or safety restriction on those rights, and the patient's right, subject to the patients consent, to receive visitors whom the patient designates.
5. Determine eligibility for and provide services, financial aid, and other benefits to all patients in a similar manner, without subjecting any individual to separate or different treatment of the basis of race, color, creed, religion, age, disability, national origin, marital status, sex (including pregnancy), sexual orientation, gender identity or expression, veteran or military status, citizenship or immigration status, or any other basis prohibited by federal or state law.

Related Policies:

Compliance and Ethics Program, Reporting and Investigating Concerns of Violations Patient Grievances

Equal Employment Opportunity and Employment Law

Emergency Medical Treatment and Active Labor (EMTALA), Compliance with Employee Complaint Grievance Procedure

References:

Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, Section 1557 if the Patient Protection and Affordable Care Act and Regulations of the U.S. Department of Health and Human Services issued pursuant to:

45 C.F.R. § 80 (2012) – Nondiscrimination under programs receiving Federal assistance through the Department of Health and Human Services effectuation of Title VI of the Civil Rights Act of 1964.

45 C.F.R. § 84 (2012) – Enforcement of nondiscrimination on the basis of handicap in

	programs or activities conducted by the Department of Health and Human Services. 45 C.F.R. § 91 (2012) – Nondiscrimination on the basis of age in programs or activities receiving Federal financial assistance from HHS. RCW 49.60 – Discrimination – Human Rights Commission Idaho Title 67, Chapter 59 – Idaho Human Rights Act 29 U.S.C. § 794 – Nondiscrimination under Federal grants and programs. RCW 49.60 I.C. § 67-5909
	Point of Contact: compliance@multicare.org

Approval By:	***Date of Approval:***
Compliance/Privacy Leadership	***8/19, 8/20***
CapMC Compliance/Privacy	***7/21***
MHS Quality Safety Steering Council	***8/12, 9/17, 9/19, 9/20***
Original Date:	*6/12*
Revision Dates:	*8/17, 8/19, 8/20*
Reviewed with no Changes Dates:	*X/XX; X/XX*

Distribution: MHS Intranet
Approved at SKRB 4/12/18 and QSSC e-vote 4/18/18 to apply to Covington Medical Center
Approved at QSSC September 2019 to apply to Home Health and Hospice
Update scope to include Protected Health Information (PHI) and Personally Identifiable Information (PII) as well as Community-based locations – November, 2020
Approved by QSSC e-vote 8/15/2021 to apply to Capital Medical Center

Exhibit 8
Medical Director Job Description

MULTICARE HEALTH SYSTEM

MultiCare believes that each employee makes a significant contribution to our success. Contributions can be within and outside of assigned responsibilities. It is our expectation that each employee will offer his/her services wherever and whenever necessary to ensure the success of our endeavors.

JOB TITLE: Med Dir-Home Health & Hospice

POSITION CODE: Q3522

DEPARTMENT: Home Health, Hospice

FLSA STATUS: Exempt

REPORTS TO: Executive Dir-HHH

DATE: December 2018

GENERAL DESCRIPTION

As Home Health/Hospice Medical Director, Physician shall be responsible for oversight of the quality of care provided to patients receiving Home Health & Hospice services across the care continuum as well as providing medical leadership for clinical and business planning, medical quality assessment/assurance and continuing medical education.

PRINCIPAL ACCOUNTABILITIES

Core Medical Director Responsibilities:

- Available by phone or in person if needed and is an active participant in the development of the Hospice and Community Palliative Care programs
- Equitable and fair with all physician issues independent of personal, clinical specialty or institutional bias
- Supports the existing MultiCare Health System (MHS) Bylaws and Medical Staff Policy, directions and decisions
- Places the patient's quality of care and safety at the center of any decision regarding medical staff
- Responsible for decisions that are made by the Provider r Staff and supports those decisions to other involved providers with regard to clinical care, behavior and utilization management
- Maintains sufficient clinical contact with Home Health& Hospice Care to make informed decisions
- Supports physician adoption, utilization and optimization of electronic medical record

Specific Home Health & Hospice Responsibilities:

- Assumes responsibility for the medical component of the Hospice program to include patients whose medical needs are not met by an attending physician
- Actively participates and provides leadership in quality management, physician performance issues, clinical guideline development, patient satisfaction initiatives and utilization review
- Provides oversight for other Providers, , participating in Peer Review, Quality Review and communication, providing feedback to physicians regarding clinical and performance issues
- Supports and/or participate in MHS self-regulatory, quality control and/or service enhancement efforts and initiatives, including without limitation MHS's Corporate Compliance Program, internal and external audit activities, credentialing processes, peer review proceedings, utilization management programs, quality improvement programs, discharge planning processes, treatment and other protocols, and pharmaceutical formularies;
- Orients physicians to the "Home health & Hospice care-specific" elements of their position
    - Intervenes in disruptive behavior and conducts corrective discussions
    - Provides leadership in quality initiatives, helping to set targets and engages physicians in said initiatives
    - Audits selected medical records and provides feedback

- Participates in sourcing and recruiting talented physicians

– Collaborates with Home Health and Hospice Leadership to assure adequate staffing and scheduling to meet Clinical Medical Director coverage requirements, ensuring that the service is covered 24 hours per day/7 days per week
– Acts as a liaison to physicians in the community, providing educational insight on Hospice philosophy and care delivery for the terminally ill patient and his/her family of choice
– Coordinates efforts with each attending physician to provide care in the event the attending physician is unable or unwilling to retain responsibility for patient care
– Assists with determination of patient medical eligibility for Hospice services in accordance with Hospice program policy and relevant regulatory guidelines. Appropriate documentation and communication with care team members regarding all consultations and recommendations.
– Documenting consults/family conferences/plan of care updates immediately on completion, with copies sent to the patient's primary care provider and any specialists involved with patient as appropriate.
– Certifies, after reviewing appropriate clinical information and considering the primary terminal condition, health conditions, whether related or unrelated to the terminal condition, and current clinically relevant information supporting all diagnoses, that the individual patient is terminally ill and that it is anticipated that the patient's life expectancy is 6 months or less if the illness runs its normal course
  Reviews pertinent clinical information, for each Hospice patient, prior to recertification
– Participates as a member of the interdisciplinary group (IDG) in decision-making regarding the admission, re-certification, discharge, or transfer of patients and participates in weekly interdisciplinary case conferencing on Hospice patients
– Participates in the development and revision of patient care plans for all levels of hospice care, suggesting appropriate medical/nursing interventions, as necessary
– Helps the IDG define and measure meaningful outcomes to assess effectively of interventions and medications
– Assures that Clinical Protocols and Guidelines are accurate and up-to-date
– Makes home visits to Hospice patients and rounds on Hospice patients in in-patient care settings, as appropriate and requested
– Acts as a medical resource to the IDG
– Actively participates in strategic planning, performance improvement, and Home Health & Hospice infection control program
– Maintains collegial relationships with the medical staff of Skilled Nursing Facilities
– Develops and promotes community awareness of Home Health, Hospice and Palliative Care
– Contributes to the competency of the IDG through education, mentoring and feedback
– Assists in the establishment of guidelines and parameters necessary to determine and maintain quality of care for any identified acceptable medical research
– Partners with MHS to ensure cost-effective, efficient care delivery
– Adhere to MHS Attendance and Punctuality Policy and Procedure standards. Maintains reliable attendance.
– Contribute to the success of the organization by meeting organizational competency expectations and core values (Respect | Integrity | Stewardship | Excellence | Collaboration | Kindness), continuously learning, and by performing other duties as needed or assigned

LEADERSHIP COMPETENCIES

Personal Competencies
- Integrity
- Accountability
- Self-Development

Interpersonal Competencies
- Communication
- Collaboration
- Fostering Teamwork
- Developing Others

Organizational competencies
- Community Focus
- Strategic Focus
- Operational Management

MINIMUM QUALIFICATIONS

KNOWLEDGE, SKILLS, & ABILITIES

- Knowledge of home health, hospice and palliative care philosophy, principles, and practices
- Knowledge of community needs around Home Health and Hospice services and community resources with potential to assist Hospice in meeting those needs
- Knowledge of the physical, psychosocial and spiritual needs of the terminally ill, elderly and disabled
- Knowledge of available interventions and medications, the expected palliative benefits in the hospice population, and the likely ability to meet the needs of an individual patient
- Knowledge of group process and dynamics
- Knowledge of Medicare, Medicaid, Joint Commission and State rules and regulations pertaining to home health and hospice
- Skill in customer relations techniques including problem solving, mediation, and conflict resolution
- Skill in effective interpersonal, oral, and written communications
- Ability to maintain professional presence in representing Agency with employees and customers
- Ability to set a climate for performance at optimum levels
- Ability to work efficiently under pressure
- Ability to work independently and take initiative
- Ability to set priorities and use good judgment
- Ability to meet organization and departmental appearance standards on the job

EDUCATION, EXPERIENCE & LICENSURE

- Graduate of an accredited School of Medicine required
- Hospice or Palliative Medicine experience required
- Licensed in the State of Washington as a doctor of medicine or osteopathy
- Current Board Certification, required
- Hospice or Palliative Care Board Certification, preferred
- Current Pierce county Medical Society member

- Current CPR certification
- Current Washington State Drivers License
- Current Car Insurance per state law

PHYSICAL & ENVIRONMENTAL FACTORS

- Ability to bend, stoop, lift supplies, etc., at least 25 pounds
- Ability to sit for long periods
- Visual, speaking and hearing acuity for answering telephone calls and inquires
- Visual acuity for detail-oriented office work
- Constant manual dexterity associated with data entry and word processing

Job descriptions represent a general outline of job duties, functions, and qualifications. They are not intended to be comprehensive in nature. In addition jobs evolve over time and therefore their description may not reflect the precise nature of the position at a given point in time.

It is MultiCare's policy to base hiring decisions solely on the individual's ability to perform essential job functions. Persons with disabilities are eligible for this position provided they can perform those functions with reasonable accommodation.

Original Approval:	10-89	AHS
Reviewed/Revised:	11-90 - 8-94 - 10-97 - 7-98 - 3-01	
Reviewed/Revised:	7/02	Deanna Squyres/Carol Ord
Reformatted:	4/05	Amy Breeze
Reviewed/Revised:	12/09	A Breeze/P Isenhower
Reviewed/Revised:	1/10	A Breeze/
Reviewed/Revised:	4/17	Kelly Pajinag/LDaigle
Reviewed/Revised:	2/18	Kelly Pajinag/LDaigle
Revised:	12/18	Kit Hughes/LDaigle

Exhibit 9
Site Control Documents

Exhibit 9a
1313 Broadway Lease

LEASE AGREEMENT

BETWEEN

X2 BROADWAY, LLC

AND

MULTICARE HEALTH SYSTEM

SEPTEMBER 1, 2019

Table of Contents

LEASE AGREEMENT
1313 BROADWAY, TACOMA

THIS LEASE AGREEMENT ("Lease") is dated for reference purposes September 1, 2019 (the "Effective Date"), and is made by and between **X2 BROADWAY, LLC**, a Washington limited liability company ("Landlord") and **MULTICARE HEALTH SYSTEM**, a Washington nonprofit corporation (Tenant"). Landlord and Tenant agree as follows:

1. LEASE SUMMARY.

a. Leased Premises. The leased commercial premises ("Premises") consist of an estimated area of 46,413 rentable square feet, and are outlined on the floor plans attached as EXHIBIT A, located in a building ("Building") constructed on land ("Land") legally described on the attached EXHIBIT B, and commonly known as 1313 Broadway, Tacoma, Washington. The Premises do not include, and Landlord reserves, the exterior walls and roof of the Building, the Land on which the Building is constructed, the pipes and ducts, conduits, wires, fixtures, and equipment above the suspended ceiling or the structural elements of the Building. The Building, the Land, all other improvements located on such Land, and all common areas within or appurtenant to the Building are referred to as the "Property."

b. Term. The term of this Lease shall be ten (10) years, commencing on the "Commencement Date" for floors one (1) and two (2) as more particularly defined in Section 2(b) and terminating at midnight on the calendar day prior to the tenth (10th) anniversary of the Commencement Date or such earlier or later date as provided in Section 3 ("Termination Date"). Tenant acknowledges that the 5th floor is currently occupied under a tenant lease which expires on or before December 31, 2019. The Commencement Date for the portion of the Premises consisting of the 5th floor shall start immediately after the existing tenant has terminated the lease and vacated the floor, but in no event prior to January 1, 2020 ("5th Floor Commencement Date"), and shall terminate on the Termination Date described above.

c. Base Rent. The annual base rent for the Premises shall be based on the rental rates and the rentable square footage described for each floor and suite on EXHIBIT C. The initial monthly "Base Rent" due under this Lease shall be equal to the rental rate identified on EXHIBIT C multiplied by the agreed area of the Premises set forth on EXHIBIT C, divided by twelve (12). No Base Rent shall be due during the first four (4) months of the Term; except that, with respect to the Fifth (5th) floor, no rent shall be due during the first four (4) months following the 5th Floor Commencement Date. The first monthly payment of Base Rent shall be made on the first day of the month following the expiration of the fourth (4th) month from the Commencement Date as outlined on Exhibit C (collectively, the "Rent Commencement Date"). Base Rent shall be reduced by the rent credit set forth in Section 2(d). Payments of Base Rent shall be made at the following address or at such other address as may be set forth in a notice from Landlord to Tenant: c/o X2

Broadway, LLC, 820 A Street, Suite 702, Tacoma, WA 98402, or at Lessee's option via electronic payments or automated transfers. The Parties will enter into a revised Exhibit C once the Commencement Date for the entirety of the Premises is established.

d. Annual Adjustment of Base Rent. The Base Rent shall be increased on the first day of the second Lease Year (as defined in Section 3 below) and on first day of each succeeding Lease Year (each, an "Adjustment Date") in an amount equal to 2.2% of the Base Rent payable immediately prior to each such Adjustment Date.

e. Permitted Uses. The Permitted Uses are (i) the conduct of administrative office and ancillary activities in support of Tenant's medical or related health care practices; and (ii) ingress, egress, and the parking of motor vehicles in the parking areas by Tenant's health care providers, employees, patients, visitors and invitees.

f. Intentionally Deleted.

g. Excluded Health Care Tenants. Notwithstanding any other term or condition of this Lease to be contrary, during the term of this Lease, Landlord shall not lease space to any of the following entities without Tenant's express written permission within the confines of the Property: any entity or physician group that directly competes with Tenant in the delivery of health care services in the region and/or any competing health care system or physician practice group employing more than 25 physicians, including but not limited to CHI-Franciscan Health System, , Kaiser Permanente, Swedish Medical Center, Proliance Surgeons, Inc., University of Washington Physicians/UW Medicine, Virginia Mason Medical Center, Children's Hospital and Regional Medical Center, Valley Medical Center -and Providence St. Joseph Health System.

h. Allowed Third Party Medical Services. Tenant specifically authorizes Landlord to enter into lease agreements with third parties within the Property, for the provision of any of the following health care services, which are specifically excluded from Tenant's areas of exclusivity as otherwise set forth within this Lease: dentistry, orthodontia, oral surgery, chiropractic medicine, podiatry, ophthalmology, optometry and cosmetic / plastic surgery, kidney dialysis and any other uses approved by Tenant in writing.

i. Notice Addresses.

Landlord:

X2 Broadway LLC
Attn: John M. Xitco, manager
820 A Street, Suite 702
Tacoma, WA 98402

Tenant:

MultiCare Health System
Attn: CBRE, Inc. / Prop. Mgmt
315 Martin Luther King Jr Way
MS: 737-3-CBRE
PO Box 5299
Tacoma, WA 98145-0299
MHSrealestateleaseadministration@multicare.org

With a Copy to:
MultiCare Health System
Attn: General Counsel
315 Martin Luther King Jr. Way
MS: MS: 820-3-LEG
PO Box 5299
Tacoma, WA 98415-0299
Legal.Services@multicare.org
Contractsupport@multicare.org

2. PREMISES.

a. Lease of Premises. As of the date of mutual execution of this Lease by Landlord and Tenant, Landlord leases to Tenant, and Tenant leases from Landlord the Premises upon the terms specified in this Lease.

b. Commencement Date. The Commencement Date of this Lease shall be the date that Landlord delivers to Tenant all suites within the Premises, as such suites are identified on the attached EXHIBIT C, to allow Tenant to commence its tenant improvement work.

c. Delivery of Premises. Landlord shall provide possession of the first and second floor of the Premises upon mutual execution of the Lease Agreement.

d. Tenant Improvement Allowance. Landlord shall grant a Tenant Improvement Allowance in the amount of $ 40.00 per rentable square foot of the Premises for the construction of tenant improvements ("Tenant's Work") to make the Premises functional for its Permitted Use. Tenant shall have the right to use its own architect and contractor. The Tenant Improvement Allowance shall be reimbursed to Tenant in the form of a credit ("Rent Credit"). The Rent Credit shall be in the amount of $16,004.48 per month during the first Lease Year. The Rent Credit is calculated based upon a total Tenant Improvement Allowance of

$1,856,520.00 [46,413 rsf @ $40 rsf] divided by 116 months). For the second and each succeeding Lease Year, the Rent Credit amount shall be increased in the same manner as Base Rent under Section 1(d).

Upon Tenant's completion of the Tenant's Work, Tenant shall submit the following documentation to Landlord:

(i) A certificate of occupancy with respect to the Premises;

(ii) Tenant's certification that it has performed all of the work in accordance with the approved plans and specifications and in accordance with all other applicable provisions of the Lease;

(iii) Copies of substantiating invoices for Tenant's work at the Premises and original, valid, unconditional mechanic's lien releases from the general and all other contractors and suppliers who performed work or furnished supplies for or in connection with Tenant's work at the Premises covering all of the work and such other evidence as Landlord may reasonably request to evidence that no liens can arise from the work; and

(iv) Tenant's certification that it is not in default under the Lease beyond any applicable cure period.

e. **Refund of Prior Earnest Money.** Within thirty (30) days from the date Landlord approves cost and scope of work required for any asbestos remediation work as a result of Tenant's initial improvements, Landlord agrees to refund the $100,000.00 earnest money that Tenant paid to Landlord as part of the prior purchase arrangements for the Property ("Refund Amount"). If Landlord terminates the Lease or Tenant's right to possession based on a default by Tenant, Tenant shall repay Landlord the Refund Amount hereunder, as additional damages, without in any way limiting Landlord's other rights or remedies, within thirty (30) days from the date of the default and written demand from Landlord.

3. TERM. The term of this Lease shall be ten (10) years unless sooner terminated as provided herein, or extended by Tenant's exercise of its option rights as provided in Section 3 (a) below. The first "Lease Year" shall commence on the Commencement Date and shall end on the date which is twelve (12) months from the end of the month in which the Commencement Date occurs. Each successive Lease Year during the initial term and any extension terms shall be twelve (12) months, commencing on the first day following the end of the preceding Lease Year, except that the last Lease Year shall end on the Termination Date specified in Section 1.

a. **Option to Extend.** Provided Tenant is not in default (after receipt of any required notices and failure to cure within any applicable cure periods) at the time of the exercise or upon the commencement of any extension term described below, Tenant shall have two (2) successive options to extend the term of this Lease for five (5) years each.

If Tenant desires to exercise an option, it must deliver written notice to Landlord not less than one hundred and eighty (180) days prior to the expiration of the then-current Lease term, time being of the essence in connection therewith. Upon timely and proper exercise of any option, the term of this Lease shall be extended for the period of the subject option upon all of the same terms, conditions and covenants as set forth herein, except that (i) the amount of the Base Rent shall be adjusted to be the fair market value of the Premises, as determined in the manner described below; and (ii) after exercise of Tenant's final extension term option, there shall be no further extension or renewal term options. In each subsequent Lease Year of the extension term, the Base Rent shall be adjusted pursuant to Section 1(d).

If Landlord and Tenant are unable to agree on the fair market rental value for the Premises during the applicable extension term, then, within thirty (30) days after the date Tenant exercises the applicable extension term option, Landlord and Tenant shall agree within ten (10) days thereafter on one real estate appraiser (who shall be a Member of the American Institute of Real Estate Appraisers ["M.A.I."] or equivalent) who will determine the fair market rental value of the Premises.

If Landlord and Tenant cannot mutually agree upon an appraiser within said ten (10) day period, then one M.A.I.-qualified appraiser shall be appointed by Tenant and one M.A.I.-qualified appraiser shall be appointed by Landlord within ten (10) days of notice to the other of such disagreement. The two appraisers shall determine the fair market rental value of the Premises within twenty (20) days of their appointment; provided, however, if either party fails to appoint an appraiser within such ten (10) day period, then the determination of the appraiser first appointed shall be final, conclusive and binding upon both parties.

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

The third appraiser so appointed shall promptly determine the fair market rental value of the Premises and the average of the appraisals of the two closest appraisers shall be final, conclusive and binding upon both parties. The fees and expenses of said third appraiser or the one appraiser Landlord and Tenant agree upon, shall be borne equally between Landlord and Tenant. Landlord and Tenant shall pay the fees and expenses of their respective appraiser if the parties fail to agree on a single appraiser. All M.A.I. appraisers appointed or selected pursuant to this subsection

shall have at least ten (10) years' experience appraising commercial properties in the commercial leasing market in which the Premises are located.

4. RENT.

a. Payment of Rent. Tenant shall pay Landlord without notice, demand, deduction or offset, in lawful money of the United States, the monthly Base Rent stated in Section 1 in advance on or before the Rent Commencement Date and on or before the first (1st) day of each calendar month thereafter during the remainder of the Lease Term, together with any other additional payments due to Landlord ("Additional Rent") (collectively, "rent" or "Rent") when required under this Lease. Payments for any partial month at the beginning or end of the Lease term shall be prorated. All payments due to Landlord under this Lease, including late fees and interest, shall be rent, and upon failure of Tenant to pay any such costs, charges or expenses, Landlord shall have the same rights and remedies as otherwise provided in this Lease for the failure of Tenant to pay rent. Tenant may pay rent via ACH, and Landlord shall cooperate in providing any necessary account information to set up this method.

b. Base Rent Adjustment. The monthly Base Rent shall be increased on each Adjustment Date as provided in Section 1(d) above.

c. Late Charges; Default Interest. If any sums payable by Tenant to Landlord under this Lease are not received within ten (10) business days after their due date, Tenant shall pay Landlord in addition to the amount due, for the cost of collecting and handling such late payment, an amount equal to the lesser of two percent (2%) of the delinquent amount or two hundred dollars ($200). In addition, all delinquent sums payable by Tenant to Landlord and not paid within ten (10) business days after their due date shall, at Landlord's option, bear interest at the rate of ten percent (10%) per annum (the "Default Rate"). Interest on all delinquent amounts shall be calculated from the original due date to the date of payment.

5. ADDITIONAL RENT.

Base Rent paid by Tenant includes Tenant's Pro-Rata Share of Operating Expenses (as defined below) for the 2019 calendar year (the "Base Year"). As more particularly set forth below, Tenant shall pay to Landlord, as Additional Rent, commencing in calendar year 2020 and continuing for each remaining calendar year of the Lease Term, Tenant's Pro Rata share of the amount by which Operating Expenses such year exceed the amount of Operating Expenses for the Base Year, which shall be calculated and set forth in an addendum to this Lease to be executed by Landlord and Tenant within 90 days after completion of the Base Year. For such purposes, as soon as practical following completion of the initial accounting for the Base Year, Landlord shall provide a summary to Tenant of the amount of such actual costs incurred during the Base Year and the actual costs shall then be used to determine the Operating Expenses for the Base Year.

a. Pro-Rata Share. Tenant's "Pro-rata Share", which is based on the ratio of the rentable square footage of the Premises (46,413 RSF) to the rentable square footage of the Building (94,707 RSF), is **49.01%.** The total rentable square footage of the Building is 94,707. Any subsequent adjustment to the rentable square footage of the Premises or the Building pursuant to Section 1(a) will be reflected in an adjustment to Tenant's Pro-rata Share.

b. Operating Expenses. As used herein, Operating Expenses shall mean:

i. Premiums incurred by Landlord for insurance coverage maintained by Landlord for the Property that is required by this Lease or that is customarily carried by landlords of comparable buildings in the area, which coverage shall include reasonable and customary deductibles.

ii. General real estate taxes levied against the Property and that accrue and are payable during the term of this Lease, but not any special assessments or taxes in the nature of improvement or betterment assessments. Real Estate Taxes shall exclude, any excise or transfer tax, income, franchise, gross receipts, corporation, capital levy, excess profits, revenue, rent, inheritance, gift, or estate tax.

iii. The costs of operation, maintenance and repair of the Common Areas of the Building and Property as defined in Section 10 below, including, but not limited to, water, sewer and all other utility charges, janitorial, refuse and trash removal, supplies, materials and tools used in the operation, repair and maintenance of the Property, heating, ventilation and air conditioning ("HVAC", subject to the provisions of paragraph 4.9 of Exhibit D, Work Letter), pest control, lighting systems, security, landscape maintenance and repair, repair and maintenance of the parking areas, sidewalks and driveways serving the Property, snow and ice removal, wages and salaries of employees whose time is directly attributable to the operation and maintenance of the Property; and a management fee equal to 5% of the total Operating Expenses described in this Section 4(b)(iii).

iv. Operating Expenses shall not include: those repairs the structural components of the Building, Common Areas, and Property, including the roof, floors, load bearing walls and foundations; capital improvements or major repairs, expenses that according to generally accepted accounting principles would be considered capital expenses to the Building shell (i.e. Building structure, exterior walls, and roof); expenses paid directly by Tenant or other tenants in the Building or otherwise reimbursed to Landlord; depreciation on the Building, the Property and equipment; corporate overhead; marketing costs and broker commissions; cost incurred

by Landlord for the repair or damage to the Building, Property and/or underlying land to the extent that Landlord is reimbursed by insurance or condemnation proceeds or by tenants, warrantors or other this parties. To the extent that any such capital expenditure is permitted and exceeds $5,000, the excess shall be amortized over such period as Landlord may reasonably elect.

c. Payment of Operating Expense Adjustment

i. Landlord shall provide to Tenant thirty (30) days prior to the start of each calendar year Landlord's estimate of Operating Expenses for the succeeding calendar year and the amount by which such estimate exceeds the amount of such Operating Expenses during the Base Year ("Operating Expense Adjustment").

ii. Tenant shall pay 1/12 of its total Pro-Rata Share of the estimated Operating Expense Adjustment amount for the succeeding year with each monthly payment of Base Rent.

iii. Within ninety (90) days after the start of each calendar year, Landlord shall provide Tenant a statement setting forth the actual Operating Expense Adjustment for the preceding year ("Reconciliation Statement"). In the event Tenant's Pro-Rata Share of the Operating Expense Adjustment for the preceding year exceeds the sum of the monthly installments paid by Tenant, Tenant shall pay Landlord the difference within forty-five (45) days of receipt of the Reconciliation Statement. If the sum of the monthly Operating Expense Adjustment installments paid by Tenant exceeds the amount of the actual Operating Expense Adjustment payment owed by Tenant for the preceding year, Landlord shall apply the excess amount as a credit to Tenant's future Pro-Rata Share of the Operating Expense Adjustment payment. If the term of the Lease has expired, Landlord shall reimburse Tenant the excess within thirty (30) days of issuance of the Reconciliation Statement.

iv. Should Tenant dispute Landlord's Reconciliation Statement, it shall give notice to Landlord not later than one (1) year after receipt of the Reconciliation Statement, provided, however if Tenant fails to provide notice within such one (1) year period, Landlord's computation shall be final and conclusive. If Landlord and Tenant are unable to reach a resolution of the dispute, Tenant shall have the right, on ten (10) days written notice, to audit Landlord's books and records for the calendar year covered by such Reconciliation Statement. In the event of an audit, Landlord shall cooperate with Tenant in providing Tenant reasonable access to its books and records during normal business hours. Any audit conducted by

Tenant shall be completed within sixty (60) days after Tenant's request thereof. In the event the audit shows that the amount of Tenant's Pro-rata Share of the Operating Expense Adjustment exceeds the sum of the monthly installments actually paid by Tenant for such calendar year, Tenant shall pay to Landlord the difference within thirty (30) days following completion of the audit. In the event the sum of the monthly installments actually paid by Tenant for such calendar year exceeds the amount of Tenant's Pro-rata Share of Operating Expense Adjustment actually due and owing, the difference shall be applied as a credit to Tenant's future share of Operating Expense Adjustment estimates payable by Tenant pursuant to this Section, or if the term of this Lease has expired, Landlord shall reimburse Tenant the excess payment within thirty (30) days after completion of the audit. If the results of the audit shows an overcharge to Tenant of more than five percent (5%) of the actual amount owed by Tenant, then Landlord shall pay the reasonable cost of such audit up to an amount of $2,000.00. Landlord and Tenant shall cooperate as reasonably necessary in order to facilitate the timely completion of any audit. Nothing in this Section shall in any manner modify Tenant's obligations to make payments as and when provided under this Lease. Tenant shall have the right to challenge if Tenant provides Landlord notice within 120 days of receipt.

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

7. COMPLIANCE WITH LAWS. Tenant shall not cause or permit the Premises to be used in any way which violates any law, ordinance, or governmental regulation or order. Landlord represents to Tenant that, to the best of Landlord's knowledge, the Premises comply with all applicable laws, rules, regulations, or orders, including without limitation, the Americans With Disabilities Act, if applicable, and Landlord shall be responsible to promptly cure at its sole cost any noncompliance which existed on the Commencement Date. If the enactment or enforcement of any law, ordinance, regulation or code during the Lease term requires any changes to the Premises during the Lease term, the Landlord shall perform all such changes at its expense.

8. UTILITIES AND SERVICES. Landlord shall provide the Premises the following services: water and electricity for the Premises seven (7) days per week, twenty-four (24) hours per day, and heating, ventilation and air conditioning from 7:00 a.m. to 6:00 p.m. Monday through Friday, and 7:00 a.m. to 12:00 p.m. on Saturday, and shall provide janitorial service and trash removal, including lamp replacement, to the Premises and

Building five (5) nights each week, exclusive of holidays. Heating, ventilation and air conditioning services will also be provided by Landlord to the Premises during additional hours on reasonable notice to Landlord, at Tenant's sole cost and expense, at an hourly rate not to exceed that charged by landlords of comparable buildings in the area. Any such charge shall be payable by Tenant, when billed, as Additional Rent.

Tenant shall obtain all other utilities (including, but not limited to, telephone and cable service if available) and other services which Tenant requires with respect to the Premises, except those to be provided by Landlord as described above, and shall pay, at Tenant's sole expense, the cost of all utilities separately metered to the Premises, and of all other utilities and other services which Tenant requires with respect to the Premises, except those to be provided by Landlord as described above. Unless due to Landlord's negligence, Landlord shall not be liable in any respect whatsoever for the inadequacy, stoppage, interruption, or discontinuance of any utility or service due to riot, strike, labor dispute, breakdown, accident, repair, or other cause beyond Landlord's reasonable control or which occurs in cooperation with governmental request or directions. In the event of Landlord's negligence, rent shall be abated as a result thereof.

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

10. COMMON AREAS.

a. Definition. The term "Common Areas" means all areas and facilities on the Property that are provided and designated from time to time by Landlord for the general non-exclusive use and convenience of Tenant with other tenants and which are not leased or held for the exclusive use of a particular tenant. To the extent that such areas exist within the Property, Common Areas include lobbies, hallways, entryways, stairs, elevators, driveways, walkways, terraces, docks, loading areas, restrooms, trash facilities, parking areas and garages, roadways, pedestrian sidewalks, any patio areas which are accessible by multiple tenants, landscaped areas, security areas, common heating, ventilating and air conditioning systems, common electrical service, equipment and facilities, and common mechanical systems, equipment and facilities.

b. **Repairs and Alterations.** With Tenant's consent, not to be unreasonably withheld, Landlord may change the size, use, or nature of any Common Areas, erect improvements on the Common Areas or convert any portion of the Common Areas to the exclusive use of Landlord or selected tenants; provided, however, that no such action shall unreasonably deny Tenant access to or the beneficial use of the Premises. Landlord anticipates that the Common Area currently shared on a particular floor by multiple tenants will be converted to rentable area if such floor is held exclusively by a single tenant. If the amount of Common Area is diminished

as a result of action taken in accordance with the immediately preceding sentence, such diminution shall not be deemed constructive or actual eviction, and Landlord shall not be subject to any liability, nor shall Tenant be entitled to any compensation or reduction or abatement of rent; provided that Tenant's beneficial use of the Premises and the Building is not adversely impacted. In addition, Landlord shall use reasonable efforts to minimize impact to Tenant and will abate rent due under this Lease if such work causes Tenant to close its business or suffer a significant obstruction to the use thereof for more than 24 hours. Provided work is performed on a schedule mutually agreed upon between Landlord and Tenant, Landlord shall have the right to install, maintain, use, repair and replace pipes, ducts, conduits, and wires leading through the Premises in areas which will not materially interfere with Tenant's use thereof or deny Tenant the beneficial use of the Premises.

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

d. Parking. During the term, Landlord shall provide and reserve (with appropriate reserved parking signage) for Tenant and its employees and invitees a total of forty-six (46) parking spaces on the Property ,with the following located in the parking garage within the Building and outside parking areas upon the Commencement Date:

	Parking Stall Numbers
Inside	1-7, 25, 26, 29-31, 42-46
Outside	3-5, 6-13 *, 26-30, 36-45, 51-53

*Parking stalls 6 through 13 in the outside surface parking will not be available until the 5th Floor Commencement Date for on or before January 1, 2020.

Starting as of the Rent Commencement Date or the 5th Floor Commencement Date, whichever the case may be, Tenant shall pay $150 per month for each reserved parking space. From time to time, if Landlord determines that any other parking spaces are available and not subject to the requirements of any other tenant, Tenant may (but is not required to) lease any such available parking at a charge of $150 per month for each such space. The foregoing parking rates are applicable to the first Lease Year. For the second and each succeeding Lease Year, the parking rate shall be increased in the same manner as Base Rent under Section 1(d). Tenant shall comply and shall be responsible for the compliance of its employees, patients and invitees with the terms of the Lease and any riders, reasonable rules and regulations adopted by Landlord from time to time for the safe and orderly sharing of parking. All automobiles (including all contents thereof) shall be parked in the parking garage within the Building and any outside parking areas at the sole risk of Tenant, its employees, agents, invitees and licensees. Landlord has no duty to insure any automobiles (including the contents thereof), and Landlord is not responsible for the

protection and security of such automobiles. Landlord shall have no liability whatsoever for any property damage and/or personal injury which might occur as a result of or in connection with the parking of said automobiles in the parking garage within the Building and any outside parking areas, and Tenant hereby agrees to indemnify and hold Landlord harmless from and against any and all liabilities, costs, claims, expenses, and/or causes of action which Landlord may incur in connection with or arising out of the use of the parking garage within the Building and any outside parking areas by Tenant or its employees, agents, invitees, or licensees pursuant to this Lease. If Tenant, its agents or employees wrongfully park in any of the parking areas or parking spaces designated for the use of any other tenant of the Building, then Landlord shall be entitled and is hereby authorized to have any such automobile towed away, at Tenant's sole risk and expense. Tenant hereby agrees to pay all amounts falling due under this Section 10(c) upon demand with its next rental payment due. In addition, Landlord shall have the right, at its option, upon sixty (60) days written notice to Tenant, to temporarily relocate some or all of the designated parking areas used by Tenant and to provide substitute parking spaces in the close vicinity of the Property

11. ALTERATIONS.

a. Permission. Tenant may make non-structural alterations, additions or improvements to the Premises ("Alterations") that do not exceed $25,000 without the consent of the Landlord. In the event, the Alterations exceed $25,000, Tenant may only make such Alterations with the prior written consent of Landlord, which shall not be unreasonably withheld, conditioned or delayed. Such requests shall be accompanied by reasonably detailed plans. Landlord shall have fifteen (15) business days to review alteration requests. If Landlord fails to respond, such non-response shall be deemed approval. The term "Alterations" shall not include the installation of shelves, movable partitions, Tenant's equipment, and trade fixtures that may be performed without damaging existing improvements or the structural integrity of the Premises, and Landlord's consent shall not be required for Tenant's installation or removal of those items. Tenant shall perform all work within the Premises at Tenant's expense in compliance with all applicable laws, and shall complete all Alterations in accordance with the aforementioned plans approved by Landlord, and in a manner so as to not unreasonably interfere with other tenants. Tenant shall pay, when due, all claims for labor or materials furnished to or for Tenant at or for use in the Premises, which claims are or may be secured by any mechanics' or materialmen's' liens against the Premises or any interest therein.

12. REPAIRS AND SURRENDER. Tenant shall, at its sole expense, maintain the Premises in good condition and promptly make all non-structural repairs and replacements necessary to keep the Premises safe and in good condition, excluding all HVAC components covered by the provisions of paragraph 4.9 of Exhibit D, Work Letter, however Tenant will be responsible for routine maintenance (including replacement of filters), lighting fixtures (including replacement of bulbs), and other utilities and systems to the extent exclusively serving the Premises. Tenant shall not damage any demising wall or disturb the structural integrity of the Premises and shall promptly repair any damage or

injury done to any such demising walls or structural elements caused by Tenant or its employees, agents, contractors, or invitees. Notwithstanding anything in this Section to the contrary, Tenant shall not be responsible for any repairs to the Premises made necessary by the negligence or willful misconduct of Landlord or its agents, employees, contractors or invitees therein. Upon expiration of the Lease term, whether by lapse of time or otherwise, Tenant shall not be required to remove cabling or restore the Premises to the condition before Tenant's Work was completed, but will remove all personal property and office trade fixtures that may be readily removed without damage to the Premises or Building and promptly and peacefully surrender the Premises, together with all keys, to Landlord in good condition; reasonable wear and tear and insured casualty excepted.

13. MAINTENANCE OF PROPERTY. Except for Tenant's maintenance obligations pursuant to Section 12, Landlord shall maintain the Building, Common Areas and Property in good order, condition and repair provided however that such work shall not impact Tenant's ability to conduct its business and further provided such work will be performed on a mutually agreed schedule between Landlord and Tenant. In performing such repairs and maintenance and provided no such work or activity shall deny Tenant the beneficial use of the Premises, Landlord shall use reasonable efforts to minimize interference with Tenant's use and enjoyment of the Premises. Landlord shall make repairs or ensure that repairs are made in a safe and workmanlike manner, keeping in mind Tenant's employees and invitees and their health and safety. Tenant shall not be responsible for defects or deferred maintenance incurred in/or on the Building(s) or Property prior to the Commencement Date

14. ACCESS AND RIGHT OF ENTRY. After forty-eight (48) hours' prior written notice from Landlord (except in cases of emergency, when no notice shall be required), Tenant shall permit Landlord and its agents, employees and contractors to enter the Premises to make repairs, inspections, alterations or improvements, provided however that any repairs, alterations or improvements are made on a schedule mutually agreed upon by Landlord and Tenant and further provided that such work does not interfere with Tenant's ability to conduct its business or does not deny Tenant the beneficial use of the Premises. In the event Landlord makes repairs, alterations or improvements, Landlord shall ensure that such repairs are made in a safe and workmanlike manner, keeping in mind Tenant's employees and invitees and their health and safety. At times mutually agreed upon, Landlord shall have the right to enter the Premises for the purpose of showing the Premises to prospective purchasers or lenders, and to prospective tenants within ninety (90) days prior to the expiration or sooner termination of the Lease term, and for posting "for lease" signs within ninety (90) days prior to the expiration or sooner termination of the Lease term.

15. SIGNAGE. Landlord, at Landlord's expense shall install Tenant's name on the monument sign in the front of the Building, placement to be mutually agreed upon. Tenant, at Tenant's cost and expense, shall have the right to install a sign on the exterior portion of the Building, provided that Landlord shall have the right to approve the size, location, materials, method of attachment, and appearance, before installing the exterior sign or those viewable from outside the Premises. Landlord shall have thirty (30) business days to

review and approve signage requests. If Landlord fails to respond, such non-response shall be deemed approval. Tenant shall install any approved signage at Tenant's sole expense and in compliance with all applicable laws. Tenant shall not damage or deface the Premises in installing or removing signage and shall repair any injury or damage to the Premises caused by such installation or removal. Tenant shall not be required to pay any additional rent for signage throughout the entire Term of the Lease including any subsequent Renewal Terms.

16. DESTRUCTION OR CONDEMNATION.

a. Damage and Repair. If the Premises or the portion of the Property necessary for Tenant's occupancy are partially damaged but not rendered untenantable, by fire or other insured casualty, then Landlord shall diligently restore the Premises and the portion of the Property necessary for Tenant's occupancy to the extent required below and this Lease shall not terminate; provided, however, Tenant may terminate the Lease if Landlord is unable to restore the Premises within one hundred twenty (120) days of the casualty event. The Premises or the portion of the Property necessary for Tenant's occupancy shall not be deemed untenantable if less than twenty percent (20%) of each of those areas are damaged and Landlord shall be obligated to restore those areas regardless of insurance proceeds.

If the Premises is made untenable as defined above, or more than twenty percent (20%) or more of the rentable area of the Property is entirely destroyed, or partially damaged and rendered untenantable, by fire or other casualty, Landlord may, at its option: (a) terminate this Lease as provided herein, or (b) restore the Premises and the portion of the Property necessary for Tenant's occupancy to their previous condition to the extent required below; provided, however, if such casualty event occurs during the last six (6) months of the Lease term (after considering any option to extend the term timely exercised by Tenant) then either Tenant or Landlord may elect to terminate the Lease. If, within thirty (30) days after receipt by Landlord from Tenant of written notice that Tenant deems the Premises or the portion of the Property necessary for Tenant's occupancy untenantable, Landlord fails to notify Tenant of its election to restore those areas, or if Landlord is unable to restore those areas within thirty (30) days of the date of the casualty event, then Tenant may elect to terminate the Lease upon thirty (30) days' written notice to Landlord unless Landlord, within such thirty (30) day period, notifies Tenant that it will in fact restore the Premises or actually completes such restoration work to the extent required below, as applicable.

If Landlord restores the Premises or the Property under this Section, Landlord shall proceed with reasonable diligence to complete the work, and the Base Rent shall be abated in the same proportion as the untenantable portion of the Premises bears to the whole Premises, provided that there shall be a rent abatement only if the damage or destruction of the Premises or the Property did not result from, or was not contributed to directly or indirectly by the act, fault or neglect of Tenant, or Tenant's officers, contractors, licensees, subtenants, agents, servants, employees, guests, invitees or visitors. No damages, compensation or claim shall be payable

by Landlord for inconvenience, loss of business or annoyance directly, incidentally or consequentially arising from any repair or restoration of any portion of the Premises or the Property, unless the repairs to the Premises are made necessary by the negligence or willful misconduct of Landlord or its agents, employees, contractors or invitees therein. Landlord will not carry insurance of any kind for the protection of Tenant or Tenant's furniture, fixtures, or equipment, and Landlord's restoration obligations hereunder shall not include any obligation to repair any damage thereto or replace the same, unless said damage is the result of negligence or willful misconduct of Landlord or its agents, employees, contractors or invitees therein.

b. Condemnation. If the Premises, the portion of the Property necessary for Tenant's occupancy, or 25% or more of the rentable area of the Property are made untenantable by eminent domain, or conveyed under a threat of condemnation, this Lease shall terminate at the option of either Landlord or Tenant as of the earlier of the date title vests in the condemning or the condemning authority first has possession of the Premises or the portion of the Property and all Rents and other payments shall be paid to that date. In case of taking of a part of the Premises or the portion of the Property necessary for Tenant's occupancy that does not render those areas untenantable, then this Lease shall continue in full force and effect and the Base Rent shall be equitably reduced based on the proportion by which the floor area of any structures is reduced, such reduction in Rent to be effective as of the earlier of the date the condemning authority first has possession of such portion or title vests in the condemning authority. The Premises or the portion of the Property necessary for Tenant's occupancy shall not be deemed untenantable if less than twenty percent (20%) of each of those areas are condemned. Landlord shall be entitled to the entire award from the condemning authority attributable to the value of the Premises or the Property and Tenant shall make no claim for the value of its leasehold. Tenant shall be permitted to make a separate claim against the condemning authority for moving expenses, provided that in no event shall Tenant's claim reduce Landlord's award. Landlord will compensate Tenant for loss of rentable space with proportional rent abatement.

17. INSURANCE.

a. Tenant's Insurance. Tenant shall, during the entire Lease term, keep in full force and effect a policy or policies of (i) commercial general liability insurance and property damage insurance with respect to the Premises and the business operated by Tenant, for which the limit of liability shall be not less than Two Million Dollars ($2,000,000) per occurrence and shall name Landlord and its property manager as additional insured; and (ii) property insurance written with a replacement cost endorsement, covering all of Tenant's personal property in the Premises, the tenant improvements and all other leasehold improvements installed in the Premises by or on behalf of Tenant. Such policies shall contain a clause that the Tenant shall endeavor to not cancel or change the insurance coverage limits without first giving Landlord thirty (30) days' prior written notice, except cancellation for nonpayment of premium, in which case ten (10) days' prior written

notice shall be required. Tenant's insurance policies shall be carried with an insurance company or companies with a general policy holders' rating of not less than "A-/VII" as rated in the most current available Best's Insurance Reports and which are qualified to do business in the state of Washington.

Notwithstanding the above, Tenant, shall have the right to satisfy its insurance obligations under this Lease by means of self-insurance to the extent of all or part of the insurance required hereunder but only so long as such self-insurance is permitted under all laws applicable to Tenant at the time in question. If Tenant elects to self-insure, Landlord shall have the same benefits and protections as if Tenant carried insurance with a third-party insurance company satisfying the requirements of this Lease. In the event Tenant assigns its interest under this Lease, the subsequent assignee shall have the same right of self-insurance as the current Tenant, provided that the assignee has a financial net worth of at least $100,000,000.00.

b. **Landlord's insurance**. Landlord will carry and maintain general liability and property insurance as set forth herein. Landlord agrees to carry during the Lease term commercial general liability insurance with a limit of not less than Two Million Dollars ($2,000,000) per occurrence insuring against any and all liability of Landlord with respect to the ownership, operation and/or use of the property. Landlord shall also carry Causes of Loss Special Form insurance covering the full replacement cost of the Property, and at Landlord's election, earthquake and building ordinance insurance less a commercially reasonable deductible. Landlord may, but is not obligated to, maintain such other insurance or additional coverage(s) as it may deem necessary, including, but not limited to rent loss insurance. The cost of premiums for all such insurance required under this Section shall be included in the Operation Expenses described in Section 5(b). Said insurance policies shall be carried with an insurance company or companies with general policy holders' rating of not less than "A/VII" as rated in the most current available Best's Insurance Reports and which are qualified to do business in the state of Washington. Landlord shall upon request furnish Tenant with a certificate of such insurance policy.

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

18. INDEMNIFICATION.

a. Indemnification by Tenant. Tenant shall defend, indemnify and hold Landlord and its managing agent harmless from any claim, liability, damage or loss, including attorneys' fees, occurring on the Property, arising out of any negligent or wrongful act or omission of Tenant, or Tenant's officers, contractors, agents, employees or invitees or arising from Tenant's breach of any term of this Lease. Neither Landlord nor its managing agent shall have any liability to Tenant because of loss or damage to Tenant's property or for death or bodily injury caused by the acts or omissions of other tenants of the Building, or by third parties (including criminal acts).

b. Indemnification by Landlord. Landlord shall defend, indemnify and hold Tenant and its managing agent harmless from any claim, liability, damage or loss, including attorneys' fees, occurring on the Property, arising out of any negligent or wrongful act or omission of Landlord, or Landlord's officers, contractors, agents, employees or invitees or arising from Landlord's breach of any term of this Lease. Neither Tenant nor its managing agent shall have any liability to Landlord because of loss or damage to Landlord's property or for death or bodily injury caused by the acts or omissions of other tenants of the Building, or by third parties (including criminal acts).

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

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

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

19. ASSIGNMENT AND SUBLETTING.

a. This Lease and any right of Tenant hereunder or in the Premises may not be assigned, transferred, encumbered or sublet in whole or in part by Tenant, expressly or by operation of law or otherwise, without Landlord's prior consent, which consent shall not be unreasonably withheld, conditioned or delayed. In the event Tenant desires to assign this Lease or sublet the Leased Premises or any part hereof, Tenant shall give Landlord written notice at least thirty (30) days in advance of the date on which Tenant desires to make such assignment or sublease, which notice shall

specify: (a) the name, address and business of the proposed assignee or sublessee, (b) the size and location of the space affected, (c) the rental amount to be paid, and (d) the proposed effective date and duration of the subletting or assignment. Landlord may condition such consent upon the right to receive one-half of the profit, if any, which Tenant may realize on account of such assignment, conveyance, transfer or sublease of the Leased Premises. For purposes of this paragraph, "profit" shall mean any sum which the assignee, sublessee or transferee is required to pay, or which is credited to Tenant as rent in excess of the rents required to be paid by Tenant to Landlord under this Lease. Provided Tenant is not in default, beyond any applicable cure period, under this Lease, Landlord's consent shall not be required for an assignment or sublease of all or any portion of the Premises to (a) a parent, subsidiary, affiliate, division or other entity controlling, controlled by, or under common control with Tenant; or (b) a successor to Tenant by merger, consolidation, reorganization or government action (each, a "Permitted Transferee"), provided that Landlord is provided with prior written notice thereof and with an insurance certificate reflecting insurance meeting the requirements of Section 16 above. No such transfer shall release Tenant from primary liability under this Lease, with exception for 19.d.

b. Any prospective assignee or sublessee otherwise shall assume in writing all obligations of Tenant under this Lease pursuant to a document reasonably acceptable to Landlord.

c. Landlord may assign its interests, rights, duties and obligations under this Lease to any person without the consent of Tenant. Landlord shall provide thirty (30) days' written notice in advance of such action to Tenant. Landlord shall be jointly and severally liable with the assignee for the performance of all terms, conditions, covenants, and agreements contained in this Lease.

d. If Landlord signs a new lease with a prospective assignee or sublessee as a result of dealing directly with that party, Tenant shall be relieved of its responsibilities under this Lease.

e. This provision shall not apply if Tenant transfers Lease to a wholly owned subsidiary including but not limited to Medis Corporation.

f. In the event of any transfer or transfers of Landlord's interest in the Premises, other than a transfer for security purposes only, upon the assumption of this Lease by the transferee, Landlord shall not be relieved of obligations and liabilities accruing from and after the date of such transfer, including any liability for any retained security deposit or prepaid rent, for which the transferee shall also be liable.

20. LIENS. Tenant is not authorized to subject the Landlord's estate to any liens or claims of lien. Tenant shall keep the Premises free from any liens created by or through Tenant. Tenant shall indemnify and hold Landlord harmless from liability for any such liens including, without limitation, liens arising from any Alterations. If a lien is filed against the Premises by any person claiming by, through or under Tenant, Tenant shall,

within ten (10) days after Landlord's demand, at Tenant's expense, either remove the lien or furnish to Landlord a bond in form and amount and issued by a surety satisfactory to Landlord, indemnifying Landlord and the Premises against all liabilities, costs and expenses, including attorneys' fees, which Landlord could reasonably incur as a result of such lien(s).

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

a. Failure to Pay. Tenant fails to pay any uncontested sum, including Rent, due under this Lease following ten (10) business days' written notice from Landlord of the failure to pay.

b. Abandonment. Tenant abandons the Premises (defined as an absence of fifteen (15) days or more while Tenant is in breach of some other term of this Lease). Provided however, as long as Tenant is paying rent and keeping up the Premises, such abandonment shall not be considered an event of default.

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

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

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

f. Tenant Default. If Tenant shall be in default of any covenant of this Lease to be performed by it, Landlord, prior to exercising any right or remedy it may have against the Tenant on account thereof, shall give Tenant a thirty (30) day written notice of such default, specifying the nature of such default. Notwithstanding anything contrary elsewhere in this Lease, Landlord agrees that if the default is of such nature that it can be cured by Tenant, but cannot with reasonable diligence be cured within thirty (30) days, then such default shall be deemed cured if Tenant within said thirty (30) day period shall have commenced the cure and shall continue thereafter with all due diligence to cause such curing to proceed to completion

g. Landlord Default. If Landlord defaults in the performance of any covenant required to be performed by Landlord, Tenant may service upon Landlord a written notice specifying the default. If Landlord does not remedy the default within thirty (30) days following receipt thereof or, in the case of default which reasonably requires more than thirty (30) days to cure, if Landlord has not commenced to remedy the same within thirty (30) days following receipt thereof and be diligently prosecuting such cure to completion, then Tenant may, after written notice and the expiration of any notice period required hereunder (i) pay any sums necessary to perform any obligation of Landlord in default hereunder and deduct the cost thereof from Rent then and thereafter becoming due to Landlord hereunder, or require Landlord to reimburse such sum to Tenant immediately upon Landlord's receipt of Tenant's written demand therefor; or (ii) pursue any other available legal or equitable remedy. In the event Tenant incurs any expenses because of Landlord's failure to fulfill its obligations set forth in this Lease, Landlord agrees to reimburse Tenant for such expense upon demand by Tenant. In the event of Landlord's failure to so reimburse Tenant, Tenant, in addition to any other remedies it may have, may deduct such expense from any Rent then or thereafter becoming due to Landlord hereunder. The parties' rights and obligations under this Section 21 shall survive the expiration or earlier termination of this Lease.

If Landlord fails to cure any such default within the allotted time, Tenant's sole remedy shall be to seek actual money damages (but not consequential or punitive damages) for loss arising from Landlord's failure to discharge its obligations under this Lease. Nothing herein contained shall relieve Landlord from its duty to perform of any of its obligations to the standard prescribed in this Lease.

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

a. Termination of Lease. Landlord may terminate Tenant's interest under the Lease, but no act by Landlord other than written notice of termination from Landlord to Tenant shall terminate this Lease. The Lease shall terminate on the date specified in the notice of termination. Upon termination of this Lease, Tenant will remain liable to Landlord for damages in an amount equal to the rent and other sums that would have been owing by Tenant under this Lease for the balance of the Lease term, less the net proceeds, if any, of any re-letting of the Premises by Landlord subsequent to the termination, after deducting all Landlord's Reletting Expenses (as defined below). Landlord shall be entitled to either collect damages from Tenant monthly on the days on which rent or other amounts would have been payable under the Lease, or alternatively, Landlord may accelerate Tenant's obligations under the Lease and recover from Tenant: (i) unpaid rent which had been earned at the time of termination; (ii) the amount by which the unpaid rent which would have been earned after termination until the time of award exceeds

the amount of rent loss that Tenant proves could reasonably have been avoided; (iii) the amount by which the unpaid rent for the balance of the term of the Lease after the time of award exceeds the amount of rent loss that Tenant proves could reasonably be avoided (discounting such amount by the discount rate specified in the Wall Street Journal at the time of the award, plus 1%); and (iv) any other amount necessary to compensate Landlord for all the detriment proximately caused by Tenant's failure to perform its obligations under the Lease, or which in the ordinary course would be likely to result from the Event of Default, including without limitation Reletting Expenses described below.

b. Re-Entry and Reletting. Landlord may continue this Lease in full force and effect, and with ten (10) days' written notice, re-enter and take possession of the Premises or any part thereof, expel the Tenant from the Premises and anyone claiming through or under the Tenant, and remove the personal property of either. Landlord may relet the Premises, or any part of them, in Landlord's or Tenant's name for the account of Tenant, for such period of time and at such other terms and conditions, as Landlord, in its discretion, may determine. Landlord may collect and receive the rents for the Premises. To the fullest extent permitted by law, the proceeds of any reletting shall be applied: first, to pay Landlord all costs and expenses of such reletting (including without limitation, costs and expenses incurred in retaking or repossessing the Premises, removing persons or property therefrom, securing new tenants, and, if Landlord maintains and operates the Premises, the costs thereof); second, to pay any indebtedness of Tenant to Landlord other than rent; third, to the rent due and unpaid hereunder; and fourth, the residue, if any, shall be held by Landlord and applied in payment of other or future obligations of Tenant to Landlord as the same may become due and payable, and Tenant shall not be entitled to receive any portion of such revenue. Re-entry or taking possession of the Premises by Landlord under this Section shall not be construed as an election on Landlord's part to terminate this Lease, unless a written notice of termination is given to Tenant. Landlord reserves the right following any re-entry or reletting, or both, under this Section to exercise its right to terminate the Lease. Tenant will pay Landlord the rent and other sums which would be payable under this Lease if repossession had not occurred, less the net proceeds, if any, after reletting the Premises, after deducting Landlord's Reletting Expenses. "Reletting Expenses" is defined to include all expenses incurred by Landlord in connection with reletting the Premises, including without limitation, all repossession costs, brokerage commissions, attorneys' fees, remodeling and repair costs, costs for removing and storing Tenant's property and equipment, and tenant improvements and rent concessions granted by Landlord to any new Tenant, prorated over the life of the new lease.

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

d. Failure to Remove Property. If Tenant fails to remove any of its property from the Premises at Landlord's request following an uncured Event of Default, Landlord may, at its option, remove and store the property at Tenant's expense and risk. If Tenant does not pay the storage cost within ten (10) business days of Landlord's request, Landlord may, at its option, have any or all of such property sold at public or private sale (and Landlord may become a purchaser at such sale), in such manner as Landlord deems proper, so long as adequate notice is given to Tenant. Landlord shall apply the proceeds of such sale: (i) to the expense of such sale, including reasonable attorneys' fees actually incurred; (ii) to the payment of the costs or charges for storing such property; (iii) to the payment of any other sums of money which may then be or thereafter become due Landlord from Tenant under any of the terms hereof; and (iv) the balance, if any, to Tenant. Nothing in this Section shall limit Landlord's right to sell Tenant's personal property as permitted by law or to foreclose Landlord's lien for unpaid rent.

23. MORTGAGE SUBORDINATION AND ATTORNMENT. This Lease shall automatically be subordinate to any mortgage or deed of trust created by Landlord which is now existing or hereafter placed upon the Premises including any advances, interest, modifications, renewals, replacements or extensions ("Landlord's Mortgage"). Tenant shall attorn to the holder of any Landlord's Mortgage or any person(s) acquiring the Premises at any sale or other proceeding under any Landlord's Mortgage provided such person(s) assume the obligations of Landlord under this Lease. Tenant shall promptly and in no event later than thirty (30) days after request execute, acknowledge and deliver documents which the holder of any Landlord's Mortgage may reasonably require as further evidence of this subordination and attornment. Notwithstanding the foregoing, Tenant's obligations under this Section to subordinate in the future are conditioned on the holder of each Landlord's Mortgage and each person acquiring the Premises at any sale or other proceeding under any such Landlord's Mortgage not disturbing Tenant's occupancy or use of the Premises, not increasing Tenant's obligations and/or diminishing Tenant's rights under this Lease, so long as no uncured Event of Default exists.

24. NON-WAIVER. Either Party's waiver of any breach of any term contained in this Lease shall not be deemed to be a waiver of the same term for subsequent acts

25. HOLDOVER. If Tenant remains in possession of the Premises or any part thereof after the expiration of the term hereof with the express written consent of the Landlord, such occupancy shall be a tenancy from month to month at the rental paid for the month immediately preceding the expiration of the term. Termination of such month to month tenancy shall be upon thirty (30) days advance written notice. If Tenant remains in possession without the written consent of Landlord, such tenancy shall be a month to month tenancy at a rental in the amount of 125% of the rent last paid for the month immediately preceding the expiration of the term.

26. NOTICES. All notices under this Lease shall be in writing and effective (i) when delivered in person or via overnight courier, (ii) three (3) days after being sent by registered or certified mail, or (iii) via e-mail if an electronic address is listed above, with an original sent by registered or certified mail if the recipient has designated one or more

e-mail addresses in this Lease, to Landlord or Tenant, as the case may be, at the Notice Addresses set forth in Section 1 or such other addresses as may from time to time be designated by such parties in writing. Notices delivered to Tenant must be received at both of the addresses mentioned in Section 1 to satisfy notice requirements.

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

28. ESTOPPEL CERTIFICATES. Tenant shall, from time to time, upon written request of Landlord, execute, acknowledge and deliver to Landlord or its designee within 15 business days of such request a written statement specifying the following, subject to any modifications necessary to make such statements true and complete: (i) the date the Lease term commenced and the date it expires; (ii) the amount of minimum monthly Rent and the date to which such Rent has been paid; (iii) that this Lease is in full force and effect and has not been assigned, modified, supplemented or amended in any way; (iv) that this Lease represents the entire agreement between the parties; (v) that all conditions under this Lease to be performed by Landlord have been satisfied; (vi) that there are no existing claims, defenses or offsets which the Tenant has against the enforcement of this Lease by Landlord; (vii) that no Rent has been paid more than one month in advance; and (viii) that no security has been deposited with Landlord (or, if so, the amount thereof).

29. HAZARDOUS MATERIAL. Landlord represents and warrants to Tenant that, to the best of Landlord's knowledge there is no other "Hazardous Material" (as defined below) on, in or under the Premises as of the Commencement Date, or as may otherwise have been disclosed to Tenant in writing before the execution of this Lease. If there is any Hazardous Material on, in, or under the Premises as of the Commencement Date which has been or thereafter becomes unlawfully released through no fault of Tenant, then Landlord shall indemnify, defend and hold Tenant harmless from any and all claims, judgments, damages, penalties, fines, costs, liabilities, or losses including without limitation sums paid in settlement of claims, attorneys' fees, consultant fees and expert fees, incurred or suffered by Tenant either during or after the Lease term as the result of such contamination. Prior to incurring any costs or expenses hereunder, Tenant agrees to notify Landlord in writing and provide Landlord an opportunity to remedy all items identified by Tenant and associated with such Hazardous Material, at Landlord's sole cost and expense.

Tenant shall not cause or permit any Hazardous Material to be brought upon, kept, or used in or about, or disposed of on the Premises by Tenant, its agents, employees, contractors or invitees, except with Landlord's prior consent and then only upon strict compliance with all applicable federal, state and local laws, regulations, codes and ordinances. Notwithstanding the foregoing, Tenant may handle Hazardous Material to the extent necessary for the Permitted Use as provided in the following paragraph. In addition, Tenant may handle ordinary and general office supplies typically used in office buildings.

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

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

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

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

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

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

32. GENERAL.

a. Rule of Construction. Each party and its counsel have fully participated in the review and revision of this Lease and any rule of construction to the effect that ambiguities are to be resolved against the drafting party shall not apply in the interpretation of this Lease or any exhibit or amendment hereto.

b. Assigns. This Lease shall apply to and be binding upon Landlord and Tenant and their respective successors and assigns.

c. Brokers' Fees Tenant warrants and represents to Landlord that, except for CBRE Group, Inc. ("CBRE"), no brokerage or finder has been engaged by it in connection with the transaction contemplated by this Agreement. Landlord will pay a brokerage fee or commission to CBRE in the amount of two and one-half percent (2.5%) of the gross rent for years 1 through 5 and one and one-quarter percent (1.25%) of the gross base rent for years 6 through 10. The commission shall be earned as follows:

1) Fifty (50%) percent of the total commission due shall be payable within fifteen (15) days after execution of the Lease by Landlord and Tenant. CBRE must furnish Landlord with an invoice for the commission due.

2) The remaining Fifty (50%) percent of the commission due shall be payable not more than fifteen (15) days after Tenant has tendered payment for the Rent on the first and second floor. CBRE must furnish Landlord with an invoice for the commission due.

Should the Tenant execute a Lease but fail to take possession, no commission shall be due to CBRE. This commission agreement is limited to the Base Rent only and only the Lease at the Property. No commission shall be earned by CBRE if Tenant fails to execute a Lease. In the event any other claims for additional commissions by CBRE or another broker for Tenant are made in connection with the negotiation, execution, or consummation of this Agreement, then Tenant shall indemnify, hold harmless, and defend Landlord from and against such claims.

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

e. Severability. Any provision of this Lease which shall prove to be invalid, void or illegal shall in no way affect, impair or invalidate any other provision of this Lease. Any waiver of any terms and conditions hereof must be in writing, and

signed by the parties hereto. A waiver of any term or condition hereof shall not be construed as a future waiver of the same or any other term or condition hereof.

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

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

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

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

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

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

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

m. Records. Notwithstanding anything to the contrary within this Lease or applicable law, Landlord agrees it will not have the right nor shall it lien any of Tenant's patient records, be they in document or electronic form.

n. Right of First Opportunity. Except as provided below, Tenant shall have an on-going and continuing right of first opportunity ("ROFO") to lease: (i) any space within the Building that is now available, before Landlord leases it to any third party; and (ii) any space in the Building that is covered by any lease between

Landlord and any third party and that may become available effective upon expiration of such third party lease, subject to any renewal or extension with respect to such space by such third party. If any space subject to this ROFO is currently available or subsequently becomes available, Landlord shall notify Tenant in writing of the availability of such space (the "ROFO Notice"). The ROFO Notice shall identify specifically the available space location and net rentable area. Tenant shall have the right to lease the space covered by the ROFO Notice by providing Landlord written notice within fifteen (15) Business Days after Tenant's receipt of the ROFO Notice. If Tenant exercises such right, the rentable area of the space covered by the ROFO Notice shall be added to the rentable area of the Premises and shall be leased to Tenant on the same terms and conditions of this Lease, but the Base Rent shall be the fair market rental rate as determined by the appraisal procedure set forth in Section 3(a)above; provided, that the appraisers shall take into consideration any tenant improvement allowance, free rent or other concessions appropriate to any such determination. Upon determination of the applicable Base Rent, the parties shall execute and deliver an amendment to this Lease subjecting such space to this Lease. Such additional space shall be "as is, where is". Notwithstanding anything to the contrary in this Section, Tenant shall not have the right to exercise the ROFO at any time during which an uncured event of default exists under this Lease.

33. CONFIDENTIALITY. In performing their obligations under this Lease, the parties do not expect to exchange any protected health information as defined under federal and state law but Landlord or its agent may be exposed to confidential information if present on the Premises. If at some point the Health Insurance Portability and Accountability Act of 1996 is found to apply to the parties under the terms of the Lease, the parties agree to enter into a business associate agreement.

34. AMENDMENTS. This Lease and each of the Exhibits attached hereto, may be amended at any time by mutual agreement of the parties without additional consideration, provided that before any amendment shall become effective, it shall be reduced to writing and signed by the parties. Notwithstanding the foregoing, should any provision of this Lease be in conflict with a governing state or federal law, it shall be deemed amended accordingly.

35. COUNTERPARTS. This Lease or any subsequent Amendment may be executed in several counterparts, as long as each party to the Lease or Amendment executes at least one such counterpart. Each of such counterparts shall be an original but all of the counterparts, when taken together, shall constitute one and the same instrument and shall become effective when each party hereto has executed at least one such counterpart. The parties hereto agree that an electronic or facsimile signature shall constitute an original signature hereunder.

36. EXHIBITS. The following exhibits and riders are made a part of this Lease.

Exhibit A: Floor Plan/Outline of the Premises
Exhibit B: Legal Description
Exhibit C: Rental Schedule and Commencement Date
Exhibit D: Work Letter
Exhibit E: Commencement Date Memorandum
Exhibit F: Parking Site Plan

[Signatures appear on the following pages.]

IN WITNESS WHEREOF, the parties have executed this Lease as of the dates set forth below.

Tenant:

MULTICARE HEALTH SYSTEM

By: Jim McManus
Its: Senior Vice President and Chief Financial Officer

By: Florence Chang
Its: Executive Vice President and COO

STATE OF WASHINGTON }
ss.
COUNTY OF Pierce }

I certify that I know or have satisfactory evidence that Jim McManus is the person who appeared before me, and said person acknowledged that he signed this instrument, on oath stated that he was authorized to execute the instrument and acknowledged it as the Senior Vice President and Chief Financial Officer of **MultiCare Health System**, a Washington nonprofit corporation, to be the free and voluntary act of such party for the uses and purposes mentioned in the instrument.

DATED this 13th day of September, 2019.

JULIE L STEIN
NOTARY PUBLIC #88137
STATE OF WASHINGTON
COMMISSION EXPIRES
OCTOBER 23, 2022

Printed Name Julie Stein
NOTARY PUBLIC in and for the State of Washington,
residing at Pierce County
My Commission Expires 10/23/2022

STATE OF WASHINGTON }
ss.
COUNTY OF Pierce }

I certify that I know or have satisfactory evidence that Florence Chang is the person who appeared before me, and said person acknowledged that she signed this instrument, on oath stated that she was authorized to execute the instrument and acknowledged it as the Executive Vice President and COO of **MultiCare Health System**, a Washington nonprofit corporation, to be the free and voluntary act of such party for the uses and purposes mentioned in the instrument.

DATED this 13th day of September, 2019.

JULIE L STEIN
NOTARY PUBLIC #88137
STATE OF WASHINGTON
COMMISSION EXPIRES
OCTOBER 23, 2022

Printed Name Julie Stein
NOTARY PUBLIC in and for the State of Washington,
residing at Pierce County
My Commission Expires 10/23/2022

Landlord:

X2 BROADWAY, LLC

By: _____
John M. Xitco, manager

STATE OF WASHINGTON)
) ss.
COUNTY OF PIERCE)

I certify that I know or have satisfactory evidence that John M. Xitco is the person who appeared before me, and said person acknowledged that he signed this instrument, on oath stated that he/she was authorized to execute the instrument and acknowledged it as the Manager of **X2 Broadway, LLC**, a Washington limited liability company, to be the free and voluntary act of such party for the uses and purposes mentioned in the instrument.

DATED this 16 day of September, 2019.

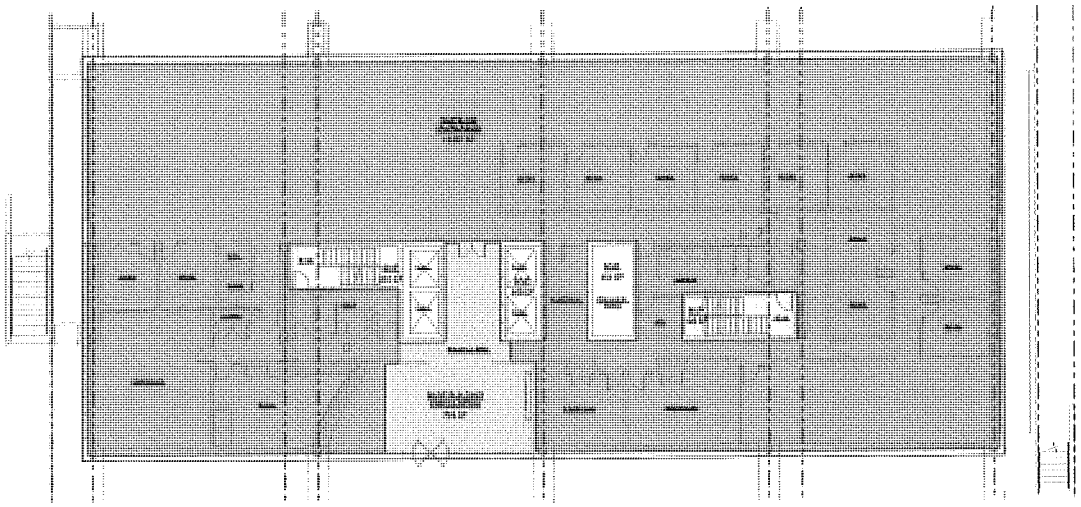
MARK E. HOLCOMB
NOTARY PUBLIC
STATE OF WASHINGTON
COMMISSION EXPIRES
9-19-19

_____
Printed Name Mark Holcomb
NOTARY PUBLIC in and for the State of Washington,
residing at Tacoma
My Commission Expires 9/19/19

EXHIBIT A

Floor Plan/Outline of the Premises

FIRST FLOOR



SECOND FLOOR

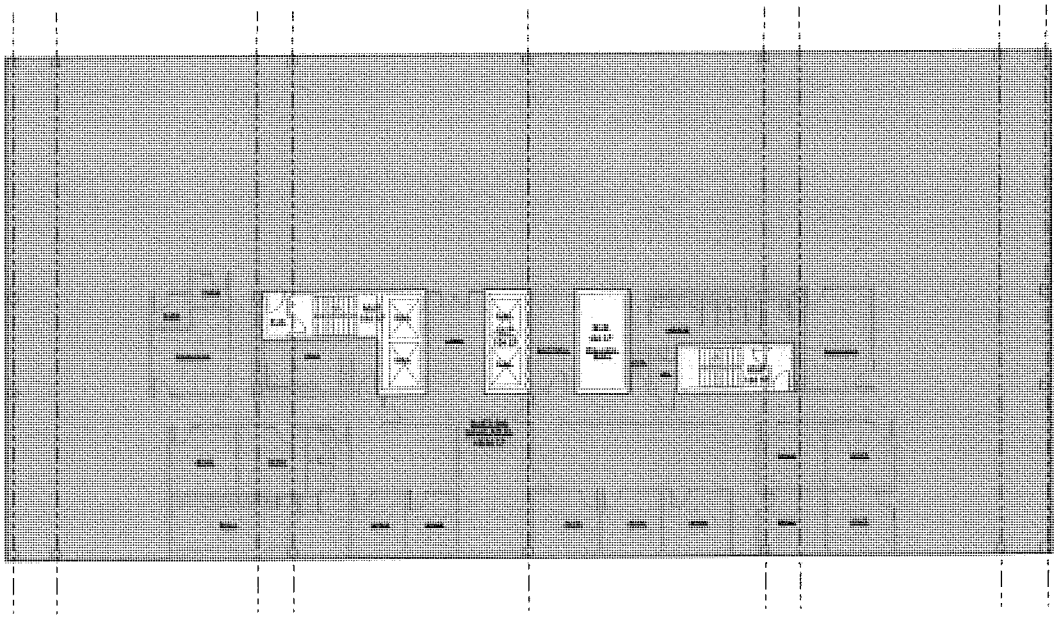


EXHIBIT A ---Continued

Floor Plan/Outline of the Premises

FIFTH FLOOR

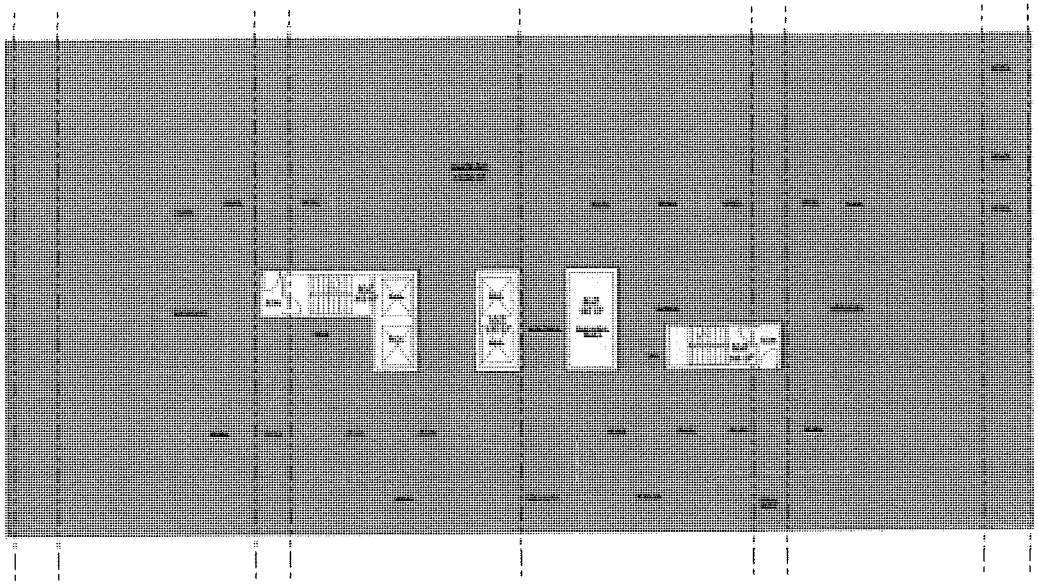


EXHIBIT B

Legal Description

Lots 1 through 15, inclusive, and the North 10 feet of Lot 16, Block 1305, Map of New Tacoma, Washington Territory, according to plat recorded February 3, 1875, in Volume A of Plats, records of Pierce County Auditor;

Situate in the City of Tacoma, County of Pierce, State of Washington.

Tax Parcel No.: 2013050121

EXHIBIT C

Rental Schedule and Commencement Dates

FLOOR	SUITE NO.	RENTABLE SQUARE FOOTAGE*	RENTAL RATE PER RSF	COMMENCEMENT DATE/RENT COMMENCEMENT DATE	TENANT IMPROVEMENT ALLOWANCE PER RSF
First	All	11,667	$24.00	upon mutual execution of Lease Agreement, Rent Commencement is 4 months after Commencement Date	$40.00
Second	All	17,373	$24.00	upon mutual execution of Lease Agreement, Rent Commencement is 4 months after Commencement Date	$40.00
Fifth	All	17,373	$24.00	January 1, 2020 or sooner* Rent Commencement is 4 months after 5th Floor Commencement Date	$40.00

Total estimated RSF of Premises: 46,413

*The lease for the existing tenant located on the Fifth floor expires December 31, 2019; but that tenant has expressed an interest in vacating the Fifth-floor premises earlier. Upon vacation and delivery of the 5th floor from the existing tenant, Landlord shall make the 5th floor and its related parking available to Tenant on or before January 1, 2020. Upon Landlord delivery of the 5th floor to Tenant, no additional Base Rent shall be due that is attributed to the 5th Floor Premises until the first of the month following the expiration of four (4) months from the 5th Floor Commencement Date, however rent commencement shall not occur prior to January 1, 2020..

EXHIBIT D

Work Letter

The improvements to the Premises under the terms of the Lease shall be performed in accordance with the terms of this Work Letter.

1. No Landlord's Work. Landlord shall deliver the Premises in broom clean condition, free from all hazardous materials, and Tenant agrees to accept the Premises "AS-IS". Landlord shall not be obligated to do any improvements to the Premises or Common Area as a condition to the Commencement of this Lease. Landlord shall not be obligated for any improvements or upgrades to the Premises arising out of Tenant's Work, including the cost for sprinkler installation for the Premises (which shall be paid out of the Tenant Improvement Allowance).

2. Tenant's Work. All improvements to the Premises that Tenant requires to ready the Premises for Tenant's use are referred to herein collectively as "Tenant's Work" and shall be designed and made at Tenant's expense and in accordance with the terms of this Work Letter, subject to reimbursement of such costs by Landlord in accordance with Section 2(d) of the Lease. Except as may be otherwise set forth in the Lease, Tenant shall take the Premises on an "as is" condition and all work to be performed at the Premises shall be performed by Tenant at Tenant's expense (except to the extent that Landlord is required to reimburse Tenant for such expenses by providing the Tenant Improvement Allowance described in Section 2(d) of the Lease and Section 4.9 of this Work Letter). Landlord shall be responsible for all asbestos abatement required in the Premises and the Building, subject to Landlord's right of approval as provided below. Tenant shall conduct its own asbestos abatement assessment and provide Landlord with a written estimate of the costs for removing the asbestos resulting from Tenant's Work ("Asbestos Work"). Within three (3) business days from the date of Landlord's receipt of the Asbestos Work bids and plans, Landlord shall approve the same. In the event total estimates for all required Asbestos Work exceed $100,000, Tenant has the option to assume the financial responsibility to pay any excess fees or will have the right to terminate the lease and the parties shall have no further obligations hereunder. Furthermore, if Tenant elects to terminate this Lease, Tenant shall be refunded any and all monies paid to the Landlord preceding the termination in the form of prepaid rent, base rent, occupancy expenses, etc. Tenant agrees to coordinate all asbestos abatement, if necessary, in the Premises with Landlord prior to commencement of Tenant's Work. Landlord shall approve the scope and cost of any asbestos abatement to be performed by Tenant or its contractors. Tenant shall be allowed to submit its total expense incurred for asbestos abatement to Landlord for reimbursement. Landlord agrees to reimburse Tenant for the Asbestos Work within sixty (60) days after the request of Tenant, provided that payment of the reimbursement shall be further subject to the following:

(a) Tenant shall not be in default under the Lease beyond any applicable cure period;

(b) Tenant has performed all the Asbestos Work in accordance

with the approved bid and plans and in accordance with all other applicable provisions of the Lease; and

(c) receipt by Landlord from Tenant of a written representation that all bills for labor and materials for the Asbestos Work have been paid (with invoices or other back-up confirming all costs incurred by tenant for the work with such costs equal to or in excess of the reimbursement amount).

The maximum amount of Landlord's reimbursement for Asbestos Work under this Section shall not exceed $100,000.00 and shall be in addition to any tenant improvement allowance provided in the Lease.

At Landlord's option, Landlord may elect to reimburse Tenant in the form of a rent credit by providing written notice to Tenant of its election. The amount of the rent credit shall be the total amount of the cost of Asbestos Work, divided by twelve (12) with the credit being applied to the next monthly rent due and continuing in the same credit amount until the Asbestos Work is paid in full.

3. Design of Tenant's Work.

3.1 Tenant's Architect. Within ten (10) business days of execution of this Lease Tenant shall engage the services of a licensed architect ("Tenant's Architect") to provide the professional services required for Tenant's Work. Tenant's Architect shall provide all architectural and engineering service as required for Tenant's Work. Tenant shall work diligently with Tenant's Architect in preparing preliminary and final plans, specifications and engineering and construction drawings for Tenant's Work. Tenant's Architect shall work with and be subject to Tenant's direction and control with respect to Tenant's Work, subject to Landlord's approval rights as provided for herein. All plans for Tenant's Work and all modifications thereto shall be subject to the approval of Landlord, which shall not be unreasonably withheld, conditioned or delayed.

3.2 Plans for Tenant's Work. Promptly after Lease execution Tenant shall cause Tenant's Architect to commence preparation of a space plan for Landlord's review and approval. After Landlord's approval thereof, Tenant shall cause Tenant's Architect to prepare preliminary working drawings and plans and specifications for Tenant's Work which shall be based on the space plan approved by Landlord. After completion thereof, Tenant shall submit such to Landlord for its review and comment. After obtaining Landlord's comments therein, Tenant shall cause Tenant's Architect to incorporate Landlord's comments into the final plans and specifications (the "Final Contract Documents") and submit them to Landlord for its final review and approval which approval shall not be unreasonably withheld so long as they are consistent and compatible with base Building plans and systems and do not increase Landlord's costs of operating the Building.

3.3 Contract Administration. Tenant's Architect will provide construction administration during the execution of Tenant's Work and will observe progress of that work, attend necessary contractor coordination meetings, advise Tenant and Landlord on status and progress payments, prepare a punch-list for Tenant's Work of any construction deficiencies at completion and certify Tenant's Work complete prior to move-in.

3.4 Tenant Costs. Tenant shall be responsible and immediately reimburse Landlord upon demand for any damages or other costs incurred by Landlord which are caused by (a) the acts or omissions of Tenant or its employees, agents or contractors while on the Premises; (b) Tenant's requests for changes to the Building; or (c) Tenant's breach of the Lease.

4. Construction of Tenant's Work.

4.1 Commencement. After Landlord's approval or deemed approval of the Final Contract Documents, Tenant shall obtain all governmental approvals and permits required therefor and enter into a construction contract with a general contractor selected by Tenant, and approved by Landlord, , such approval not to be unreasonably withheld; provided that the following General Contractors are pre-approved by Landlord: Howard S. Wright, Anderson Construction, BNBuilders, Abbott Construction, Korsmo Construction and Skanska. The Tenant's Work may commence promptly after obtaining such approval.

4.2 Final Contract Documents and Modifications. If Tenant desires any material change to the Final Contract Documents, Tenant shall submit such change in writing to Landlord for its review and approval, which shall not be unreasonably withheld, and such request shall be accompanied by all plans and specifications necessary to show and explain changes from the approved Final Contract Documents. Landlord shall provide its response within a reasonable period after its receipt of such submittals from Tenant. Tenant shall be responsible for any resulting delay in completion of the Premises due to a modification of Final Contract Documents.

4.3 Tenant's Telephone, Computer and Cable System. Tenant shall be solely responsible for, and shall bear the cost of, the design and installation of its telephone, computer and cable system. Information concerning telephone equipment and cabling sizes and any special requirements must be given to Landlord during the planning phase.

4.4 Inspection. Tenant's Work shall be subject to the inspection of Landlord's representative from time to time during the period in which the Tenant's Work is being performed.

4.5 Hazardous Material Disposal. Tenant shall be solely responsible for the removal and legal disposal of any materials considered as hazardous waste by the local sanitation authority and Tenant shall take all precautions to assure that such materials are not placed in Landlord's disposal containers.

4.6 Performance of Tenant's Work. All work performed by Tenant during its construction period, or otherwise during the Lease term, shall be performed so as to cause the least possible interference with other tenants and the operation of the Building, and Landlord shall have the right to impose reasonable requirements with respect to timing and performance of the Tenant's Work in order to minimize such interference. Tenant shall take all reasonably necessary precautionary steps to protect the Premises and the Building from Tenant's Work, and shall comply with all other reasonable requirements of Landlord with respect to Tenant's Work, including traffic regulations, and delivery and

removal requirements. Landlord shall have the right to order any of Tenant's Contractors who willfully, or at the specific direction of Tenant, violate the above requirements to cease Tenant's Work and to remove its equipment and employees from the Building, but only after Landlord has reasonably attempted to resolve any on site work issues with Tenant and/or Tenant's Contractor.

4.7 Insurance. Tenant shall cause Tenant's Contractors to maintain during the construction period the following insurance: (i) commercial general liability insurance, with limits of not less than $2 million per occurrence, for personal injury, bodily injury or death or property damage or destruction, arising out of or relating to the contractor's work at or in connection with the Premises and completed operations coverage for one (1) year following job completion; (ii) workers' compensation insurance with respect to each contractor's workers at the site or involved in the Tenant's Work, in the amount required by statute; (iii) comprehensive automobile liability insurance covering all owned, hired or non-owned vehicles, including the loading and unloading thereof, with limits of not less than $1 million per occurrence; and (iv) builder's risk property insurance in amounts reasonably determined by Landlord upon consultation with Tenant. Tenant shall require that each of Tenant's Contractors name Landlord, Landlord's property manager, and such other parties as designated by Landlord, as additional insured under clause (i) above. All insurance required hereunder shall be provided by responsible insurers rated at A X or better by A.M. Best's and authorized to do business in the State of Washington. Upon request of Landlord, Tenant shall provide, or cause its contractors to provide, certificates of insurance illustrating compliance with the requirements in this Section 4.7. Such certificates shall state that the coverage may not be reduced or canceled without at least thirty (30) days' prior written notice to Landlord.

4.8 No Penetrations. Due to the construction type of the building, Tenant shall make no penetrations into the roof, ceiling, exterior walls, or floors, unless approved by Landlord in advance.

4.9 HVAC Major Repair Reimbursement. In the event Tenant's Work relating to the HVAC system within the Premises is not covered by warranty from Tenant's contractors or requires any repairs beyond normal maintenance during the initial 24 months of the Lease, Landlord agrees to reimburse Tenant within sixty (60) days after the request of Tenant for the costs of any repairs to its HVAC system serving the Premises which exceed $5,000.00 under the following conditions:

(a) Tenant shall not be in default under the Lease beyond any applicable cure period;

(b) Tenant has performed all the HVAC work in accordance with the approved plans and specifications and in accordance with all other applicable provisions of the Lease, including, but not limited to, the completion of all punchlist items; and

(c) receipt by Landlord from Tenant of a written representation that all bills for labor and materials for the HVAC work done or authorized by Tenant or performed to Tenant's account in connection with the Premises have been paid (with invoices

or other back-up confirming all costs incurred by tenant for the work with such costs equal to or in excess of the reimbursement amount).

The maximum amount of Landlord's reimbursement for HVAC repair under this Section 4.9 shall not exceed $100,000.00 and shall be in addition to any tenant improvement allowance provided in the Lease.

At Landlord's option, Landlord may elect to reimburse Tenant for the HVAC repair in the form of a rent credit by providing written notice to Tenant of its election. The amount of the rent credit shall be the amount of the cost of HVAC repair in excess of $5,000, divided by twelve (12) with the credit being applied to the next monthly rent due and continuing in the same credit amount until the HVAC Work is paid in full.

5. General Provisions. The following provisions shall be applicable to all Tenant's Work, and all subsequent improvements performed by Tenant with respect to the Premises:

(a) Tenant shall be responsible for any increase in energy cost, as additional rent, for all special lighting and any lighting not consistent with applicable energy codes and such lighting shall not be installed without the prior approval of the Landlord.

(b) All work shall be done in conformity with a valid building permit, when required, a copy of which shall be furnished for Landlord before such work is commenced, and in any case, all such work shall be performed in accordance with all applicable laws. Notwithstanding any failure by Landlord to object to any such work, Landlord shall have no responsibility for Tenant's failure to meet all applicable laws.

(c) All work by Tenant or Tenant's Contractors shall be scheduled through Landlord and coordinated with the work of other contractors working on the Building so that it does not delay such other work. Landlord and Tenant shall use good faith efforts to avoid scheduling conflicts.

(d) Landlord shall have the right to post a notice or notices in conspicuous places in or about the Premises announcing its non-responsibility for the work being performed therein.

(e) No improvements shall be constructed that will increase Landlord's costs of maintaining the structural integrity of, or operating, the Premises or Building without Landlord's prior written consent and without Tenant reimbursing Landlord for all increased costs resulting therefrom.

EXHIBIT E

Commencement Date Memorandum

COMMENCEMENT DATE MEMORANDUM AND CONFIRMATION OF LEASE TERMS

Reference is made to that certain Lease Agreement ("Lease") dated _____ between MultiCare Health System ("Tenant") and _____ ("Landlord"), whereby Landlord leased to Tenant and Tenant leased from Landlord certain premises in the building located at _____, Washington and commonly known as _____ ("Building").

Landlord and Tenant hereby acknowledge as follows:

(1) The Parties agree that the correct address of the premises is _____("Premises");

(2) Landlord delivered possession of the Premises to Tenant in a substantially complete condition on _____;

(3) Tenant has accepted possession of the Premises and now occupies the same;

(4) The initial term of the Lease commenced on _____ and will expire on _____; Tenant opened for business on _____;

(5) The Premises contains approximately _____ rentable square feet of space; and

(6) Tenant's obligation to pay rent commenced on _____; provided however, Base Rent shall be abated for the period _____ through _____; and

(7) Tenant has _____ successive options to extend the Lease for _____ years each and the last date for Tenant to exercise the first extension option is _____; and the last date for Tenant to exercise the second extension option is_____; and

(8)

Tenant has Right of First Opportunity to lease any space which comes available in the Building during the Lease Term, including any extensions thereof, subject to the provisions of Paragraph 32 (n) of the Lease; and

(9) Tenant Improvement Allowance of _____ (or $XX.00/RSF) shall be paid by Landlord as cash reimbursement or, upon Tenant's request, as a credit to Base Rent, within thirty (30) days of substantial completion of Tenant's Work and

Tenant's opening for business. As of the date hereof, the Tenant Improvement Allowance remains unpaid by Landlord; and

IN WITNESS WHEREOF, this Commencement Date Memorandum and Confirmation of Lease Terms is dated as of this ___ day of ____, 2019.

TENANT MULTICARE HEALTH SYSTEM

By: _____
Name: _____
Its: _____

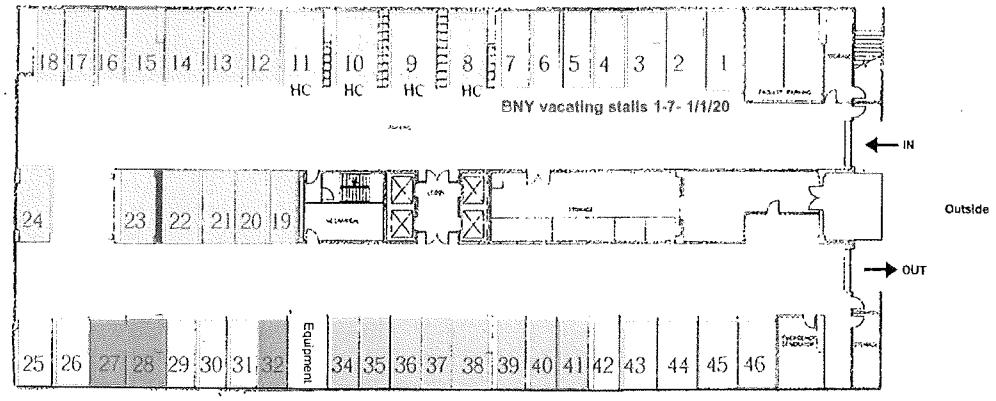
LANDLORD X2 BROADWAY, LLC

By: _____
Name: _____
Its: _____

EXHIBIT F

Parking Site Plan--Outside

1313 BROADWAY PLAZA
TACOMA, WA



INSIDE/UNDER BUILDING PARKING

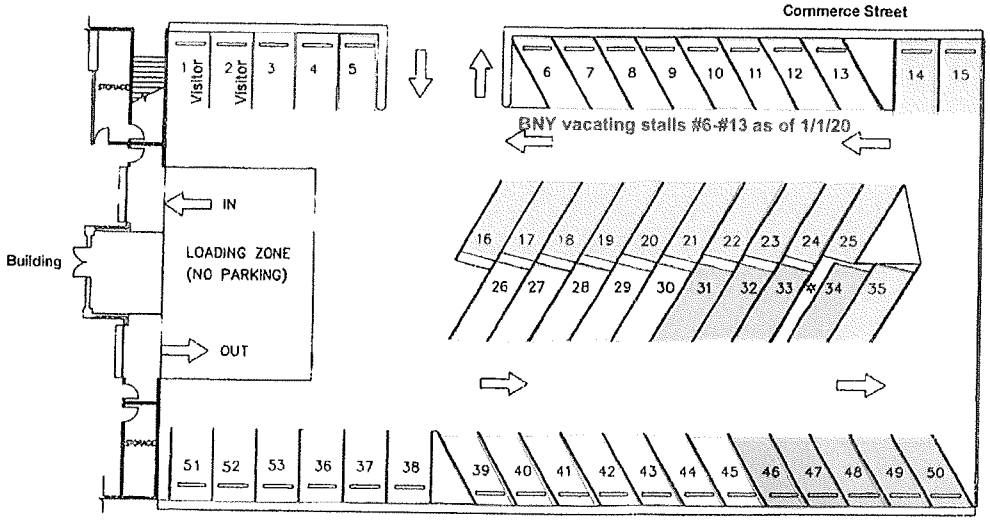
BNY*,per Lease
NW Hardwoods, per Lease
NICB, per Lease
JD Merit, per Lease
Securitas, per Lease
Vacant or MTM

* BNY reducing to 13 stalls as of 1/1/20

EXHIBIT F

Parking Site Plan---Inside

1313 BROADWAY PLAZA
TACOMA, WA



OUTSIDE SURFACE PARKING

- BNY*, per Lease
- NW Hardwoods, per Lease
- NICB, per Lease
- JD Merit, per Lease
- Vacant or MTM

* BNY reducing to 13 stalls as of 1/1/20

Exhibit 9b

First Amendment to 1313 Broadway Lease

FIRST AMENDMENT TO LEASE AGREEMENT
1313 BROADWAY, TACOMA

THIS FIRST AMENDMENT TO LEASE AGREEMENT is dated for reference purposes March 17, 2020, and is made by and between **X2 BROADWAY, LLC**, a Washington limited liability company ("Landlord") and **MULTICARE HEALTH SYSTEM**, a Washington nonprofit corporation (Tenant"), with respect to the following:

RECITALS

A. Landlord and Tenant are the parties to that certain Lease Agreement dated for reference purposes September 1, 2019 ("Lease"), together with all exhibits thereto.

B. Tenant is currently leasing 46,413 RSF under the Lease and desires to lease additional space of 2,215 rentable square feet on the mezzanine area "Expansion Space", as provided below.

C. The parties wish to amend certain provisions of Section 1(a) and Section 2(d) of the Lease to make them consistent with the rentable square footage ("RSF") of the Premises set forth in Exhibit C to the Lease.

D. Capitalized terms used herein shall have their meanings set forth in the Lease, except as otherwise defined herein.

For good and valuable consideration, the parties agree as follows:

AGREEMENT

1. **Leased Premises.**

A. The Premises shall be modified to add the mezzanine floor (2,215 RSF), commonly known as Spaces A, B, C, and D only as outlined on attached Exhibit 1. Exhibit A to the Lease is modified to add the additional floor plan/outline of the Premises attached as Exhibit 1 hereto.

B. The first and second sentences of Section 1(a) of the Lease are hereby amended in its entirety as follows:

> The leased commercial premises ("Premises") consist of an estimated area of 48,628 RSF, and are outlined on the floor plans attached as EXHIBIT A, located in a building ("Building") constructed on land ("Land") legally described on the attached EXHIBIT B, and commonly known as 1313 Broadway, Tacoma, Washington.

C. Rent Commencement Date for the additional Premises described in Paragraph 1(A) above shall be May1, 2020.

D. Base Rent for the "Expansion Space" will be $18.00 per RSF.

E. Tenant will have an on-going right to terminate the "Expansion Space" only by providing Landlord a minimum of one hundred eighty (180) days prior written notice. If Tenant exercises the termination right in this paragraph, Tenant shall pay prior to the termination date for the "Expansion Space" a Termination Fee equal to the unamortized broker commission costs paid in association with the "Expansion Space".

F. Exhibit C to the Lease is hereby amended in its entirety and replaced with Substitute Exhibit C attached hereto.

2. **No Tenant Improvement Allowance**. The additional square footage is provided "as is" where is with no additional allowance for tenant improvement budget.

3. **Pro-Rata Share.** Paragraph 5(a) of the Lease is revised in its entirety to read:

> a. **Pro-Rata Share.** Tenant's "Pro-rata Share" is 51.35%, which is based on the ratio of the rentable square footage of the Premises (48,628 RSF) to the rentable square footage of the Building (94,707 RSF). Any subsequent adjustment to the rentable square footage of the Premises or the Building pursuant to Section 1(a) will be reflected in the adjustment to the Tenant's Pro-rata Share.

4. **No Additional Parking.** No additional parking shall be available or provided by Landlord as part of this amendment to the Lease.

5. **Full Force and Effect**. Except as expressly amended herein, the Lease is unmodified and remains in full force and effect.

6. **Counterparts**. In accordance with Section 35 of the Lease, this First Amendment may be executed in counterparts.

[Signatures appear on following pages.]

IN WITNESS WHEREOF, the parties hereto have executed this First Amendment to the Lease.

Tenant:

MULTICARE HEALTH SYSTEM,
a Washington nonprofit corporation

By: James P. McManus
Its: Senior Vice President and Chief Financial Officer

By: Florence Chang
Its: Executive Vice-President Finance and COO

STATE OF WASHINGTON

} ss.

COUNTY OF PIERCE

I certify that I know or have satisfactory evidence that James P. McManus is the person who appeared before me, and said person acknowledged that he signed this instrument, on oath stated that he was authorized to execute the instrument and acknowledged it as the Senior Vice President and Chief Financial Officer of **MultiCare Health System**, a Washington nonprofit corporation, to be the free and voluntary act of such party for the uses and purposes mentioned in the instrument.

Dated this 17 day of MARCH, 2020.

SOPHIA C GWYNNE
Notary Public
State of Washington
Commission # 209804
My Comm. Expires Jul 13, 2023

SOPHIA C. GWYNNE
Printed Name

Notary Public in and for the State of Washington,
residing at 820 A STREET TACOMA, WA 98402
My Commission Expires JULY 13, 2023

STATE OF WASHINGTON

} ss.

COUNTY OF PIERCE

I certify that I know or have satisfactory evidence that Florence Chang is the person who appeared before me, and said person acknowledged that she signed this instrument, on oath stated that she was authorized to execute the instrument and acknowledged it as the Executive Vice-President and COO of **MultiCare Health System**, a Washington nonprofit corporation, to be the free and voluntary act of such party for the uses and purposes mentioned in the instrument.

Dated this 17 day of MARCH, 2020.

SOPHIA C GWYNNE
Notary Public
State of Washington
Commission # 209804
My Comm. Expires Jul 13, 2023

SOPHIA C. GWYNNE
Printed Name

Notary Public in and for the State of Washington,
residing at 820 A STREET TACOMA, WA 98402
My Commission Expires JULY 13, 2023

--signatures continue--

Landlord:

X2 BROADWAY, LLC,
a Washington limited liability company

By: _____
Name: John M. Xitco
Title: Manager

STATE OF WASHINGTON)
) ss.
COUNTY OF PIERCE)

I certify that I know or have satisfactory evidence that John M. Xitco is the person who appeared before me, and said person acknowledged that he signed this instrument, on oath stated that he was authorized to execute the instrument and acknowledged it as the Manager of **X2 Broadway, LLC**, a Washington limited liability company, to be the free and voluntary act of such party for the uses and purposes mentioned in the instrument.

DATED this 18th day of March, 2020.

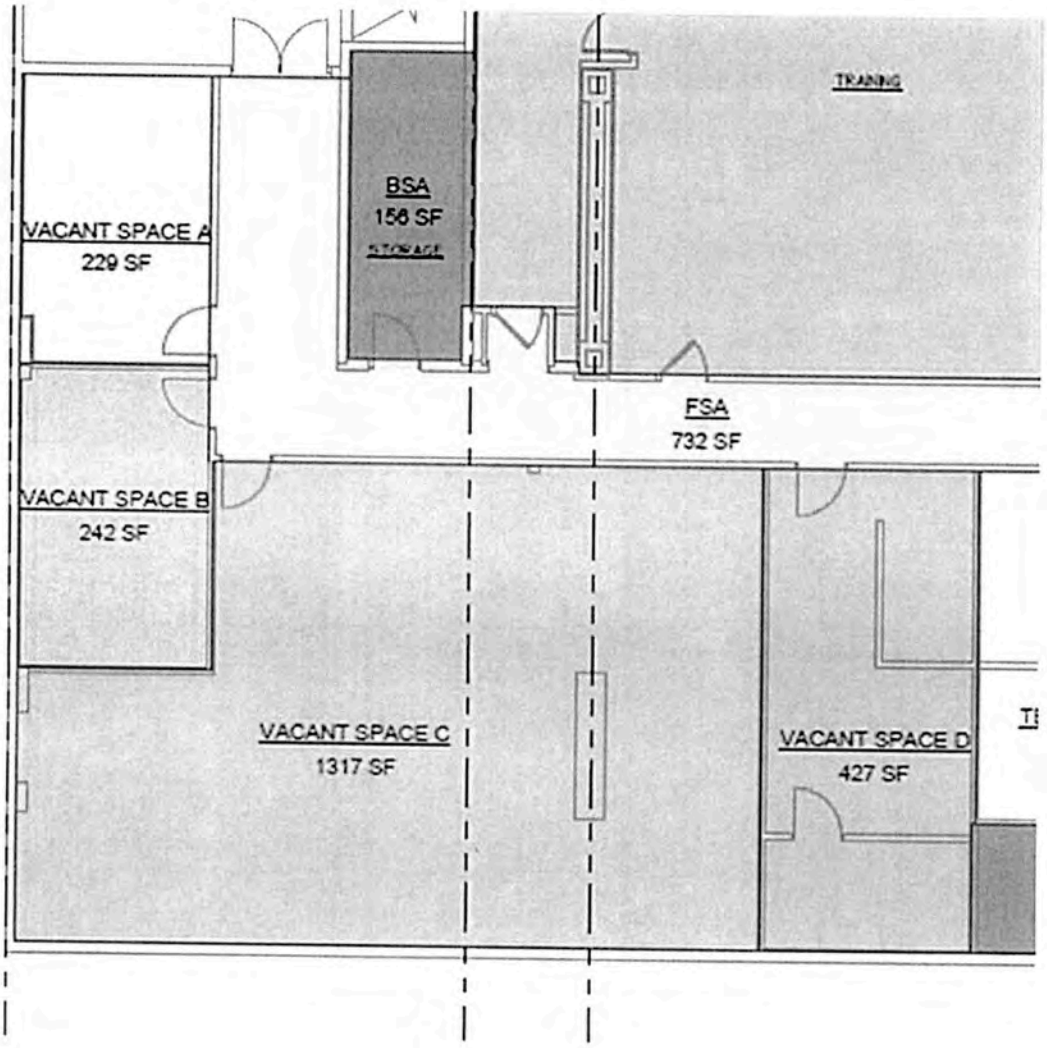
MEGAN M CORDELL
Notary Public
State of Washington
My Appointment Expires Apr 17, 2020

Megan M. Cordell
Printed Name Megan M Cordell
NOTARY PUBLIC in and for the State of Washington,
residing at Lake Tapps
My Commission Expires 4-17-2020

EXHIBIT 1

ADDITIONAL FLOOR PLAN/OUTLINE OF THE PREMISES

-Space A, B, C, and D ONLY



SUBSTITUTE EXHIBIT C

Rental Schedule and Commencement Dates

FLOOR	SUITE NO.	RENTABLE SQUARE FOOTAGE*	RENTAL RATE PER RSF	COMMENCEMENT DATE/RENT COMMENCEMENT DATE	TENANT IMPROVEMENT ALLOWANCE PER RSF
Mezzanine	Spaces A, B, C, and D	2,215	$18.00	May 1, 2020	None
First	All	11,667	$24.00	upon mutual execution of Lease Agreement, Rent Commencement is 4 months after Commencement Date	$40.00
Second	All	17,373	$24.00	upon mutual execution of Lease Agreement, Rent Commencement is 4 months after Commencement Date	$40.00
Fifth	All	17,373	$24.00	January 1, 2020 or sooner* Rent Commencement is 4 months after 5th Floor Commencement Date	$40.00

Total estimated RSF of Premises: 48,628

*The lease for the existing tenant located on the Fifth floor expires December 31, 2019; but that tenant has expressed an interest in vacating the Fifth floor premises earlier. Upon vacation and delivery of the 5th floor from the existing tenant, Landlord shall make the 5th floor and its related parking available to Tenant on or before January 1, 2020. Upon Landlord delivery of the 5th floor to Tenant, no additional Base Rent shall be due that is attributed to the 5th Floor Premises until the first of the month following the expiration of four (4) months from the 5th Floor Commencement Date, however rent commencement shall not occur prior to January 1, 2020

COMMENCEMENT DATE MEMORANDUM
AND CONFIRMATION OF LEASE TERMS

Reference is made to that certain Lease Agreement ("Lease") dated September 1, 2019 between MultiCare Health System ("Tenant") and X2 Broadway, LLC ("Landlord"), whereby Landlord leased to Tenant and Tenant leased from Landlord certain premises in the building located at 1313 Broadway, Tacoma, Washington and commonly known as 1313 Broadway ("Building").

Landlord and Tenant hereby acknowledge as follows:

(1) The Parties agree that the correct address of the premises is 1313 Broadway, Tacoma, WA ("Premises");

(2) Landlord delivered possession of the Premises to Tenant in a substantially complete condition on September 1, 2019 with regards to 1st and 2nd floors, and January 1, 2020 with regards to the 5th floor;

(3) Tenant has accepted possession of the Premises and now occupies the same;

(4) The initial term of the Lease commenced on September 1, 2019 with regards to 1st and 2nd floors, and January 1, 2020 with regards to the 5th floor and will expire on August 31, 2029; Tenant opened for business on or about May 30, 2020 with regards to 1st floor, on or about June 12, 2020 with regards to the 2nd floor, and on or about June 20, 2020 with regards to the 5th floor;

(5) The Premises contains approximately 46,413 rentable square feet of space; and

(6) Tenant's obligation to pay rent commenced on September 1, 2019 with regards to 1st and 2nd floors, and January 1, 2020 with regards to the 5th floor; provided however, Base Rent shall be abated for the period September 1, 2019 through December 31, 2019 with regards to 1st and 2nd floors, and January 1, 2020 through April 30, 2020 with regards to the 5th floor; and

(7) Tenant has two successive options to extend the Lease for five years each and the last date for Tenant to exercise the first extension option is March 4, 2029; and the last date for Tenant to exercise the second extension option is March 4, 2034; and

(8) Tenant has Right of First Opportunity to lease any space which comes available in the Building during the Lease Term, including any extensions thereof, subject to the provisions of Paragraph 32(n) of the Lease; and

(9) Tenant Improvement Allowance of $1,856,520.00 (or $40.00/RSF) shall be paid as a credit to Base Rent ("Rent Credit") per Sec. 2(d) of the Lease. The Rent Credit shall be in the amount of $16,004.48 per month for the first Lease Year (as defined in the Lease, and as confirmed in this memo, the first Lease Year shall be September 1, 2019 – August 31, 2020), and shall increase in the same manner as Base Rent under Sec. 1(d) of the Lease for each Lease Year thereafter (e.g. September 1 of each year) by an amount equal to 2.2% until the full amount of the Tenant Improvement Allowance has been credited.

IN WITNESS WHEREOF, this Commencement Date Memorandum and Confirmation of Lease Terms is dated as of this 12th day of November, 2020.

TENANT

MULTICARE HEALTH SYSTEM

DocuSigned by:
James P. McManus
E46554FCA8C046F...

By: _____
Name: James P. McManus
Its: Senior VP and CFO

LANDLORD

X2 BROADWAY, LLC

By: _____
Name: John M. Xitco
Its: Manager

Exhibit 9c

801 W. 5th Avenue Bargain and Sale Deed

06/30/2017 11:02:56 AM 6617253
Recording Fee $85.00 Page 1 of 13
Deed FIRST, AMERICAN TITLE INSURANCE COMPANY
Spokane County Washington

AFTER RECORDING RETURN TO:

Steven R. Rovig
Hillis Clark Martin & Peterson P.S.
999 Third Avenue, Suite 4600
Seattle, WA 98104

6/30/2017 20170366
MWG $2,143,030.50 (1of2)

BARGAIN AND SALE DEED

809461-2

Grantor(s): SPOKANE WASHINGTON HOSPITAL COMPANY, LLC, a Delaware limited liability company

Grantee(s): MULTICARE HEALTH SYSTEM, a Washington nonprofit corporation

Parcel (per Legal Description)	Assessor's Property Tax Parcel Numbers	Abbreviated Legal Descriptions
Parcel A	35192.5102, 35192.5114, 35192.5103, 35192.5105, 35192.5104, 35192.5113, 35192.3619	L1-12/BLK47 FIRST ADD TO SPOKANE FALLS
Parcel B	35192.3801, 35192.3802, 35192.3803, 35192.3807, 35192.3808, 35192.3809, 35192.3810, 35192.3811, 35192.3812	L1, 2, 3, 7, 8, 9, 10, 11, AND 12/BLK 49 FIRST ADD TO THE TOWN OF SPOKANE FALLS
Parcel C	35192.5222	PTN. BLK "B" AMENDED PLAT OF BLKS A & B, 2nd ADD TO RR ADD
Parcel D	35192.5208	PTN. BLK "A" & "B" AMENDED PLAT OF BLKS A & B, 2nd ADD TO RR ADD
Parcel E	35192.5210	PTN. BLK "B" AMENDED PLAT OF BLKS A & B, 2nd ADD TO RR ADD TO SPK FALLS
Parcel F	35192.5211	PTN. BLK "B" AMENDED PLAT OF BLKS A & B, 2nd ADD TO RR ADD
Parcel G	35192.5212	PTN. BLK B AMENDED PLAT BLKS "A" AND "B" 2ND ADD TO RR ADD
Parcel H	35193.0003	PTN. W1/2 19-25-43 AND TT "D" HILL PK
Parcel I	35193.0004	NE SW 19-25-43 AND TT "C" HILL PK
Parcel J	35193.0006	L "A" AND W25FT OF L "B" HILL PK AND PTN. NE SW 19-25-43
Parcel N	35191.3201	PTN. L1-2 BLK 74 RAILROAD SECOND ADD
Parcel O	35203.0321	LOTS 17 & 18/BLK 1 CAZENOVIA HGTS.

(Complete legal descriptions attached as Exhibit A)

BARGAIN AND SALE DEED

That the undersigned, **SPOKANE WASHINGTON HOSPITAL COMPANY, LLC**, a Delaware limited liability company ("Grantor"), for and in consideration of the sum of TEN AND 00/100 DOLLARS ($10.00) and other good and valuable consideration, in hand paid by **MULTICARE HEALTH SYSTEM**, a Washington not-for-profit corporation ("Grantee"), the receipt of which is hereby acknowledged, hereby bargains, sells and conveys to Grantee, and unto its successors and assigns forever, that certain real property lying in Spokane County, Washington, as more particularly described on Exhibit A, which is attached hereto and incorporated herein by reference, together with all improvements, any construction in progress, any other buildings and fixtures thereon, and all rights, privileges and easements appurtenant thereto (all of the foregoing being hereinafter collectively referred to as the "Property").

This conveyance of the Property, and all covenants and warranties contained herein, are subject only to the matters described on Exhibit B, which is attached hereto and incorporated herein by reference (the "Permitted Encumbrances").

The Grantor for itself and for its successors in interest does hereby covenant that against all persons whomsoever lawfully claiming or to claim by, through, or under said Grantor, but not otherwise, it will forever warrant and defend the said described real estate, subject to the Permitted Encumbrances.

[Remainder of Page Intentionally Left Blank; Signature Page Follows]

IN WITNESS WHEREOF, Grantor has executed this Bargain and Sale Deed as of June 26, 2017.

SPOKANE WASHINGTON HOSPITAL COMPANY, LLC, a Delaware limited liability company

By: _____
Terry H. Hendon, Vice President

STATE OF TENNESSEE)
) ss
COUNTY OF Davidson)

I certify that I know or have satisfactory evidence that **TERRY H. HENDON** is the person who appeared before me, and said person acknowledged that he signed this instrument, and acknowledged it as the Vice President of **SPOKANE WASHINGTON HOSPITAL COMPANY, LLC**, a Delaware limited liability company, to be the free and voluntary act of such entity for the uses and purposes mentioned in the instrument.

DATED: June 26, 2017

COLLEEN L. LLOY
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY
My Commission Expires MAY 5, 2020

_____
NAME Colleen L. Lloy
(Print Name)

Notary Public in and for the State of Tennessee
Commission Expires: May 5, 2020

EXHIBIT A

Description of the Property

THE LAND REFERRED TO HEREIN BELOW IS SITUATED IN THE COUNTY OF SPOKANE, STATE OF WASHINGTON, AND IS DESCRIBED AS FOLLOWS:

PARCEL A:

LOTS 1 THROUGH 12 IN BLOCK 47 OF FIRST ADDITION TO SPOKANE FALLS, AS PER PLAT THEREOF RECORDED IN VOLUME "A" OF PLATS, PAGE 7, IN SPOKANE COUNTY, WASHINGTON.

TOGETHER WITH ALL OF THE VACATED ALLEYS IN SAID BLOCK 47.

AND LOTS 1 THROUGH 14, INCLUSIVE, BLOCK "A", AMENDED PLAT OF BLOCKS A AND B, SECOND ADDITION TO RAILROAD ADDITION AS PER PLAT THEREOF RECORDED IN VOLUME "A" OF PLATS, PAGE 10, IN SPOKANE COUNTY, WASHINGTON.

TOGETHER WITH ALL OF VACATED ALLEYS IN SAID BLOCK "A".

PARCEL B:

LOTS 1, 2, 3, 7, 8, 9, 10, 11 AND 12 IN BLOCK 49 OF FIRST ADDITION TO THE TOWN OF SPOKANE FALLS AS PER PLAT THEREOF RECORDED IN VOLUME "A" OF PLATS, PAGE 7, IN SPOKANE COUNTY, WASHINGTON.

TOGETHER WITH ALL OF THE VACATED ALLEY IN SAID BLOCK.

ALSO TOGETHER WITH THE WEST HALF OF VACATED MADISON STREET LYING EAST OF AND ADJACENT TO LOT 7 AND THE VACATED ALLEY.

PARCEL C:

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

COMMENCING AT THE NORTHWEST CORNER OF SAID BLOCK;
THENCE EAST 426.35 FEET;
THENCE SOUTH 234 FEET;
THENCE WEST 100 FEET;
THENCE NORTH 7 FEET;
THENCE WEST 176.35 FEET;
THENCE NORTH 27 FEET;
THENCE WEST 150 FEET;
THENCE NORTH 200 FEET TO THE POINT OF BEGINNING;

ALSO THAT PORTION OF SAID BLOCK B DESCRIBED AS FOLLOWS:

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

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

PARCEL D:

A TRACT OF LAND IN AMENDED PLAT OF BLOCKS A AND B OF SECOND ADDITION TO THE RAILROAD ADDITION, IN SPOKANE COUNTY, WASHINGTON, DESCRIBED AS FOLLOWS:

BEGINNING AT A POINT 150 FEET EAST OF THE EAST SIDE OF LINCOLN STREET AND 227 FEET SOUTH OF THE SOUTH SIDE OF 5TH AVENUE;
THENCE RUNNING SOUTH 65 FEET;
THENCE EAST 151-1/4 FEET, MORE OR LESS TO THE WEST SIDE OF POST STREET;
THENCE NORTH ALONG THE WEST SIDE OF POST STREET 65 FEET;
THENCE WEST 151-1/4 FEET, MORE OR LESS TO THE POINT OF BEGINNING.

PARCEL E:

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

BEGINNING AT A POINT ON THE WEST LINE OF SAID BLOCK, 200 FEET SOUTH OF THE NORTHWEST CORNER OF SAID BLOCK;
THENCE SOUTH ALONG THE WEST LINE OF SAID BLOCK, A DISTANCE OF 92 FEET;
THENCE EAST 150 FEET;
THENCE NORTH 92 FEET;
THENCE WEST 150 FEET TO THE POINT OF BEGINNING.

PARCEL F:

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

BEGINNING AT A POINT 292 FEET SOUTH OF THE NORTHWEST CORNER;
THENCE EAST 301.35 FEET;
THENCE SOUTH 84 FEET;
THENCE EAST 12.5 FEET;
THENCE SOUTH 141 FEET;
THENCE WEST 313.85 FEET;
THENCE NORTH 225 FEET TO THE POINT OF BEGINNING.

PARCEL G:

THAT PORTION OF BLOCK B, AMENDED PLAT BLOCKS "A" AND "B" 2ND ADDITION TO RAILROAD ADDITION AS PER PLAT THEREOF RECORDED IN VOLUME "A" OF PLATS, PAGE 10, IN SPOKANE COUNTY, WASHINGTON, DESCRIBED AS FOLLOWS:

BEGINNING 376 FEET SOUTH AND 342.5 FEET WEST OF THE NORTHEAST CORNER OF BLOCK B;
THENCE EAST 112.5 FEET;

THENCE SOUTH 149 FEET;
THENCE WEST 75 FEET;
THENCE NORTH 8 FEET;
THENCE WEST 37.5 FEET;
THENCE NORTH 141 FEET TO THE POINT OF BEGINNING.

PARCEL H:

THAT PORTION OF THE WEST HALF OF SECTION 19, TOWNSHIP 25 NORTH, RANGE 43 EAST, W.M., AND OF TRACT D, HILL PARK AS PER PLAT THEREOF RECORDED IN VOLUME "D" OF PLATS, PAGE 23, IN SPOKANE COUNTY, WASHINGTON, DESCRIBED AS FOLLOWS:

BEGINNING AT A POINT 231.35 FEET WEST OF A POINT 8 FEET SOUTH OF THE SOUTHEAST CORNER OF BLOCK B OF THE AMENDED PLAT OF BLOCKS A AND B OF SECOND ADDITION TO THE RAILROAD ADDITION TO SPOKANE FALLS (NOW SPOKANE), AND RUNNING
THENCE SOUTHERLY PARALLEL WITH THE WEST LINE OF BLOCK 95 OF SECOND ADDITION TO THE RAILROAD ADDITION TO SPOKANE FALLS (NOW SPOKANE) TO THE SOUTH LINE OF TRACT D IN HILL PARK, SAID SOUTH LINE OF SAID TRACT D BEING THE NORTH LINE OF SEVENTH AVENUE;
THENCE WESTERLY ALONG THE SOUTH LINE OF SAID TRACT D TO THE SOUTHWEST CORNER OF SAID TRACT D; THENCE NORTHERLY ON A LINE PARALLEL WITH THE EAST LINE OF BLOCK 57 OF RAILROAD ADDITION TO SPOKANE FALLS (NOW SPOKANE) 157.5 FEET, MORE OR LESS TO A POINT 8 FEET SOUTH OF THE SOUTH LINE OF SAID BLOCK B OF THE AMENDED PLAT OF BLOCKS A AND B OF SECOND ADDITION TO THE RAILROAD ADDITION TO SPOKANE FALLS (NOW SPOKANE);
THENCE EAST PARALLEL WITH THE SOUTH LINE OF SAID BLOCK B, 75 FEET TO THE PLACE OF BEGINNING.

PARCEL I:

THAT PORTION OF THE NORTHEAST QUARTER OF THE SOUTHWEST QUARTER OF SECTION 19, TOWNSHIP 25 NORTH, RANGE 43 EAST, W.M., SPOKANE COUNTY, WASHINGTON DESCRIBED AS FOLLOWS:

BEGINNING AT A POINT ON THE SOUTH LINE OF BLOCK "B" OF THE 2ND ADDITION TO RAILROAD ADDITION TO THE TOWN OF SPOKANE, WHICH POINT IS 306.35 FEET WESTERLY FROM THE SOUTHEAST CORNER OF SAID BLOCK "B";
THENCE SOUTH PARALLEL WITH THE WEST LINE OF BLOCK 95 OF SAID ADDITION, 158 FEET;
THENCE WEST PARALLEL WITH THE SOUTH LINE OF SAID BLOCK "B" 100 FEET;
THENCE NORTH PARALLEL WITH THE EAST LINE OF BLOCK 57 OF SAID ADDITION 158 FEET;
THENCE EAST ALONG THE SOUTH LINE OF SAID BLOCK "B" 100 FEET TO THE POINT OF BEGINNING;

ALSO TRACT "C" OF HILL PARK AS PER PLAT THEREOF RECORDED IN VOLUME "D" OF PLATS, PAGE 23, IN SPOKANE COUNTY, WASHINGTON.

PARCEL J:

LOT "A" AND THE WEST 25 FEET OF LOT "B" OF HILL PARK AS PER PLAT THEREOF RECORDED IN VOLUME "D" OF PLATS, PAGE 23, IN SPOKANE COUNTY, WASHINGTON.

ALSO, THAT PORTION OF THE NORTHEAST QUARTER OF THE SOUTHWEST QUARTER OF SECTION 19, TOWNSHIP 25 NORTH, RANGE 43 EAST, W.M., SPOKANE COUNTY, WASHINGTON, DESCRIBED AS FOLLOWS:

BEGINNING AT THE NORTHWEST CORNER OF LOT "A" OF HILL PARK;
THENCE NORTH 158 FEET ALONG THE EASTERLY LINE OF LINCOLN STREET 158 FEET TO THE SOUTHWEST CORNER OF UNPLATTED BLOCK "B" OF SECOND ADDITION TO THE RAILROAD ADDITION AS PER PLAT THEREOF RECORDED IN VOLUME "A" OF PLATS, PAGES 8 AND 9;
THENCE EAST ALONG THE SOUTH LINE OF SAID UNPLATTED BLOCK "B", 125 FEET;
THENCE SOUTH AND PARALLEL TO THE EASTERLY LINE OF LINCOLN STREET, 158 FEET TO THE NORTH LINE OF LOT "B" OF HILL PARK;
THENCE WESTERLY ALONG THE NORTH LINE OF LOTS "B" AND "A" OF SAID HILL PARK, 125 FEET TO THE POINT OF
BEGINNING.

PARCELS C THROUGH J ARE ALSO DESCRIBED AS FOLLOWS:

A TRACT OF LAND BEING A PORTION OF BLOCK "B" AMENDED PLAT OF BLOCKS A AND B, SECOND ADDITION TO RAILROAD ADDITION TO SPOKANE FALLS ACCORDING TO THE PLAT RECORDED IN VOLUME A OF PLATS PAGE 10; ALSO BEING A PORTION OF THE NORTHEAST QUARTER OF THE SOUTHWEST QUARTER OF SECTION 19, TOWNSHIP 25 NORTH RANGE 43 EAST, W.M.; ALSO BEING A PORTION OF HILL PARK AS PER PLAT THEREOF RECORDED IN VOLUME "D" OF PLATS PAGE 23; IN SPOKANE COUNTY, WASHINGTON; ALL BEING MORE PARTICULARLY DESCRIBED AS FOLLOWS:

BEGINNING AT THE NORTHWEST CORNER OF BLOCK "B" AMENDED PLAT OF BLOCKS A AND B, SECOND ADDITION TO RAILROAD ADDITION;
THENCE SOUTH 89° 58' 17" EAST ALONG THE SOUTH RIGHT OF WAY LINE OF WEST 5TH AVENUE A DISTANCE OF 426.11 FEET;
THENCE SOUTH 00° 03' 57" WEST A DISTANCE OF 170.00 FEET;
THENCE SOUTH 89° 58' 17" EAST A DISTANCE OF 79.95 FEET;
THENCE NORTH 00° 03' 57" EAST, A DISTANCE OF 170.00 FEET TO A POINT ON THE SOUTH RIGHT OF WAY OF WEST 5TH AVENUE;
THENCE SOUTH 89° 58' 17" EAST ALONG THE SOUTH RIGHT OF WAY LINE OF WEST 5TH AVENUE A DISTANCE OF 10.00 FEET;
THENCE SOUTH 00° 03' 57" WEST A DISTANCE OF 234.00 FEET;
THENCE NORTH 89° 58' 17" WEST A DISTANCE OF 189.95 FEET;
THENCE NORTH 00° 03' 57" EAST A DISTANCE OF 7.00 FEET;
THENCE NORTH 89° 58' 17" WEST A DISTANCE OF 25.97 FEET;
THENCE SOUTH 00° 04' 48" EAST A DISTANCE OF 147.12 FEET TO A POINT ON THE SOUTH RIGHT OF WAY LINE WEST 6TH AVENUE;
THENCE SOUTH 89° 56' 30" EAST ALONG SAID SOUTH RIGHT OF WAY LINE A DISTANCE OF 126.09 FEET;
THENCE SOUTH 00° 03' 57" WEST A DISTANCE OF 149.00 FEET;
THENCE NORTH 89° 58' 17" WEST A DISTANCE OF 1.48 FEET;
THENCE SOUTH 00° 03' 57" WEST A DISTANCE OF 160.48 TO A POINT ON THE NORTH RIGHT OF WAY LINE OF WEST 7TH AVENUE;
THENCE ALONG SAID NORTH RIGHT OF WAY LINE THE FOLLOWING COURSES:
NORTH 62° 15' 18" WEST A DISTANCE OF 2.90 FEET,
NORTH 70° 39' 52" WEST A DISTANCE OF 21.19 FEET,
SOUTH 87° 10' 59" WEST A DISTANCE OF 20.02 FEET,
SOUTH 81° 30' 53" WEST A DISTANCE OF 20.22 FEET,
SOUTH 80° 50' 48" WEST A DISTANCE OF 12.51 FEET,
SOUTH 75° 23' 39" WEST A DISTANCE OF 7.91 FEET,
SOUTH 82° 55' 14" WEST A DISTANCE OF 20.16 FEET,
NORTH 84° 14' 38" WEST A DISTANCE OF 20.10 FEET,
NORTH 81° 25' 26" WEST A DISTANCE OF 20.22 FEET,
NORTH 88° 31' 21" WEST A DISTANCE OF 20.01 FEET,

NORTH 82° 49' 46" WEST A DISTANCE OF 12.45 FEET;
THENCE NORTH 00° 05' 02" EAST A DISTANCE OF 162.96 FEET;
THENCE NORTH 89° 57' 16" WEST A DISTANCE OF 125.00 FEET;
THENCE SOUTH 00° 05' 02" WEST A DISTANCE OF 163.53 FEET TO A POINT ON THE NORTH RIGHT OF WAY LINE OF WEST 7TH AVENUE;
THENCE ALONG SAID NORTH RIGHT OF WAY LINE THE FOLLOWING COURSES:
NORTH 78° 38' 41" WEST A DISTANCE OF 2.70 FEET,
SOUTH 78° 44' 08" WEST A DISTANCE OF 20.40 FEET,
SOUTH 66° 59' 39" WEST A DISTANCE OF 2.55 FEET,
SOUTH 56° 52' 37" WEST A DISTANCE OF 9.14 FEET,
SOUTH 82° 55' 14" WEST A DISTANCE OF 20.16 FEET,
NORTH 89° 57' 16" WEST A DISTANCE OF 72.36 FEET;
TO A POINT ON THE EAST RIGHT OF WAY LINE OF SOUTH LINCOLN STREET;
THENCE NORTH 00° 05' 02" EAST ALONG SAID EAST RIGHT OF WAY LINE A DISTANCE OF 691.19 FEET TO THE POINT
OF BEGINNING.

PARCEL N:

LOT 1 AND THE WEST 32 FEET OF LOT 2 IN BLOCK 74 OF SECOND ADDITION TO RAILROAD ADDITION AS PER PLAT THEREOF RECORDED IN VOLUME "A" OF PLATS, PAGE 8, IN SPOKANE COUNTY, WASHINGTON.

PARCEL O:

LOTS 17 AND 18 IN BLOCK 1 OF CAZENOVIA HEIGHTS ADDITION AS PER PLAT THEREOF RECORDED IN VOLUME "B" OF PLATS, PAGE 26, IN SPOKANE COUNTY, WASHINGTON.

PARCEL P:

AN EASEMENT FOR PLANNING, CONSTRUCTION, ESTABLISHMENT, MAINTENANCE AND USE OF SKYWALK BRIDGE AND CORRIDORS THERETO FOR ACCESS TO, FROM AND BETWEEN THE SHRINERS HOSPITAL AND DEACONESS HOSPITAL AS PROVIDED FOR IN SKYWALK EASEMENT AND MAINTENANCE AGREEMENT RECORDED UNDER RECORDING NO. 8904280330.

EXHIBIT B

Permitted Encumbrances

1. Taxes and assessments for the year 2017 and subsequent years, not yet due and payable.

2. Rights of tenants pursuant to unrecorded leases assumed by Grantee.

3. Easements, restrictions and other matters of record, so long as such matters do not, collectively or individually, materially interfere with the operations of the Property in a manner consistent with the current use by Grantor.

4. Zoning regulations and other governmental laws, rules, regulations, codes, orders and directives affecting the Property.

5. Unrecorded easements, discrepancies, boundary line disputes, overlaps, encroachments and other matters that would be revealed by an accurate survey or inspection of the Property, so long as such matters do not, collectively or individually, materially interfere with the operations of the Property in a manner consistent with the current use by Grantor.

6. Any non-monetary encumbrances or defects that do not materially interfere with the operations of the Property in a manner consistent with the current use by Grantor.

7. Matters disclosed by an ALTA/NSPS survey made by Boundary Boys, LLC for Bock & Clark National Coordinators on February 5, 2017, last revised May 10, 2017, designated Job Number 201604522-001.

8. Right, title and interest of the City of Spokane to that portion of Parcel P lying within West Fifth Avenue.

The Following Matters Affect Parcel A:

9. Easement rights and maintenance agreements, if any, for utilities which may have been granted in vacated streets and alleys prior to their vacation. (Ordinance No. C-23065 and C-20730)

10. The terms and provisions contained in the document entitled "Easement and Permit" recorded March 18, 1983 as Recording No. 8303180147 of Official Records.

11. The terms and provisions contained in the document entitled "Covenant" recorded October 20, 1988 as Recording No. 8810200249 of Official Records.

12. The terms and provisions contained in the document entitled "Skywalk Easement and Maintenance Agreement" recorded April 28, 1989 as Recording No. 8904280330 of Official Records.

13. The terms and provisions contained in the document entitled "Application for Approval of Encroachment" recorded August 27, 1991 as Recording No. 9108270224 of Official Records.

14. The terms and provisions contained in the document entitled "Covenant" recorded October 17, 1991 as Recording No. 9110170135 of Official Records.

15. The terms and provisions contained in the document entitled "Easement and Permit" recorded April 27, 1993 as Recording No. 9304270376 of Official Records.

16. The terms and provisions contained in the document entitled "Agreement and Permit" recorded April 27, 1993 as Recording No. 9304270377 of Official Records.

17. The terms and provisions contained in the document entitled "Skywalk Permit and Agreement" recorded April 27, 1993 as Recording No. 9304270378 of Official Records.

18. The terms and provisions contained in the document entitled "Covenant" recorded May 18, 1993 as Recording No. 9305180592 of Official Records.

19. The terms and provisions contained in the document entitled "Covenant" recorded July 25, 2001 as Recording No. 4613199 of Official Records.

20. Easement, including terms and provisions contained therein:

    Recording Information: September 15, 2003 under Recording No. 4963097
    In Favor of: Comcast of Pennsylvania/Washington/West Virginia, L.P., a Colorado limited partnership
    For: Construct, operate and maintain broadband communication system

21. Easement, including terms and provisions contained therein:

    Recording Information: December 9, 2009 as Recording No. 5858331
    In Favor of: Comcast of Pennsylvania/Washington/West Virginia, LP
    For: Cable communications system

The Following Matters Affect Parcel B

22. Easement rights and maintenance agreements, if any, for utilities which may have been granted in vacated streets and alleys prior to their vacation. (Ordinance C-23107 and C-26351)

23. Easement, including terms and provisions contained therein:

Recording Information: October 15, 1947 under Recording No. 778816A
In Favor of: Not stated
For: Water line

24. The terms and provisions contained in the document entitled "Easement and Permit" recorded October 21, 1986 as Recording No. 8610210206 of Official Records.

The Following Matters Affect Parcel C:

25. Easement, including terms and provisions contained therein:

Recording Information: November 27, 1909 under Recording No. 260793
In Favor of: Martin H. Conger
For: Construct a private sewer

26. Easement, including terms and provisions contained therein:

Recording Information: December 6, 1909 under Recording No. 261699
In Favor of: Elizabeth O'Brien
For: Maintain sewer

27. Easement, including terms and provisions contained therein:

Recording Information: December 29, 1988 under Recording No. 8812290181
In Favor of: The Washington Water Power Company, a Washington corporation
For: Construct, operate and maintain an electrical distribution/transmission line with associated fixtures; remove brush and trees

The Following Matters Affect Parcel D:

28. Easement, including terms and provisions contained therein:

Recording Information: October 9, 1973 under Recording No. 7310090411
In Favor of: The Washington Water Power Company, a Washington corporation
For: Construct, operate and maintain an electrical distribution/transmission line with associated fixtures

The Following Matters Affect Parcel F:

29. Easement, including terms and provisions contained therein:

Recording Information: May 23, 1941 under Recording No. 495857A
In Favor of: The Washington Water Power Company
For: Construct, operate and maintain an electrical distribution line; remove brush and trees

30. Easement, including terms and provisions contained therein:

Recording Information: October 9, 1973 under Recording No. 7310090411
In Favor of: The Washington Water Power Company, a Washington corporation
For: Construct, operate and maintain an electrical distribution/transmission line with associated fixtures

The Following Matters Affect Parcel G:

31. Easement, including terms and provisions contained therein:

Recording Information: May 23, 1941 under Recording No. 495826A
In Favor of: The Washington Water Power Company, a Washington corporation
For: Construct, operate and maintain an electrical distribution/transmission line with associated fixtures; remove brush and trees

The Following Matters Affect Parcel I:

32. Easement, including terms and provisions contained therein:

Recording Information: March 25, 1992 under Recording No. 9203250314
In Favor of: The Washington Water Power Company
For: Maintain the existing natural gas pipeline; remove brush and trees

33. 48. Easement, including terms and provisions contained therein:

Recording Information: November 30, 1992 under Recording No. 9211300128
In Favor of: The Washington Water Power Company
For: Construct, operate and maintain and electrical distribution line; remove brush and trees

The Following Matters Affect Parcel N:

34. The terms and provisions contained in the document entitled "Special Permit" recorded January 21, 1986 as Recording No. 8601210146 of Official Records.

The Following Matters Affect Parcel O:

35. Easement, including terms and provisions contained therein:

Recording Information: May 22, 1989 under Recording No. 8905220227
In Favor of: The Washington Water Power Company, a Washington corporation
For: Construct, operate and maintain an electrical distribution/transmission line with associated fixtures; remove brush and trees

36. Easement, including terms and provisions contained therein:

Recording Information: October 9, 1995 under Recording No. 9510090297
In Favor of: Inland Northwest Health Services, a Washington non-profit corporation
For: Maintain and replace telecommunication and computer service lines

Exhibit 10
Financial Pro Forma

MultiCare Health System - Home Health and Hospice
Statement of Operations

	For The Period Ending December 31, 2020	For The Period Ending December 31, 2021	For The Period Ending December 31, 2022	For The Period Ending September 30, 2023	Annualized 2023
PATIENT SERVICE REVENUES:					
TOTAL PATIENT SERVICE REVENUES	32,341,487	29,907,740	27,701,765	25,088,255	33,451,007
DEDUCTIONS FROM REVENUES:					
Contractual Adjustments	4,379,936	3,143,180	3,485,877	3,583,036	4,777,381
Charity Care	118,966	49,995	141,363	116,907	155,876
Provision for Bad Debts	8,062	175,822	(33,052)	52,058	69,411
Allocated Deductions	51	(584)	0	0	0
TOTAL	4,507,015	3,368,413	3,594,188	3,752,001	5,002,668
NET PATIENT SERVICE REVENUE	27,834,473	26,539,327	24,107,577	21,336,254	28,448,338
OTHER OPERATING REVENUE:					
Other Operating Revenue	380,260	1,462,388	(3,548)	313,291	417,721
Net Assets Released From Restrictions	67,348	66,000	66,000	63,065	84,087
TOTAL	447,608	1,528,388	62,452	376,356	501,808
TOTAL OPERATING REVENUE	28,282,081	28,067,715	24,170,029	21,712,610	28,950,147
Operating Expenses					
Salaries and Wages	14,838,605	14,886,654	15,281,515	13,145,991	17,527,988
SW - Gainshare/ICP	194,380	163,954	68,217	81,557	108,742
Employee Benefits	3,654,328	3,814,845	3,644,480	2,978,470	3,971,294
EB - FICA Gainshare/ICP	14,870	10,545	4,698	1,705	2,273
Pharmaceutical Supplies	214,137	260,616	151,916	144,048	192,065
Supplies	602,669	548,697	530,520	546,104	728,139
Professional Fees	1,452,496	1,229,387	375,836	1,186,918	1,582,557
Purchased Services	899,237	1,020,810	566,626	358,722	478,296
PS - Under Arrangement Services	0	0	0	0	0
Other Operating Costs	1,612,684	1,315,564	1,217,087	752,583	1,003,444
Lease & Rental Fees	1,159,602	1,270,818	864,299	730,643	974,191
Interest	11,278	3,171	0	0	0
Depreciation & Amort.	318,334	337,577	8,215	6,161	8,215
TOTAL	24,972,619	24,862,637	22,713,409	19,932,903	26,577,204
NON-OPERATING EXPENSES:					
Health System Membership Fees			497,353	308,754	411,672
System Support Services	453,426	501,735	1,914,093	1,399,304	1,865,738
Regional/Local Support Services			276,160	230,150	306,867
Taxes	0	0	0	0	0
TOTAL	453,426	501,735	2,687,606	1,938,208	2,584,277
NON-OPERATING REVENUE:					

TOTAL	0	0	0	0	0
OPERATING MARGIN	2,856,036	2,703,343	(1,230,985)	(158,500)	(211,334)

Note: 2023 annulized numbers based on 9/30 YTD financials annualized over a full twelve months.

MultiCare Health System - MultiCare Hospice
Statement of Operations

	For The Period Ending December 31, 2020	For The Period Ending December 31, 2021	For The Period Ending December 31, 2022	For The Period Ending September 30, 2023	For The Period Ending December 31, 2023
PATIENT SERVICE REVENUES:					
TOTAL PATIENT SERVICE REVENUES	21,323,823	19,276,293	16,369,920	16,808,192	22,410,923
DEDUCTIONS FROM REVENUES:					
Contractual Adjustments	2,333,816	1,482,500	1,322,342	1,975,799	2,634,398
Charity Care	63,869	45,276	136,651	54,888	73,185
Provision for Bad Debts	(7,864)	96,269	(4,990)	51,410	68,546
Allocated Deductions	51	(584)	0	0	0
TOTAL	2,389,872	1,623,462	1,454,002	2,082,097	2,776,129
NET PATIENT SERVICE REVENUE	18,933,952	17,652,831	14,915,918	14,726,095	19,634,793
OTHER OPERATING REVENUE:					
Other Operating Revenue	929	(19)	21	71	94
Net Assets Released From Restrictions	66,000	66,000	66,000	63,065	84,087
TOTAL	66,929	65,981	66,021	63,136	84,181
TOTAL OPERATING REVENUE	19,000,881	17,718,813	14,981,938	14,789,231	19,718,975
Operating Expenses					
Salaries and Wages	7,628,072	7,612,317	8,460,931	7,935,776	10,581,034
SW - Gainshare/ICP	114,897	91,023	30,532	42,433	56,578
Employee Benefits	1,843,882	1,933,229	1,988,279	1,777,193	2,369,591
EB - FICA Gainshare/ICP	8,790	4,966	1,815	1,134	1,513
Pharmaceutical Supplies	214,137	260,616	151,916	144,048	192,065
Supplies	382,224	361,210	344,173	382,518	510,024
Professional Fees	1,397,982	1,028,202	334,965	1,030,901	1,374,535
Purchased Services	353,318	258,474	412,094	250,866	334,488
PS - Under Arrangement Services	0	0	0	0	0
Other Operating Costs	697,053	652,278	806,767	438,889	585,186
Lease & Rental Fees	967,543	1,077,450	719,506	605,666	807,554
Interest	0	0	0	0	0
Depreciation & Amort.	20,938	20,017	7,762	5,821	7,762
TOTAL	13,628,836	13,299,781	13,258,739	12,615,246	16,820,328
NON-OPERATING EXPENSES:					
Health System Membership Fees	0	0	304,541	229,923	306,564
System Support Services	0	0	1,126,947	990,375	1,320,500
Regional/Local Support Services	0	0	162,167	156,833	209,111
Taxes	0	0	0	0	0
TOTAL	0	0	1,593,654	1,377,131	1,836,175
NON-OPERATING REVENUE:					
TOTAL	0	0	0	0	0

NET INCOME	5,372,045	4,419,031	129,545	796,854	1,062,472

Note: 2023 annulized numbers based on 9/30 YTD financials annualized over a full twelve months.

MultiCare Hospice Pro Forma Forecast - Spokane Only
Revenue & Expense Statement

	2025	2026	2027	2028
Months	**9**	**12**	**12**	**12**
Gross Revenue				
Medicare/Mgd Medicare	680,851	1,513,002	2,103,073	2,708,274
Medicaid/Mgd Medicaid	26,726	59,391	82,553	106,309
Commercial	19,063	42,362	58,883	75,827
Self Pay	2,361	5,246	7,291	9,390
Health Care Exchange	2,309	5,132	7,133	9,186
Other	16,729	37,176	51,674	66,544
Total Gross Revenue	**748,038**	**1,662,307**	**2,310,607**	**2,975,530**
Deductions				
Contractual Adjustments	87,894	195,321	271,496	349,625
Charity Care	8,827	19,615	27,265	35,111
Provision for Bad Debts	2,319	5,153	7,163	9,224
Total Deductions From Revenue	**99,040**	**220,089**	**305,924**	**393,960**
Net Revenue	**648,998**	**1,442,218**	**2,004,683**	**2,581,570**
Operating Expenses				
Salaries and Wages	481,361	849,411	1,108,498	1,346,667
SW - Gainshare/ICP	2,551	4,502	5,875	7,137
Employee Benefits	107,777	190,183	248,193	301,519
EB - FICA Gainshare/ICP	68	120	157	191
Pharmaceutical Supplies	6,411	14,246	19,802	25,501
Supplies	17,024	37,830	52,584	67,716
Professional Fees	45,879	101,954	141,717	182,498
Purchased Services	11,165	24,810	34,486	44,410
Other Operating Costs	19,532	43,405	60,333	77,695
Occupancy	37,800	50,400	50,400	50,400
Depreciation & Amort.	4,974	6,632	6,632	6,632
Total Operating Expenses	**734,541**	**1,323,493**	**1,728,676**	**2,110,365**
Non-Operating Expenses				
Health System Membership Fees	10,124	22,499	31,273	40,272
System Support Services	43,678	97,061	134,915	173,740
Regional/Local Support Services	6,944	15,432	21,450	27,623
Total Non-Operating Expenses	**60,746**	**134,992**	**187,638**	**241,635**
Total Expenses	**795,288**	**1,458,485**	**1,916,314**	**2,352,000**
Total Operating Margin	**(146,290)**	**(16,267)**	**88,368**	**229,570**

MultiCare Health System - Home Health and Hospice
Forecast Statement of Operations

	2024	2025	2026	2027	2028
PATIENT SERVICE REVENUES:					
TOTAL PATIENT SERVICE REVENUES	33,451,007	34,199,045	35,113,314	35,761,614	36,426,536
DEDUCTIONS FROM REVENUES:					
Contractual Adjustments	4,777,381	4,865,276	4,972,702	5,048,877	5,127,006
Charity Care	155,876	164,703	175,491	183,141	190,988
Provision for Bad Debts	69,411	71,730	74,564	76,574	78,635
Allocated Deductions	0	0	0	0	0
TOTAL	5,002,668	5,101,709	5,222,758	5,308,593	5,396,629
NET PATIENT SERVICE REVENUE	28,448,338	29,097,336	29,890,556	30,453,021	31,029,908
OTHER OPERATING REVENUE:					
Other Operating Revenue	417,721	417,721	417,721	417,721	417,721
Net Assets Released From Restrictions	84,087	84,087	84,087	84,087	84,087
TOTAL	501,808	501,808	501,808	501,808	501,808
TOTAL OPERATING REVENUE	28,950,147	29,599,145	30,392,364	30,954,829	31,531,716
Operating Expenses					
Salaries and Wages	17,527,988	18,009,349	18,377,399	18,636,486	18,874,655
SW - Gainshare/ICP	108,742	111,294	113,244	114,617	115,880
Employee Benefits	3,971,294	4,079,071	4,161,477	4,219,487	4,272,813
EB - FICA Gainshare/ICP	2,273	2,341	2,393	2,430	2,463
Pharmaceutical Supplies	192,065	198,475	206,311	211,867	217,566
Supplies	728,139	745,163	765,969	780,723	795,855
Professional Fees	1,582,557	1,628,437	1,684,512	1,724,274	1,765,055
Purchased Services	478,296	489,460	503,106	512,782	522,706
PS - Under Arrangement Services	0	0	0	0	0
Other Operating Costs	1,003,444	1,022,977	1,046,850	1,063,778	1,081,140
Lease & Rental Fees	974,191	1,011,991	1,024,591	1,024,591	1,024,591
Interest	0	0	0	0	0
Depreciation & Amort.	8,215	13,189	14,846	14,846	14,846
TOTAL	26,577,204	27,311,745	27,900,697	28,305,880	28,687,569
NON-OPERATING EXPENSES:					
Health System Membership Fees	411,672	421,796	434,170	442,945	451,944
System Support Services	1,865,738	1,909,416	1,962,799	2,000,653	2,039,478
Regional/Local Support Services	306,867	313,811	322,298	328,317	334,490
Taxes	0	0	0	0	0
TOTAL	2,584,277	2,645,023	2,719,268	2,771,915	2,825,912
NON-OPERATING REVENUE:					
TOTAL	0	0	0	0	0

OPERATING MARGIN	(211,334)	(357,624)	(227,601)	(122,966)	18,236

Note: Forecast financials for agency overall based on 2023 historical financials

MultiCare Hospice Revenue Assumptions - Spokane Only

Utilization	**Assumptions (Forecasted Years)**
Admits	Total admissions; see utilization forecast
ADC	ALOS of 61.11 in WA
Gross Patient Revenue	Payer Mix
Medicare/Mgd Medicare	91.02%
Medicaid/Mgd Medicaid	3.57%
Commercial	2.55%
Self Pay	0.32%
Health Care Exchange	0.31%
Other	2.24%
Total	**100%**
Revenue per admit	Assumed constant at $13,853/admit based on historical levels.
Revenue adjustments	
Contractual adjustments	Assumed constant at 11.75% of gross revenues based on historical levels.
Bad debt	Assumed constant at 0.31% of gross revenues based on historical levels.
Charity care	Assumed constant at 1.18% of gross revenues based on 2019-2021 Spokane Planning Area Hospital Charity Care Average.

MultiCare Hospice Expense Assumptions - Spokane Only

Category/Item	Assumptions (Forecasted Years)
Employee Compensation	
Salaries and Wages	Salaries are calculated as prorated FTEs by discipline, multiplied by average hourly wage rate by discipline. See Salary and Benefit tables
SW - Gainshare/ICP	Salary and wage gainsharing bonuses. Forecast to equal about 0.53% of employee compensation based on MultiCare Hospice historical levels.
Benefits	Benefits assumed at 22.39% of total employee compensation based on MultiCare Hospice historical levels.
EB - FICA Gainshare/ICP	Taxes on salary and wage gainsharing bonuses. Forecast to equal about 2.67% of gainsharing bonuses based on MultiCare Hospice historical levels.
Supplies	
Supplies	Includes medical and office supplies. About $315.25/admit based on MultiCare Hospice historical amounts
Purchased Services	
Purchased Services	About $206.75/admit based on MultiCare Hospice historical amounts
Other expenses	
Professional Fees	About $849.62/admit based on MultiCare Hospice historical amounts
Occupancy	MultiCare owns the property and space where the Spokane office will operate. Internal occupancy allocated expense based on annual rent set at $25.00 per rentable square foot at 2,016 sf.
Other Operating Costs (Incl. travel, copier and fax line, phones, mileage/ tolls/ parking, books & subscriptions, postage, taxes, & recruitment	About $361.71/admit based on MultiCare Hospice historical amounts
Depreciation & Amort.	Historical depreciation of about $0 per year, plus incremental depreciation equal to about $6,632 per year
Health System Membership Fees	1.56% of Net Revenue based on MultiCare Hospice historical amounts
System Support Services	6.73% of Net Revenue based on MultiCare Hospice historical amounts
Regional/Local Support Services	1.07% of Net Revenue based on MultiCare Hospice historical amounts

MultiCare Hospice Staffing Forecast
Spokane Only FTE Projections

FTE per Position (Productive + Non Productive)	Category	2025	2026	2027	2028
Clinical Supervisor	Not Clinical	0.38	0.50	0.50	0.50
Intake/Scheduling	Not Clinical	0.38	0.50	0.75	0.75
Hospice Outreach Coordinator	Not Clinical	0.38	0.50	1.00	1.00
Other Administrative	Not Clinical	0.38	0.75	0.75	0.75
Registered Nurse	Clinical	1.23	2.73	3.79	4.88
Medical Social Worker	Clinical	0.51	1.14	1.58	2.04
Hospice / Home Health Aide	Clinical	0.41	0.64	0.88	1.14
LPN	Clinical	0.21	0.28	0.28	0.33
Medical Director	Clinical	0.21	0.28	0.28	0.34
Other Clinical	Clinical	0.21	0.28	0.31	0.40
Total		**4.27**	**7.57**	**10.12**	**12.13**

Note: the number of FTEs were prorated over a partial year based on 2080 hours per year.

MultiCare Hospice Staffing Forecast
Spokane Only Salary and Benefit Projections

Salary Per Position	Annual Pay Rate	2025	2026	2027	2028
Clinical Supervisor	$143,395	$53,773	$71,698	$71,698	$71,698
Intake/Scheduling	$92,976	$34,866	$46,488	$69,732	$69,732
Hospice Outreach Coordinator	$68,536	$25,701	$34,268	$68,536	$68,536
Other Administrative	$68,536	$25,701	$51,402	$51,402	$51,402
Registered Nurse	$128,814	$157,960	$351,022	$487,920	$628,329
Medical Social Worker	$97,386	$49,838	$110,751	$153,944	$198,245
Hospice / Home Health Aide	$66,851	$27,576	$42,521	$59,104	$76,112
LPN	$91,853	$18,945	$25,260	$25,260	$30,051
Medical Director	$297,731	$61,407	$81,876	$81,876	$102,305
Other Clinical	$124,093	$25,594	$34,126	$39,026	$50,256
Total		**$481,361**	**$849,411**	**$1,108,498**	**$1,346,667**

Benefits Per Position	Benefits Rate	2025	2026	2027	2028
Clinical Supervisor	22.39%	$12,040	$16,053	$16,053	$16,053
Intake/Scheduling	22.39%	$7,806	$10,409	$15,613	$15,613
Hospice Outreach Coordinator	22.39%	$5,754	$7,673	$15,345	$15,345
Other Administrative	22.39%	$5,754	$11,509	$11,509	$11,509
Registered Nurse	22.39%	$35,367	$78,594	$109,245	$140,683
Medical Social Worker	22.39%	$11,159	$24,797	$34,468	$44,387
Hospice / Home Health Aide	22.39%	$6,174	$9,520	$13,233	$17,042
LPN	22.39%	$4,242	$5,656	$5,656	$6,728
Medical Director	22.39%	$13,749	$18,332	$18,332	$22,906
Other Clinical	22.39%	$5,731	$7,641	$8,738	$11,252
Total		**$107,777**	**$190,183**	**$248,193**	**$301,519**

Note: The salaries and benefits were prorated over a partial year based on 2080 hours per year.

MultiCare Hospice Balance Sheet Pro Forma - Spokane Only

		2025	2026	2027	2028
Months	**1**	**9**	**12**	**12**	**12**
ASSETS	**Pre Op Period**	**12/31/2025**	**12/31/2026**	**12/31/2027**	**12/31/2028**
Current Assets					
Cash and Cash Equivalents	0	0	0	0	0
Accounts Receivable	0	102,471	227,713	316,521	407,607
Total Current Assets	0	102,471	227,713	316,521	407,607
Fixed Assets					
Long-term Assets	66,315	66,315	66,315	66,315	66,315
Accum. Depreciation		(4,974)	(11,605)	(18,237)	(24,868)
Total Fixed Assets	66,315	61,342	54,710	48,078	41,447
Other Assets		0	0	0	0
Total Assets	**66,315**	**163,813**	**282,423**	**364,600**	**449,054**
LIABILITIES AND CAPITAL					
Current Liabilities					
Accounts Payable & Accrued Expenses	0	12,676	24,946	32,815	40,873
Accrued Compensation		32,730	43,316	56,529	68,674
Total Current Liabilities		45,406	68,263	89,344	109,548
Long-Term Liabilities		0	0	0	0
Total Liabilities	**0**	**45,406**	**68,263**	**89,344**	**109,548**
Capital Contributed	147,378	345,759	457,781	430,508	265,188
Retained Earnings	(81,063)	(227,353)	(243,620)	(155,252)	74,318
Capital	66,315	118,406	214,160	275,256	339,506
Total Liabilities & Capital	**66,315**	**163,813**	**282,423**	**364,600**	**449,054**

Exhibit 11
Letter of Financial Commitment

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

December 20, 2023

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

Re: Spokane Hospice Certificate of Need

Dear Mr. Hernandez:

Please accept this letter as evidence of financial support for the certificate of need ("CN") request by MultiCare to fund a Hospice program in Spokane County.

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

Please contact me if there are any questions regarding this letter of financial commitment. I can be reached at james.g.lee@multicare.org or at 253.403.8020. Thank you for your time and assistance in this important matter.

Respectfully,

James Lee
Executive Vice President Population Based Care and Chief Financial Officer

Exhibit 12

MultiCare Health System Audited Financial Statements

MULTICARE HEALTH SYSTEM

Consolidated Financial Statements

December 31, 2022 and 2021

(With Independent Auditors' Report Thereon)

KPMG LLP
Suite 2800
401 Union Street
Seattle, WA 98101

Independent Auditors' Report

The Board of Directors
MultiCare Health System:

Opinion

We have audited the consolidated financial statements of MultiCare Health System, (the Company)(a Washington nonprofit corporation), which comprise the consolidated balance sheets as of December 31, 2022 and 2021, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

In our opinion, the accompanying consolidated financial statements present fairly, in all material respects, the financial position of the Company as of December 31, 2022 and 2021, and the results of its operations and its cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditors' Responsibilities for the Audit of the Consolidated Financial Statements section of our report. We are required to be independent of the Company and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Consolidated Financial Statements

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

In preparing the consolidated financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern for one year after the date that the consolidated financial statements are issued.

Auditors' Responsibilities for the Audit of the Consolidated Financial Statements

Our objectives are to obtain reasonable assurance about whether the consolidated financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the consolidated financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the consolidated financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the consolidated financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control related matters that we identified during the audit.

KPMG LLP

Seattle, Washington
March 21, 2023

MULTICARE HEALTH SYSTEM

Consolidated Balance Sheets

December 31, 2022 and 2021

(In thousands)

Assets		2022	2021
Current assets:			
Cash and cash equivalents	$	542,067	308,732
Accounts receivable		511,727	460,569
Supplies inventory		60,070	60,056
Other current assets, net		165,586	96,361
Total current assets		1,279,450	925,718
Donor restricted assets held for long-term purposes		119,526	96,775
Investments		1,968,205	2,610,531
Property, plant, and equipment, net		2,109,253	2,010,134
Right-of-use operating lease asset, net		169,823	140,718
Right-of-use financing lease asset, net		16,798	20,458
Goodwill and intangible assets, net		253,274	172,063
Other assets, net		329,808	382,562
Total assets	$	6,246,137	6,358,959
Liabilities and Net Assets			
Current liabilities:			
Accounts payable and accrued expenses	$	326,664	283,004
Accrued compensation and related liabilities		329,672	340,029
Accrued interest payable		23,643	18,059
Current portion of right-of-use operating lease liability		29,908	26,376
Current portion of right-of-use financing lease liability		4,965	4,283
Current portion of long-term debt		18,496	43,609
Total current liabilities		733,348	715,360
Interest rate swap liabilities		9,470	119,100
Right-of-use operating lease liability, net of current portion		147,116	120,273
Right-of-use financing lease liability, net of current portion		12,491	16,933
Long-term debt, net of current portion		1,972,137	1,572,235
Other liabilities, net		231,045	208,307
Total liabilities		3,105,607	2,752,208
Commitments and contingencies (note 15)			
Net assets:			
Controlling interest		2,930,546	3,430,009
Noncontrolling interest		34,471	—
Without donor restrictions		2,965,017	3,430,009
With donor restrictions		175,513	176,742
Total net assets		3,140,530	3,606,751
Total liabilities and net assets	$	6,246,137	6,358,959

See accompanying notes to consolidated financial statements.

MULTICARE HEALTH SYSTEM

Consolidated Statements of Operations

Years ended December 31, 2022 and 2021

(In thousands)

	2022	2021
Revenues, gains, and other support without donor restrictions:		
Patient service revenue	$ 3,765,888	3,504,691
Other operating revenue	231,429	314,323
Net assets released from restrictions for operations	6,382	5,170
Total revenues, gains, and other support without donor restrictions	4,003,699	3,824,184
Expenses:		
Salaries and wages	2,199,265	1,870,645
Employee benefits	297,613	278,185
Supplies	658,470	600,757
Purchased services	396,747	349,159
Depreciation and amortization	140,892	126,307
Interest	56,842	47,670
Other	541,246	486,005
Total expenses	4,291,075	3,758,728
(Deficit) Excess of revenues over expenses from operations	(287,376)	65,456
Other income (loss):		
Investment (loss) income	(344,301)	213,993
Gain on interest rate swaps, net	127,688	25,873
Other loss, net	(11,047)	(13,729)
Total other (loss) income, net	(227,660)	226,137
(Deficit) Excess of revenues over expenses	$ (515,036)	291,593

See accompanying notes to consolidated financial statements.

MULTICARE HEALTH SYSTEM

Consolidated Statements of Changes in Net Assets

Years ended December 31, 2022 and 2021

(In thousands)

	Without donor restrictions			
	Controlling interests	Noncontrolling interests	With donor restrictions	Total net assets
Balance, December 31, 2020	$ 3,111,401	—	142,761	3,254,162
Excess of revenues over expenses	291,593	—	—	291,593
Changes in pension assets	24,810	—	—	24,810
Contributions and other	490	—	35,697	36,187
Net assets released from restriction for capital acquisitions	1,715	—	(1,715)	—
Net assets released from restriction for operations and other	—	—	(5,170)	(5,170)
Income on investments	—	—	1,816	1,816
Increase in assets held in trust by others	—	—	3,353	3,353
Change in net assets	318,608	—	33,981	352,589
Balance, December 31, 2021	3,430,009	—	176,742	3,606,751
Deficit of revenues over expenses	(515,036)	—	—	(515,036)
Changes in pension assets	(15,508)	—	—	(15,508)
Changes from noncontrolling interest	—	34,471	—	34,471
Contributions and other	26,539	—	14,875	41,414
Net assets released from restriction for capital acquisitions	4,542	—	(4,542)	—
Net assets released from restriction for operations	—	—	(6,382)	(6,382)
Loss on investments	—	—	(611)	(611)
Decrease in assets held in trust by others	—	—	(4,569)	(4,569)
Change in net assets	(499,463)	34,471	(1,229)	(466,221)
Balance, December 31, 2022	$ 2,930,546	34,471	175,513	3,140,530

See accompanying notes to consolidated financial statements.

MULTICARE HEALTH SYSTEM

Consolidated Statements of Cash Flows

Years ended December 31, 2022 and 2021

(In thousands)

	2022	2021
Cash flows from operating activities:		
(Decrease) increase in net assets	$ (466,221)	352,589
Adjustments to reconcile (decrease) increase in net assets to net cash (used in) provided by operating activities:		
Depreciation and amortization	140,892	126,307
Amortization of bond premiums, discounts, and issuance costs	(2,163)	(2,433)
Net realized and unrealized losses (gains) on investments	378,740	(188,615)
Change in fair value of interest rate swap	(133,126)	(35,247)
(Loss) gain on disposal of assets, net	(3,009)	2,373
Loss (gain) on joint ventures, net	7,032	(513)
Restricted contributions for long-term purposes	(4,968)	(16,952)
Changes in operating assets and liabilities:		
Accounts receivable	(51,158)	(73,590)
Supplies inventory and other current assets	(43,673)	(17,586)
Right-of-use lease asset	35,690	40,614
Other assets, net	80,665	(38,219)
Accounts payable and accrued expenses and accrued interest payable	27,421	67,751
Accrued compensation and related liabilities	(14,765)	38,053
Right-of-use lease liability	(30,021)	(30,721)
Other liabilities, net	21,842	(8,287)
Net cash (used in) provided by operating activities	(56,822)	215,524
Cash flows from investing activities:		
Purchase of property, plant, and equipment	(237,295)	(216,973)
Proceeds from disposal of property, plant, and equipment	6,360	7,629
Purchase of additional ownership in PSW and OSS, net of cash received	(86,915)	—
Purchase of Capital Medical Center and related real estate, net of cash received	—	(179,662)
Investments in joint ventures, net	(11,445)	(10,373)
Purchases of investments	(8,827,993)	(5,634,748)
Sales of investments	9,072,857	5,175,627
Change in donor trusts	(2,833)	5,700
Net cash used in investing activities	(87,264)	(852,800)
Cash flows from financing activities:		
Repayment of long-term debt	(415,646)	(8,522)
Proceeds from bond issuance	798,300	—
Payment of debt issue expenses	(5,702)	—
Principal payments on finance lease obligations	(4,499)	(8,645)
Restricted contributions for long-term purposes	4,968	16,952
Net cash provided by (used in) financing activities	377,421	(215)
Net change in cash and cash equivalents	233,335	(637,491)
Cash and cash equivalents, beginning of year	308,732	946,223
Cash and cash equivalents, end of year	$ 542,067	308,732
Supplemental disclosures of cash flow information:		
Cash paid during the year for interest, net of amount capitalized	$ 52,258	48,260
Noncash activities:		
(Decrease) increase in deferred compensation plans	(11,750)	13,471
Increase in accounts payable for purchases of property, plant, and equipment	9,301	1,266

See accompanying notes to consolidated financial statements.

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

(a) Organization Description

MultiCare Health System (MHS), a Washington nonprofit corporation, is an integrated healthcare delivery system providing inpatient, outpatient, and other healthcare services primarily to the residents of Pierce, King, Spokane and Thurston Counties and, with respect to pediatric care, much of the southwest Washington region. As of December 31, 2022, MHS was licensed to operate 2099 inpatient hospital beds, including 120 beds associated with a joint venture psychiatric hospital in Tacoma, Washington. MHS operates nine acute care facilities (Tacoma General Hospital, Good Samaritan Hospital, Allenmore Hospital, Mary Bridge Children's Hospital, Auburn Medical Center, Covington Hospital, Deaconess Hospital, Valley Hospital and Capital Medical Center) and one behavioral health hospital (Navos). MHS also operates eight outpatient surgical sites, five free-standing emergency departments, home health, hospice, and multiple urgent care, primary care and multispecialty clinics located throughout the MHS service areas.

The consolidated financial statements include the operations of these facilities and services as well as those of four wholly owned subsidiaries (Greater Lakes Mental Healthcare, Medis, Inc., MultiCare Rehabilitation Specialists, P.C., and PNW PACE Partners, LLC), a wholly owned professional services organization supporting cardiovascular services at MHS (CHVI Professional Corp), a wholly owned accountable care organization (MultiCare Connected Care), a leading population health company (Physicians of Southwest Washington), a physical therapy provider (Olympic Sports & Spine) and two fundraising foundations (Mary Bridge Children's Foundation and MultiCare Foundations, which is doing business as MultiCare Health Foundation, Good Samaritan Foundation, MultiCare South King Health Foundation, MultiCare Behavioral Health Foundation and MultiCare Inland Northwest Foundation).

On May 1, 2022, MHS completed the purchase of additional units of Physicians of Southwest Washington, LLC (PSW). Total consideration of this transaction was $49,956 and increased MHS' ownership to 75%. As part of the consideration of this business combination, MHS equity interest was valued at its estimated fair value based on the cash consideration transferred using standard valuation techniques of the equity acquired. As a result of the remeasurement of MHS equity interest in PSW, a gain of $9,105 was recognized within other operating revenue on the consolidated statement of operations for the year ended December 31, 2022. The assets acquired and liabilities assumed were recorded at their estimated fair value as determined using standard asset appraisal techniques. PSW is a leading population health company that provides management of risk contracts and manages a leading national accountable care organization (ACO) among other population health service offerings.

(Dollars in thousands)

The following table summarizes the total consideration and the estimated fair values of assets acquired and liabilities assumed as of the acquisition date along with the cash consideration paid.

Consideration:		
Cash consideration transferred	$	17,358
Fair value of MHS's equity interest before business combination		32,598
Total	$	49,956
Recognized amounts of identifiable assets acquired and liabilities assumed:		
Cash	$	24,649
Other current assets		21,640
Land, buildings and equipment		647
Intangibles and other assets		1,799
Accounts payable, accrued compensation and other current liabilities		(24,454)
Total identifiable net assets assumed		24,281
Noncontrolling interest recognized		(23,731)
Goodwill		49,406
Total	$	49,956

The following are the results of PSW in 2022 that have been included in the consolidated statement of operations and statement of changes in net assets from the acquisition date for the year ended December 31. 2022:

		2022
Total operating revenues	$	36,305
Excess of revenue over expenses		1,394

The following unaudited information presents MultiCare's results for the years ended December 31, 2022 and 2021, had the acquisition date been January 1, 2021 for the PSW acquisition:

	2022 (Unaudited)	2021 (Unaudited)
Total operating revenues	4,010,866	3,896,190
(Deficit) Excess of revenues over expenses	(513,848)	300,750

On September 22, 2022, MultiCare Rehabilitation Specialists, P.C. completed the purchase of additional units of Olympic Sports & Spine, PLLC (OSS). Total consideration of this transaction was $36,959 and increased MHS's ownership to 80.16%. As part of the consideration of this business

(Dollars in thousands)

combination, MHS equity interest was valued at its estimated fair value based on the cash consideration transferred using standard valuation techniques of the equity acquired. As a result of the remeasurement of MHS equity interest in OSS, a loss of $8,191 was recognized within other operating revenue on the consolidated statement of operations for the year ended December 31, 2022. The assets acquired and liabilities assumed were recorded at their estimated fair value as determined using standard asset appraisal techniques. OSS provides physical, occupational, and massage therapy services in the south Puget Sound area. The following table summarizes the total consideration and the estimated fair values of assets acquired and liabilities assumed as of the acquisition date along with the cash consideration paid.

Consideration:		
Cash consideration transferred	$	7,377
Fair value of MHS's equity interest before business combination		29,582
Total	$	36,959
Recognized amounts of identifiable assets acquired and liabilities assumed:		
Cash	$	5,988
Other current assets		6,167
Land, buildings and equipment		5,156
Intangibles and other assets		1,453
Accounts payable, accrued compensation and other current liabilities		(2,409)
Total identifiable net assets assumed		16,355
Noncontrolling interest recognized		(9,148)
Goodwill		29,752
Total	$	36,959

The following are the results of OSS in 2022 that have been included in the consolidated statement of operations and statement of changes in net assets from the acquisition date for the year ended December 31. 2022:

		2022
Total operating revenues	$	15,176
Excess of revenue over expenses		1,146

(Dollars in thousands)

The following unaudited information presents MultiCare's results for the years ended December 31, 2022 and 2021, had the acquisition date been January 1, 2021 for the OSS acquisition:

	2022 (Unaudited)	2021 (Unaudited)
Total operating revenues	$ 3,994,219	3,862,945
(Deficit) Excess of revenues over expenses	(512,468)	294,959

On April 1, 2021, MHS completed the purchase of Capital Medical Center in Olympia, Washington from an affiliate of LifePoint Health and physician owners to acquire a 100% ownership interest. Capital Medical Center is licensed to operate 107 inpatient hospital beds as well as operates multiple primary care and multispecialty clinics within Thurston County. The acquisition of Capital Medical Center was valued at $44,662. Assets and liabilities purchased included land, buildings, equipment, accounts receivable, intangibles and other assets offset by accounts payable, accrued compensation, other current liabilities and other liabilities and were recorded at their estimated fair values as determined based on standard asset appraisal techniques. MHS hired substantially all of the employees previously employed by Capital Medical Center. The following table summarizes the estimated fair values of assets acquired and liabilities assumed as of the acquisition date along with the cash consideration paid.

Recognized amounts of identifiable assets acquired and liabilities assumed:		
Patient accounts receivable	$	13,500
Other current assets		3,628
Land, buildings and equipment		30,551
Intangibles and other assets		8,915
Accounts payable, accrued compensation and other current liabilities		(8,695)
Other liabilities		(3,295)
Total identifiable net assets assumed		44,604
Recognized amount of goodwill assumed:		
Goodwill		58
Total	$	44,662
Total cash consideration transferred	$	39,173

(Dollars in thousands)

On December 20, 2021, MHS completed a separate purchase of land and buildings associated with the Capital Medical Center hospital campus and several surrounding clinic offices from an affiliate of Medical Properties Trust (MPT). The acquisition was valued at $135,000 of land, buildings and other related assets acquired.

Recognized amounts of identifiable assets acquired:		
Land	$	20,053
Buildings		114,069
Leasehold improvements		163
Intangible assets		715
Total		135,000
Transaction expenses		3,148
Total cash consideration transferred	$	138,148

(b) Principles of Consolidation

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

(c) Use of Estimates

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

(d) Cash and Cash Equivalents

Cash and cash equivalents include certain investments in highly liquid instruments with maturities of three months or less at the date of purchase. Cash equivalents and investments that are held by outside investment managers or restricted per contractual or regulatory requirements are classified as investments on the consolidated balance sheets.

(e) Accounts Receivable

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

(f) Supplies Inventory

Supplies inventory consists of pharmaceutical, medical-surgical, and other supplies generally used in the operations of MHS. Supplies inventory is stated at lower of cost or net realizable value using the

average cost method, except for pharmacy, which uses the first-in, first-out (FIFO) method. Obsolete and unusable items are expensed at the time such determination is made.

(g) Donor Restricted Assets

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

Charitable gift annuities, which are included in donor restricted assets, totaled $1,749 and $2,308 at December 31, 2022 and 2021, respectively. MHS has recorded a corresponding payable of $1,301 and $775 at December 31, 2022 and 2021, respectively, to pay for estimated future obligations to beneficiaries. The current portion of these obligations is included in accounts payable and accrued expenses and the long-term portions are included in other liabilities, net in the accompanying consolidated balance sheets. According to Washington State law, MHS, as a distinct legal entity holding charitable gift annuities, is required to maintain unrestricted net assets of at least $500, which MHS has done for each of the periods presented.

(h) Investments

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

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

(i) Property, Plant, and Equipment

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

Buildings	5–80 years
Land improvements	8–20 years
Equipment	3–30 years

MHS capitalizes all software implementation costs that meet the criteria for capitalization, including those that relate to a service contract (e.g., hosting arrangement). The capitalized software implementation costs are reflected within property, plant and equipment in the consolidated balance sheets. These costs are amortized together with the costs of the related software license; however, the implementation costs related to a service arrangement are amortized over the term of the arrangement. The amortization period for all capitalized implementation costs is generally 10 years.

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

MHS assesses potential impairments to its long-lived assets as well as its intangible assets, as described below, when there is evidence that events or changes in circumstances indicate that an impairment has been incurred. These changes can include a deterioration in operating performance, a reduction in reimbursement rates from government or third-party payors or a change in business strategy. An impairment charge is recognized when the sum of the expected future undiscounted net cash flows is less than the carrying amount of the asset. In 2022 and 2021, there were no impairment charges.

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

(j) Leases

Management reviews contracts in order to identify leases and properly classify leases as either operating or financing. MHS is a lessee of various equipment and facilities under noncancelable operating and financing leases. Operating and financing right-of-use (ROU) liabilities are recognized based on the net present value of lease payments over the lease term at the commencement date of the lease and are reduced by payments made on each lease on the straight-line basis. Since most of

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

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

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

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

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

(k) Goodwill and Intangible Assets

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

If it is more likely than not that goodwill is impaired, MHS records the amount that the carrying value exceeds the fair value as an impairment charge. Goodwill is not amortized and along with indefinite-lived intangible assets is evaluated at least annually for impairment. There were no impairment charges recognized during the years ended December 31, 2022 or 2021.

(Dollars in thousands)

The following table summarizes the balances of goodwill and intangible assets at December 31, 2022 and 2021:

		2022	2021
Goodwill	$	232,085	152,927
Intangible assets, net of accumulated amortization of $7,035 and $10,343, respectively		21,189	19,136
Total	$	253,274	172,063

The balance sheet as of December 31, 2022 includes goodwill recognized as part of the PSW and OSS transactions in the amounts of $49,406 and $29,752, respectively, and intangible assets recognized of $1,719 and $1,421, respectively.

Amortizing intangible assets are comprised of certificates of need, license agreements, trade names and lease arrangements, which all have finite useful lives. Amortization expense is recorded on a straight-line basis over the estimated useful life of the assets, which ranges from three to thirty years, associated with the nature of the intangible asset. Amortization expense was $1,474 and $3,544 for the years ended December 31, 2022 and 2021, respectively.

(l) Investment in Joint Ventures

MHS maintains ownership in certain joint ventures related to imaging, office buildings, behavioral health and other healthcare focused activities and accounts for these joint ventures under the equity method of accounting. As of December 31, 2022 and 2021, MHS held ownership interests in 26 and 21 joint ventures, respectively. Investment in joint ventures is included in other assets, net in the accompanying consolidated balance sheets. Loss on joint ventures for the year ended December 31, 2022 was $7,032 associated with several joint ventures. Gain on joint ventures for the year ended December 31, 2021 was $513. Gains and losses are included in other operating revenue on the consolidated statements of operations and changes in net assets.

(m) Estimated Third-Party Payor Settlements

Medicare cost reports are filed annually by MHS with the Medicare intermediary and are subject to audit and adjustment prior to settlement. Estimates of net settlements due to Medicare were $4,781 and $4,634 as of December 31, 2022 and 2021, respectively, and have been recorded within accounts payable and accrued expenses in the accompanying consolidated balance sheets. Third-party settlements are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods, based upon the amount of the final settlements. Patient service revenue decreased by $148 and $1,178 in 2022 and 2021, respectively to reflect changes in the estimated Medicare settlements for prior years.

(n) Interest Rate Swaps

MHS maintains several interest rate swap agreements as a means of hedging its exposure to variable-based interest rates and fluctuations in cash flows as part of its overall interest rate risk

management strategy. All MHS interest rate swaps are recorded at fair value. The accounting for changes in the fair value of these swaps depends on whether those had been designated as cash flow hedges. As of December 31, 2022 and 2021, none of MHS' interest rate swaps were designated as cash flow hedges and therefore, the changes in fair value are recognized and included in other income (loss) on the consolidated statements of operations and changes in net assets. These swaps have notional amounts totaling approximately $709,000 and expire starting in August 2027 through August 2049. The majority of the swaps have the economic effect of fixing the LIBOR-based variable interest rate on an equivalent amount of MHS' outstanding floating rate principal debt.

Under master netting provisions of the International Swap Dealers Association (ISDA) agreement with each of the counterparties, MHS is permitted to settle with the counterparties on a net basis. However, due to the nature of the specific swap arrangements in MHS' interest rate swap portfolio, the fair value of interest rate swap assets and swap liabilities are presented on a gross basis on the consolidated balance sheets.

(o) Net Assets with Donor Restrictions

Gifts are reported as support with donor restrictions if they are received with donor stipulations that restrict the use of the donated assets to a specific time or purpose or have been restricted by donors and are maintained by MHS in perpetuity. When restricted funds to be used for operations are expended for their restricted purposes or by the occurrence of the passage of time, these amounts are released from restrictions for operations and are classified as revenues, gains, and other support without donor restrictions. When restricted funds are expended for the acquisition of property, plant, and equipment, these amounts are recognized in net assets without donor restrictions as net assets released from restriction – capital acquisitions.

MHS applies the provisions of Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) Topic 820, *Fair Value Measurement*, related to using the present value technique to measure fair value of pledges receivable. In accordance with ASC Topic 820, MHS has applied the expected present value technique to pledges received after January 1, 2009 that adjusts for a risk premium to take into account the risks inherent in those expected cash flows. Pledges of financial support are recorded as pledges receivable when unconditional pledges are made and are stated at net realizable value. Pledges are reported net of an allowance for uncollectible pledges and pledges to be collected in future years are reflected at a discounted value using a weighted average discount rate. As of December 31, 2022 and 2021, MHS has recorded $21,265 and $20,305, respectively, of net pledge receivables, which are included in donor-restricted assets in the accompanying consolidated balance sheets. As of December 31, 2022, $12,683 of pledges are due in one year or less and $8,582 in two to eight years.

(p) Patient Service Revenue

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

several days after the services are performed or when the patient is discharged from the facility, whichever is later.

(q) Hospital Safety Net Assessment

The State of Washington (the State) has a safety net assessment program involving Washington State hospitals to increase funding from other sources and obtain additional federal funds to support increased payments to providers for Medicaid services. In connection with this program, MHS recorded increases in patient service revenue of $89,946 and $89,738 for 2022 and 2021, respectively, and incurred assessments of $63,961 and $64,570 for 2022 and 2021, respectively, which were recorded in other operating expenses in the accompanying consolidated statements of operations and changes in net assets. MHS has outstanding receivables of $17,287 and $16,737 associated with this program as of December 31, 2022 and 2021, respectively, which are included with accounts receivable on the consolidated balance sheets.

(r) Uncompensated and Undercompensated Care

MHS provides a variety of uncompensated and undercompensated healthcare services to the communities it serves within the purview of its mission. Because MHS does not pursue collection of amounts determined to qualify as uncompensated care, MHS has determined that it has provided implicit price concessions to uninsured patients and patients with other uninsured balances. The implicit price concessions included in estimating the transaction price represent the difference between amounts billed to patients and the amount MHS expects to receive based on its historical collections from these patients. Patients who meet the criteria of MHS' uncompensated care policy are eligible to receive these services without charge or at an amount less than MHS' established rates. Such amounts determined to qualify as charity care are not reported as revenue. The State provides guidelines for charity care provided by hospitals in the state. Hospitals are recommended to provide full charity care to patients who meet 100% of the federal poverty guidelines and a lesser amount to patients who meet up to 200% of the federal poverty guidelines. MHS provides full charity care to patients who meet 300% of the federal poverty guidelines and also provides uncompensated care on a sliding scale for patients whose income is between 301% and 500% of the federal poverty guidelines for true self-pay patients and patients with deductibles and coinsurance amounts. The estimated cost of charity care provided was approximately $52,000 and $48,000 in 2022 and 2021, respectively. The estimated cost of uncompensated and undercompensated services provided to patients covered under Medicaid in excess of payments received was approximately $424,000 and $300,406 in 2022 and 2021, respectively. These cost estimates are calculated based on the overall ratio of costs to charges for MHS.

(s) Other Operating Revenue

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

(t) Excess of Revenues over Expenses

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

(u) Federal Income Taxes

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

(v) Self-Insurance Reserves

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

(w) New and Pending Accounting Standards

In June 2016, FASB issued Accounting Standards Update (ASU) 2016-13 and in November 2019, issued ASU 2019-10, *Financial Instruments – Credit Losses (Topic 326): Measurement of Credit Losses on Financial Instruments.* The amendments in this update require that financial assets are measured at amortized cost basis and presented at the net amount expected to be collected. This eliminates the probable initial recognition threshold in current GAAP and, instead, reflects an entity's current estimate of all expected credit losses and broadens the information that an entity must consider in developing its expected credit loss estimate for assets measured either collectively or individually. The provisions of this ASU are effective for MHS for the year beginning on January 1, 2023. MHS does not expect the adoption of this ASU to have a material effect on its consolidated financial statements.

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

(Dollars in thousands)

applicable to MHS. MHS does not expect the adoption of this ASU to have a material effect on its consolidated financial statements.

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

(2) Coronavirus (COVID-19) Impact

On March 27, 2020, the Coronavirus Aid, Relief, and Economic Security (CARES) Act was signed into law and on March 11, 2021, the American Rescue Plan Act (ARPA) was signed into law. Both the CARES Act and ARPA were aimed to direct economic assistance for American workers, families, and small businesses, and preserve jobs for American industries. The COVID-19 pandemic impacted all hospitals and physician offices throughout the health system.

The CARES Act and ARPA require the amount of funding received to be validated, which requires management to quantify lost revenues and increased expenses associated with the pandemic. The CARES Act authorized funding to be distributed under the Provider Relief Fund (PRF) and the Coronavirus Relief Fund (CRF). MHS has recognized revenue associated with the PRF, CRF and ARPA funding according to the terms and conditions of the CARES Act and ARPA, and as contribution revenue under FASB ASC 958-605. Refunding of amounts received may be required by the CARES Act if a receiving entity is unable to quantify the financial losses intended to be covered by funding. MHS has determined that it is able to justify retaining all funding received and has not recorded any liabilities as of December 31, 2022 and 2021 for potential repayment of funds received.

MHS has filed applications and obtained reimbursement of additional expenses from the Federal Emergency Management Agency (FEMA) based on criteria due to the national emergency declaration made due to COVID-19. MHS has submitted funding applications with FEMA that covers costs incurred in order to respond to the COVID-19 pandemic and will apply for additional funding until the national disaster declaration is no longer in effect.

The following table shows the funding that has been received to prepare and respond to COVID-19 and recognized as other operating revenue for the years ended December 31, 2022 and 2021:

Sources of external relief funding		2022	2021	Total
CARES Act Provider Relief Fund	$	—	176,448	176,448
American Rescue Plan Rural Funds		—	5,284	5,284
FEMA		14,578	1,405	15,983
Total	$	14,578	183,137	197,715

(3) Revenue from Contracts with Customers

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

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

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

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

- Medicare – Inpatient acute care services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge, which provides for reimbursement based on Medicare Severity Diagnosis-Related Groups (MS-DRGs). These rates vary according to a patient classification system that is based on clinical diagnosis, acuity, and expected use of hospital resources. The majority of Medicare outpatient services is reimbursed under a prospective payment methodology, the Ambulatory Payment Classification System (APCs), or fee schedules.
- Medicaid – Inpatient services rendered to Medicaid program beneficiaries are reimbursed under a prospective payment system similar to Medicare; however, Medicaid utilizes All Payor Refined Diagnosis-Related Groups (APR-DRGs) as opposed to Medicare's MS-DRGs. The majority of Medicaid outpatient services is reimbursed under a prospective payment methodology, the Enhanced Ambulatory Patient Groups (EAPG), or fee schedules.
- Other – MHS has entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to MHS under these agreements includes prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates and fee schedules.

Laws and regulations concerning government programs, including Medicare and Medicaid, are complex and subject to varying interpretation. As a result of investigations by governmental agencies, various healthcare organizations have received requests for information and notices regarding alleged noncompliance with those laws and regulations, which, in some instances, have resulted in organizations entering into significant settlement agreements with the government. Compliance with such laws and regulations may also be subject to future government exclusion from the related programs. There can be no assurance that regulatory or governmental authorities will not challenge MHS' compliance with these laws and regulations, and it is not possible to determine the impact, if any, that such claims or penalties would have upon MHS. In addition, the contracts with commercial payors also provide for retroactive audit and review of claims that can reduce the amount of revenue ultimately received.

Settlements with third-party payors for retroactive adjustments due to audits, reviews, or investigations are considered variable consideration and are included in the determination of the current estimated transaction price for providing patient care. These settlements are estimated based on the terms of the payment agreement with the payor, correspondence from the payor, and historical settlement activity, including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known, or as years are settled and no longer subject to such audits, reviews and investigations. Adjustments arising from a change in the transaction price were not significant in 2022 or 2021.

Generally, patients who are covered by third-party payors are responsible for related deductibles and co-insurance, which vary in amount. MHS also provides services to uninsured patients, and offers those uninsured patients a discount, either by policy or law, from standard charges. MHS estimates the transaction price for patients with deductibles and co-insurance from those who are uninsured based on historical experience and current market conditions. The initial estimate of the transaction price is determined by reducing the standard charges by any contractual adjustments, discounts, and implicit price concessions. Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to patient service revenue in the period of the change. Additional revenue due to changes in estimates of implicit price concessions, discounts, and contractual adjustments for prior years were not significant for 2022 or 2021. Subsequent changes that are determined to be the result of an adverse change in the patient's ability to pay and deemed uncollectable are recorded as bad debt expense.

Consistent with MHS' mission, care is provided to patients regardless of their ability to pay. MHS has determined that it has provided implicit price concessions to uninsured patients and patients with other uninsured balances. The implicit price concessions included in estimating the transaction price represent the difference between amounts billed to patients and the amount MHS expects to receive based on its collection experience with those patients. Patients who meet the criteria for charity care are provided care without charge or at amounts less than established rates. Such amounts determined to qualify as uncompensated care are not reported as revenue.

(Dollars in thousands)

MHS has determined that the best depiction of its revenue is by its mix of payors as this shows the amount of revenue recognized from each portfolio. Patient service revenue disaggregated by payor for the years ended December 31, 2022 and 2021 are as follows:

	2022	2021
Payors:		
Medicare	$ 1,068,131	947,979
Medicaid	623,026	554,039
Premera	521,521	501,370
Regence	392,750	334,844
Aetna	192,352	202,379
Kaiser Permanente	134,237	128,538
United Healthcare	133,716	132,535
First Choice	117,366	119,596
Self-pay	23,149	25,450
Other	559,640	557,961
	$ 3,765,888	3,504,691

MHS has elected to apply the practical expedient under ASC 340-40-25-4 and therefore, all incremental customer contract acquisition costs are expensed as incurred, as the amortization period of the asset that MHS would have otherwise recognized is one year or less in duration.

(4) Concentration of Credit Risk

MHS grants credit without collateral to its patients, most of whom are residents of the communities it serves and are insured under third-party payor agreements. The mix of gross receivables from patients and third-party payors at December 31, 2022 and 2021 was as follows:

	2022	2021
Medicare	35 %	33 %
Medicaid	25	21
Premera	7	10
Regence	6	7
Self-pay	5	7
First Choice	1	1
Health Care Exchange	1	1
Other commercial insurance	20	20
	100 %	100 %

(5) Fair Value Measurements

(a) Fair Value Hierarchy

In accordance with ASC Topic 820, fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. ASC Topic 820 establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for similar assets or liabilities (Level 1 measurements) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are as follows:

- Level 1 inputs are quoted prices (unadjusted) in active markets for identical or similar assets or liabilities that MHS could access at the measurement date. Level 1 securities generally include investments in equity securities, mutual funds and certain fixed income securities.
- Level 2 inputs are inputs other than quoted prices included within Level 1 that are based upon observable market inputs for the asset or liability, either directly or indirectly. Level 2 securities generally include investments in fixed income securities (composed primarily of government, agency and corporate bonds), and interest rate swaps.
- Level 3 inputs are unobservable market inputs for the asset or liability. Level 3 securities include donor trusts where MHS is not the trustee.

The level in the fair value hierarchy within which a fair value measurement, in its entirety, falls is based on the lowest level input that is significant to the fair value measurement.

ASC Subtopic 820-10 allows for the use of a practical expedient for the estimation of the fair value of investments in investment companies for which the investment does not have a readily determinable fair value. The practical expedient used by MHS is the Net Asset Value (NAV) per share, or its equivalent. In some instances, the NAV may not equal the fair value that would be calculated under fair value accounting standards. Valuations provided by investment managers consider variables such as the financial performance of underlying investments, recent sales prices of underlying investments and other pertinent information. In addition, actual market exchanges at year-end provide additional observable market inputs of the redemption price. MHS reviews valuations and assumptions provided by investment managers for reasonableness and believes that the carrying amounts of these financial instruments approximate the estimated of fair value of the instrument. Where investments are not presented at fair value, NAV is used as a practical expedient to approximate fair value.

(Dollars in thousands)

The following tables present the placement in the fair value hierarchy of investment assets and liabilities that are measured at fair value on a recurring basis and investments valued at NAV at December 31, 2022 and 2021:

		Fair value measurements at reporting date using		
	December 31, 2022	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Assets:				
Trading securities:				
Mutual funds	$ 927,945	927,945	—	—
Equity securities	8,204	8,204	—	—
Fixed income bond funds	327,965	327,965	—	—
Fixed income governmental obligations	152,312	114,851	37,461	—
Fixed income other	178,595	—	178,595	—
Commingled trust fund – international equity	14,376	—	14,376	—
Donor trusts	29,431	—	—	29,431
Interest rate swaps	23,496	—	23,496	—
Total assets at fair value	1,662,324	$ 1,378,965	253,928	29,431
Investment assets valued at NAV	403,251			
Total assets at fair value or NAV	$ 2,065,575			
Liabilities:				
Interest rate swaps	$ 9,470	—	9,470	—

(Dollars in thousands)

		Fair value measurements at reporting date using		
	December 31, 2021	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Assets:				
Trading securities:				
Mutual funds	$ 825,254	825,254	—	—
Equity securities	304,915	304,915	—	—
Fixed income bond funds	403,280	403,280	—	—
Fixed income governmental obligations	210,812	141,941	68,871	—
Fixed income other	376,108	—	376,108	—
Commingled trust fund – international equity	172,069	—	172,069	—
Donor trusts	22,455	—	—	22,455
Total assets at fair value	2,314,893	$ 1,675,390	617,048	22,455
Investment assets valued at NAV	343,651			
Total assets at fair value or NAV	$ 2,658,544			
Liabilities:				
Interest rate swaps	$ 119,100	—	119,100	—

The following table presents information for investments where the NAV was used as a practical expedient to measure fair value at December 31, 2022 and 2021:

	NAV December 31, 2022	NAV December 31, 2021	Unfunded commitments	Redemption frequency	Redemption notice period
Hedge funds	$ 125,067	132,637	N/A	Quarterly	60 or 95 business days prior to valuation date
Common trust funds	269,628	199,212	N/A	Daily	1 or more business days prior to valuation date
Limited partnerships	8,556	11,802	1,800	N/A	N/A
Total investments valued at NAV	$ 403,251	343,651	1,800		

Hedge funds include investments in hedge fund-of-funds products with certain investment managers. The fair values of the investments in this category have been estimated using the NAV per share of the investment.

Common trust funds include investments in a collective or common trust account that invests funds in an underlying fund or set of funds. The trust account seeks an investment return that approximates the performance of an index as defined by each common trust fund. The fair value of the investments in this category are estimated using the NAV per share of the fund that is derived from the underlying investments in the trust fund.

Limited partnerships include investments in private equity and venture capital funds in both developed and emerging markets with approximately 35% invested in private equity in developed markets, 20% in venture capital in developed markets, and 45% in private equity and venture capital in emerging markets. The fair values of the investments in this category have been estimated using the NAV of MHS' ownership interest in partners' capital. These assets can never be redeemed with the partnerships. Instead, the nature of the investment in this category is that distributions are received through the liquidation of the underlying assets of the partnership.

(b) Interest Rate Swaps

The interest rate swaps are recorded at estimated fair value by using certain observable market inputs that participants would use from closing prices for similar assets. In addition, other valuation techniques and market inputs are used that help determine the fair values of these swaps, which include certain valuation models, current interest rates, forward yield curves, implied volatility and credit default swap pricing.

The fair value of the interest rate swaps liability is included in interest rate swap liabilities on the consolidated balance sheets, and the fair value of the interest rate swap asset is included in other assets, net on the consolidated balance sheets. The fair value gains of these interest rate swaps for the years ended December 31, 2022 and 2021 were $133,126 and $35,246, respectively, and are included in gain on interest rate swaps in other (loss) income, net in the consolidated statements of operations and changes in net assets. Also included in the gain (loss) on interest rate swaps is the loss on net cash settlement amounts associated with the swaps of $5,439 and $9,373 for the years ended December 31, 2022 and 2021, respectively.

(Dollars in thousands)

The following table represents both the fair value and settlement value for the interest rate swap assets and liabilities as of December 31, 2022 and 2021:

	Asset derivatives					
	2022			2021		
	Balance sheet location	Fair value	Settlement value	Balance sheet location	Fair value	Settlement value
Derivative instruments:						
Interest rate swaps	Other assets, net	$ 23,496	26,079	Other assets, net	$ —	—

	Liability derivatives					
	2022			2021		
	Balance sheet location	Fair value	Settlement value	Balance sheet location	Fair value	Settlement value
Derivative instruments:						
Interest rate swaps	Interest rates swap liabilities	$ 9,470	11,317	Interest rates swap liabilities	$ 119,100	124,921

(6) Donor Restricted Assets and Investments

A summary of donor restricted assets and investments at 2022 and 2021 is as follows:

	December 31, 2022		
	Donor restricted assets	Investments	Total
Mutual funds	$ 20,491	907,454	927,945
Equity securities	181	8,023	8,204
Fixed income securities	14,548	644,324	658,872
Commingled trust fund – international equity	317	14,059	14,376
Hedge funds	2,762	122,305	125,067
Common trust funds	5,954	263,674	269,628
Limited partnerships	190	8,366	8,556
Donor trusts	29,431	—	29,431
Pledge receivables, net and other	45,652	—	45,652
Total	$ 119,526	1,968,205	2,087,731

(Dollars in thousands)

	December 31, 2021		
	Donor restricted assets	Investments	Total
Mutual funds	$ 8,002	817,252	825,254
Equity securities	2,956	301,959	304,915
Fixed income securities	9,600	980,600	990,200
Commingled trust fund – international equity	1,668	170,401	172,069
Hedge funds	1,286	131,351	132,637
Common trust funds	1,931	197,281	199,212
Limited partnerships	115	11,687	11,802
Donor trusts	22,455	—	22,455
Pledge receivables, net and other	48,762	—	48,762
Total	$ 96,775	2,610,531	2,707,306

Fixed income securities include mutual funds, corporate bonds, mortgage-backed securities, asset-backed securities, U.S. government obligations, and state government obligations.

(7) Liquidity and Availability of Financial Assets

MHS actively monitors the availability of resources required to meet its operating obligations and other contractual commitments, while also striving to maximize investment returns of its available funds. To help meet its general obligations, MHS can also access the credit markets as a means of producing liquidity, if needed. MHS draws income, appreciation and distributions from its endowment fund up to 5% of the endowment average account value annually, as applicable donor restrictions are met, as another way of providing liquidity. For purposes of analyzing resources available to meet general expenditures over a 12-month period, MHS considers all expenditures related to its ongoing activities to provide integrated healthcare delivery as well as the conduct of services undertaken to support these activities to be general expenditures.

(Dollars in thousands)

At December 31, 2022 and 2021, MHS' financial resources are as follows:

	2022	2021
Cash and cash equivalents	$ 542,067	308,732
Accounts receivable	511,727	460,569
Other current assets, net	165,586	96,361
Donor restricted assets	119,526	96,775
Investments	1,968,205	2,610,531
	3,307,111	3,572,968
Less prepaid assets included in other current assets, net	(58,353)	(37,444)
Less donor restricted assets	(119,526)	(96,775)
Less investments with redemption limitations of greater than one year	(8,556)	(11,802)
Total financial assets available for general expenditures	$ 3,120,676	3,426,947

In addition to financial assets available to meet general expenditures over the next 12 months, MHS operates mostly using revenues, gains and other support without donor restrictions and anticipates collecting sufficient revenues to cover general expenditures. MHS also has a $200,000 line of credit available for general expenditures, if needed (note 15).

(8) Property, Plant, and Equipment, Net

A summary of property, plant, and equipment at December 31, 2022 and 2021 is as follows:

	2022	2021
Land and land improvements	$ 164,041	138,910
Buildings	2,360,383	2,313,543
Equipment	1,051,005	940,116
	3,575,429	3,392,569
Less accumulated depreciation	(1,640,005)	(1,500,929)
	1,935,424	1,891,640
Construction in progress	173,829	118,494
Property, plant, and equipment, net	$ 2,109,253	2,010,134

Total depreciation and amortization expense for the years ended December 31, 2022 and 2021 was $140,892 and $126,307, respectively. Depreciation expense charged to operations for the years ended

(Dollars in thousands)

December 31, 2022 and 2021 amounted to $139,145 and $122,293, respectively. Depreciation expense charged to operations for the year ended December 31, 2021 is net of a $48,094 reduction in expense as part of the change in estimated useful lives.

(9) Other Assets, Net

Other assets are as follows at December 31, 2022 and 2021:

		2022	2021
Investment in joint ventures	$	58,977	77,951
Deferred compensation plan assets held in trust (note 12)		87,039	98,789
Accrued pension asset (note 12)		36,428	60,951
Self-insured retention receivables, net of current portion (notes 13 and 14)		17,462	22,558
Net investment in lease (note 17(b))		22,655	23,172
Notes receivable (note 10)		75,284	75,546
Interest rate swaps (note 5(b))		23,496	—
Other		8,467	23,595
Other assets, net	$	329,808	382,562

Deferred compensation plan assets held in trust are participant-managed investments consisting of equity and fixed income mutual funds with prices quoted in active markets.

(10) Notes Receivable

In December 2020, MHS executed a promissory note with Astria Health for a $75,000 loan. The loan bears a fixed interest rate of 9.5% with payments due June 30 and December 31 of each year. In December 2022, the credit agreement was amended to extend the maturity date. The loan matures in December 2025.

(11) Other Liabilities, Net

Other liabilities are as follows at December 31, 2022 and 2021:

		2022	2021
Professional liability, net of current portion (note 13)	$	103,813	89,628
Deferred compensation liability (note 12)		87,039	98,789
Workers' compensation liability, net of current portion (note 14)		15,444	15,454
Other		24,749	4,436
Other liabilities, net	$	231,045	208,307

(Dollars in thousands)

(12) Retirement Plans

(a) Defined Benefit Pension Plan

MHS operates one qualified defined benefit pension plan (the Plan) covering eligible employees. The Plan was closed to new employees effective after July 31, 2002. The benefits are based on years of service and the employee's highest five consecutive years of compensation. MHS contributions to the Plan vary from year to year, but the minimum contribution required by law has been provided in each year. Effective December 31, 2016, participants no longer accrue pension benefits under the Plan.

The following tables set forth the changes in projected benefit obligations, changes in fair value of plan assets, and components of net periodic benefit costs for the Plan, which has measurement dates of December 31, 2022 and 2021:

		2022	2021
Change in projected benefit obligation:			
Projected benefit obligations at beginning of year	$	663,039	715,286
Service cost		650	650
Interest cost		19,329	18,786
Actuarial gain		(142,861)	(23,106)
Expected administrative expenses		(650)	(650)
Benefits paid		(85,170)	(47,927)
Projected benefit obligations at end of year	$	454,337	663,039
Change in fair value of plan assets:			
Fair value of plan assets at beginning of year	$	723,990	760,876
Actual (loss) gain on plan assets		(147,327)	11,700
Actual administrative expenses		(728)	(659)
Benefits paid		(85,170)	(47,927)
Fair value of plan assets at end of year	$	490,765	723,990
Funded status recognized in consolidated balance sheets consist of:			
Asset for pension benefits	$	36,428	60,951
Amount recognized in net assets without donor restrictions:			
Net loss		106,367	90,859

	2022	2021
Weighted average assumptions used to determine benefit obligations as of December 31:		
Discount rate	5.50 %	3.00 %

(Dollars in thousands)

The expected return on plan assets assumption is based upon an analysis of historical long-term returns for various investment categories as measured by appropriate indices. These indices are weighted based upon the extent to which plan assets are invested in the particular categories in arriving at MHS' determination of a composite expected return. An actuary reviews the assumptions annually for reasonableness.

The components of net periodic benefit cost are as follows during the years ended December 31, 2022 and 2021:

	2022	2021
Components of net periodic benefit cost:		
Service cost	$ 650	650
Interest cost	19,329	18,786
Expected return on plan assets	(30,858)	(29,726)
Amortization of net actuarial loss	5,335	16,205
Settlement cost	14,559	3,534
	$ 9,015	9,449

	2022	2021
Weighted average assumptions used to determine benefit obligation as of December 31:		
Discount rate	3.00 %	2.70 %
Expected return on plan assets	4.50	4.50

During the years ended December 31, 2022 and 2021, the Plan made lump-sum cash payments (settlements) to plan participants and in exchange the Plan was relieved of all remaining liabilities of future payments to those plan participants. These settlements are included in benefits paid within the change in projected benefit obligation. The total amount of these settlements exceeded the total service costs and interest costs for the years ended December 31, 2022 and 2021 and the pro-rata portion of the remaining balance in net assets without donor restrictions was recognized as part of net periodic benefit costs.

The accumulated benefit obligation for the Plan was $454,337 and $663,039 at December 31, 2022 and 2021, respectively.

(Dollars in thousands)

(i) Estimated Future Benefit Payments

The following benefits payments, which reflect expected future service, as appropriate, are expected to be paid as follows:

	Pension benefits
2023	$ 33,692
2024	33,463
2025	34,284
2026	33,643
2027	34,680
2028–2032	165,364

(ii) Plan Assets

The following tables set forth by level, within the fair value hierarchy, the Plans' investments at fair value:

	Fair value measurements at reporting date using			
	December 31, 2022	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Assets:				
Cash and cash equivalents	$ 8,926	8,926	—	—
Trading securities:				
Mutual funds	91,812	91,812	—	—
Fixed income bond funds	5,100	4,921	179	—
Fixed income governmental obligations	187,978	140,834	47,144	—
Fixed income other	162,979	13,368	149,611	—
Commingled trust fund – international equity	12,729	—	12,729	—
	469,524	$ 259,861	209,663	—

(Dollars in thousands)

		Fair value measurements at reporting date using		
	December 31, 2022	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Broker receivables	$ 38,910			
Broker payables	(85,854)			
Total assets at fair value	422,580			
Investments valued at NAV	68,185			
Total assets at fair value or NAV	$ 490,765			

		Fair value measurements at reporting date using		
	December 31, 2021	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Assets:				
Cash and cash equivalents	$ 11,324	11,324	—	—
Trading securities:				
Mutual funds	124,670	124,670	—	—
Fixed income bond funds	97,505	97,505	—	—
Fixed income governmental obligations	209,474	177,503	31,971	—
Fixed income other	202,017	—	202,017	—
Commingled trust fund – international equity	16,625	—	16,625	—
	661,615	$ 411,002	250,613	—

(Dollars in thousands)

		Fair value measurements at reporting date using		
	December 31, 2021	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Broker receivables	$ 5,983			
Broker payables	(34,584)			
Total assets at fair value	633,014			
Investments valued at NAV	90,976			
Total assets at fair value or NAV	$ 723,990			

There were no significant transfers into or out of Level 1 or Level 2 financial instruments during the years ended December 31, 2022 and 2021.

The following table presents information for investments where the NAV was used as a practical expedient to measure fair value at December 31, 2022 and 2021:

	NAV December 31, 2022	NAV December 31, 2021	Unfunded commitments	Redemption frequency (if currently eligible)	Redemption notice period
Absolute return funds	$ 63,783	84,911	N/A	Monthly	5 business days prior to valuation date
Limited partnerships	4,402	6,065	850	N/A	N/A
Total investments valued at NAV	$ 68,185	90,976	850		

Absolute return fund investments consist primarily of listed equity, equity-related and debt securities, including exchange-traded funds, other securities and other pooled investment vehicles. These investments use derivatives or other instruments for both investment and hedging purposes and may take long and/or short positions, and the derivative investments may include but are not restricted to futures, options, swaps, and forward currency contracts.

Limited partnerships include investments in private equity and venture capital in both developed and emerging markets with approximately 35% invested in private equity in developed markets,

(Dollars in thousands)

20% in venture capital in developed markets, and 45% in private equity and venture capital in emerging markets. The fair values of the investments in this category have been estimated using the NAV of MHS' ownership interest in partners' capital. These assets can never be redeemed with the partnerships. Instead, the nature of the investment in this category is that distributions are received through the liquidation of the underlying assets of the partnership.

The defined benefit plan weighted average asset allocations at December 31, 2022 and 2021 by asset category are as follows:

	2022	2021
Asset category:		
Domestic equities	13 %	12 %
International equities	9	7
Fixed income securities	77	80
Alternative investments	1	1
	100 %	100 %

(iii) Investment Objectives

The target asset allocations for each asset class are set based on the achieved funding levels for the Plan and are summarized below:

	2022	2021
Asset category:		
Domestic equities	12 %	12 %
International equities	8	8
Fixed income securities	80	80
	100 %	100 %

(iv) Investment Categories

Equities

The strategic role of domestic equities is to provide higher expected market returns (along with international equities) of the major asset classes; maintain a diversified exposure within the U.S. stock market using multimanager portfolio strategies; and achieve returns in excess of passive indices using active investment managers and strategies.

The strategic role of international equities is to provide higher expected market return premiums (along with domestic equities) of the major asset classes and diversify the Plans' overall equity exposure by investing in non-U.S. stocks that are less than fully correlated to domestic equities with similar return expectations; to maintain a diversified exposure within the international stock

market through the use of multimanager portfolio strategies; and achieve returns in excess of passive indices through the use of active investment managers and strategies.

The strategic role of emerging markets is to diversify the portfolio relative to domestic equities and fixed income investments and to specifically include equity investment in selected global markets and may also include currency hedging for defensive purposes.

Fixed Income

The strategic role of fixed income securities is to diversify the Plan's equity exposure by investing in fixed income securities that exhibit a low correlation to equities and lower volatility; maintain a diversified exposure within the U.S. fixed income market using multimanager portfolio strategies; and achieve returns in excess of passive indices through the use of active investment managers and strategies. It also provides effective diversification against equities and a stable level of cash flow.

Alternative Investments

The strategic role of alternative investments is for diversification relative to equities and fixed income investments, to add absolute return using hedging strategies, and to achieve expected return premiums over longer holding periods. Alternative investments include investments in equity, equity-related and debt securities, including exchange-traded funds, other securities and other pooled investment vehicles, hedge funds and private equities and are under the supervision and control of investment managers. Hedge funds include investments in a variety of instruments including stocks, bonds, commodities, and a variety of derivative instruments. Private equities consist primarily of equity investments made in companies that are not quoted on a public stock market, which can include U.S. and non-U.S. venture capital, leveraged buyouts, and mezzanine financing.

(b) Defined Contribution Plans

MHS currently maintains three defined contribution plans including the MHS 401(a) Retirement Account Plan (RAP), the MHS 403(b) Employee Savings Plan, and the MHS 401(k) Plan. Most employees assigned to work at Deaconess Hospital, Valley Hospital, Rockwood Clinic and Capital Medical Center are eligible for participation in the MHS 401(k) Plan, which is funded by both MHS and employee contributions. The MHS 403(b) Employee Savings Plan is 100% funded by employee contributions, and the RAP is 100% funded by MHS contributions.

MHS' funding for the defined contribution plans is based on certain percentages of the employees' base pay and/or a percentage of their deferred contributions. Employer contributions to the defined-contribution plans for 2022 and 2021 were approximately $58,000 and $54,545, respectively, which were included with employee benefits in the accompanying consolidated statements of operations and changes in net assets.

(c) Other

In addition to the defined benefit and defined contribution plans as described above, MHS also maintains several deferred compensation arrangements for the benefit of eligible employees.

Substantially all amounts that are deferred under these arrangements are held in trust until such time as these funds become payable to the participating employees.

(13) Professional Liability

MHS maintains a self-insurance program for professional liability with excess coverage over self-insured retention limits provided by commercial insurance carriers. MHS has recorded a liability as of December 31, 2022 and 2021, which comprises estimated deductibles and retentions for known claims at year-end and a liability for incurred but not reported claims based on an actuarially determined estimate.

During 2022, MHS began operations of a wholly owned insurance captive, Commencement Re (the Captive). On September 15, 2022, the Captive took on the risk to self-insure and reinsure certain layers of professional and general liability from MHS.

At December 31, 2022 and 2021, the estimated gross professional liability (including current and long-term portions) was $128,101 and $119,073, respectively. The current portion is included in accounts payable and accrued expenses, and the remainder is included in other liabilities, net in the accompanying consolidated balance sheets. MHS has recorded a receivable for amounts to be received from the excess insurance carriers for their portion of the claims (including current and long-term portions) of $22,754 and $33,191 as of December 31, 2022 and 2021, respectively. The current amount is included in other current assets, net, and the remainder is included in other assets, net in the accompanying consolidated balance sheets.

(14) Workers' Compensation and Employee Health Benefit Programs

MHS maintains a self-insurance program for workers' compensation with excess coverage over self-insured retention limits provided by commercial insurance carriers. MHS has recorded a liability based on an actuarial estimate of future claims payments. At December 31, 2022 and 2021, the estimated net liability based on future claims cost totaled $21,470 and $21,133, respectively. The gross liabilities (including both current and long-term portions) total $24,836 and $24,341 as of December 31, 2022 and 2021, respectively. The long-term amounts are included in other liabilities, net, and the current portions are included in accounts payable and accrued expenses in the accompanying consolidated balance sheets. These liabilities are secured by a letter of credit with the State of Washington. MHS has recorded a receivable for amounts to be received from excess insurance carriers of $3,366 and $3,207 as of December 31, 2022 and 2021, respectively, which is included with other current assets, net and other assets, net for the respective estimated current and long-term portions.

MHS maintains a self-insurance program for employee medical and dental insurance. Employees can elect to be included in the self-insurance plan as a part of their fringe benefit package. Premiums deducted from employees' wages are used in paying a portion of members' medical claims. The estimated liability for claims in 2022 and 2021 was $12,984 and $9,632, respectively. These amounts are included in accrued compensation and related liabilities in the accompanying consolidated balance sheets.

(Dollars in thousands)

(15) Long-Term Debt

Long-term debt consists of the following at December 31, 2022 and 2021:

	2022	2021
WHCFA Revenue bonds, 2022A	$ 49,985	—
WHCFA Revenue bonds, 2022B	108,145	—
WHCFA Revenue bonds, 2022C	80,000	—
WHCFA Revenue bonds, 2022D	130,170	—
WHCFA Revenue bonds, 2022 Taxable Private Placement	430,000	—
2020 Taxable bonds	300,000	300,000
2020 OCED financing	57,249	59,289
2019 Term loan	—	35,255
WHCFA Revenue bonds, 2017 Series A and B	314,550	318,220
WHCFA Revenue bonds, 2017 Series C, D, and E	111,010	191,010

	2022	2021
2017 Term loans	$ —	130,170
WHCFA Revenue bonds, 2015 Series A and B	343,675	348,085
WHCFA Revenue bonds, 2012 Series A	—	60,000
WHCFA Revenue bonds, 2009 Series A and B	—	98,130
Other	19,085	23,106
	1,943,869	1,563,265
Adjusted for:		
Current portion	(18,496)	(43,609)
Bond premiums, discounts, and debt issuance costs	46,764	52,579
Long-term debt, net of current portion	$ 1,972,137	1,572,235

(a) WHCFA Revenue Bonds, 2022A

In August 2022, MHS issued $49,985 of 2022 Series A bonds. These bonds were issued as variable rate tax exempt private placement debt with Royal Bank of Canada, with principal payments ranging from $1,845 in 2040 to final payment of $20,365 in 2044. The interest rates, which were between 2.43% and 4.45% at December 31, 2022, reset monthly and are based on SIFMA plus a spread.

(b) WHCFA Revenue Bonds, 2022B

In August 2022, MHS issued $108,145 of 2022 Series B bonds. These bonds were issued as variable rate tax exempt private placement debt with PNC Bank, NA. Principal payments range from $7,035 in 2040 to $22,085 in 2045, with a final payment of $19,715 in 2046 with interest payable semi-annually in February and August, based on SOFR plus a spread.

(c) WHCFA Revenue Bonds, 2022C

In December 2022, MHS issued $80,000 of 2022 Series C bonds. These bonds were issued as variable rate tax exempt private placement debt with Banc of America Preferred Funding Corp. The principal is due in full in 2047 with monthly interest payments starting in January 2023, based on SIFMA plus a spread.

(d) WHCFA Revenue Bonds, 2022D

In December 2022, MHS issued $130,170 of 2022 Series D bonds. These bonds were issued as variable rate tax exempt private placement debt with Bank of America, NA. The principal is due in full in 2047 with monthly interest payments starting in January 2023, based on SOFR plus a spread.

(e) WHCFA Revenue Bonds, 2022 Taxable Private Placement

In August 2022, MHS issued $430,000 of Series 2022 taxable private placement bonds. The bonds were acquired by various private investors. Included in the issuance are $130,000 in bonds bearing 4.48% fixed rate interest with principal due in full in 2037, and $300,000 in bonds bearing 4.75% fixed rate interest with principal due in full in 2052.

(f) 2020 Taxable Bonds

In July 2020, MHS issued $300,000 of taxable 2020 series bonds. These bonds were issued as fixed rate bonds that bear interest of 2.803%. The principal of $300,000 is due in 2050, with interest only payments made semiannually in February and August of each year.

(g) 2020 OCED Financing

In June 2020, MHS finalized a sale-leaseback transaction for four off-campus emergency departments (OCED) with total cash proceeds received of $61,794. Due to the specific terms of the agreement, the lease qualified as a financing type lease. The agreement did not meet the criteria for sale-leaseback accounting treatment and instead is considered a financing liability. The agreement bears an implicit interest rate of 4.64%. Annual principal payments range from $2,136 in 2023 to $4,482 in 2039 with a final principal payment of $390 in 2041.

(h) 2019 Term Loan

In August 2019, MHS entered into a fixed rate term loan agreement with JPMorgan Chase Bank, N.A., with an interest rate of 1.89%. The principal balance of $35,255 was paid in full in 2022.

(i) Washington Health Care Facility Authority (WHCFA) Revenue Bonds 2017 Series A and B

In November 2017, MHS issued $333,970 of 2017 Series A and B bonds. These bonds were issued as fixed rate bonds that bear interest ranging from 3.0% to 5.0%. Annual principal payments range from $4,135 in 2023 to $62,410 in 2047.

(j) WHCFA Revenue Bonds 2017 Series C, D, and E

In November 2017, MHS entered into a $111,010 variable rate private placement agreement (Series C and D) with JPMorgan Chase Bank, National Association. The first annual principal payment of

$55,505 is due in 2048, with a final principal payment of $55,505 in 2049. The interest rates, which were between 0.44% and 3.58% at December 31, 2022, reset monthly and are based on 70% of SOFR.

In November 2017, MHS entered into an $80,000 variable rate private placement agreement (Series E) with Wells Fargo Municipal Capital Strategies, LLC. In December 2022, MHS refunded the 2017 Series E bonds and replaced them with 2022 Series C.

(k) 2017 Term Loans

In November 2017, MHS entered into two $65,085 variable rate term loan agreements with Wells Fargo Bank, N.A. In December 2022, MHS refunded the 2017 Term Loans and replaced them with 2022 Series D.

(l) WHCFA Revenue Bonds 2015 Series A and B

In April 2015, MHS issued $373,390 of 2015 Series A and B bonds. Series A and B bonds were issued as fixed rate bonds that bear interest ranging from 2.0% to 5.0%. Annual principal payments range from $4,295 in 2040 to $24,085 in 2034 with a final payment of $8,860 due in 2045.

(m) WHCFA Revenue Bonds 2012 Series A

In November 2012, MHS issued $60,000 of 2012 Series A bonds. In August 2022, MHS refunded the 2012 Series A bonds and replaced them with 2022 Series B.

(n) WHCFA Revenue Bonds 2009 Series A and B

In May 2009, MHS issued the 2009 Series A and B bonds as variable rate demand bonds for $50,000 each. The bonds were backed by an irrecoverable letter of credit equal to the aggregate principal and interest of the bonds. In July 2012, the 2009 Series A and B bonds were converted to $98,130 of fixed rate bonds. In August 2022, MHS refunded the 2009 Series A and B bonds and replaced them with 2022 Series A and 2022 Series B.

(o) Other

The other debt listed is primarily made up of debt held by Navos. Of the outstanding debt at December 31, 2022, $16,531 is associated with certain buildings and other capital assets operated by Navos and is subject to provisions whereby the debt will be forgiven upon compliance with those provisions. These provisions state that Navos maintains the assets that were built or purchased with these notes and maintains their usage when the promissory note was signed for the length specified. If these provisions are not met, the note must be repaid based on the terms of the agreement. The forgivable debt is subject to a forgiveness provision in years 2028 through 2068.

(p) 2022 Line of Credit

In October 2022, MHS entered into a $200,000 revolving credit agreement with JPMorgan Chase Bank, NA. The term of the line of credit is for 12 months and bears interest at a variable rate based upon SOFR. The line on credit has no draws as of December 31, 2022.

(Dollars in thousands)

Revenue bonds issued by MHS through WHCFA are subject to applicable bond indenture agreements, which require that MHS satisfy certain measures of financial performance as long as the bonds are outstanding. These measures include a minimum debt service coverage ratio and a condition that the bonds are secured by a gross receivables pledge. Based on management's assessment of these requirements, MHS is in compliance with these covenants at December 31, 2022 and 2021.

Each fixed-rate revenue bond requires semiannual interest payments on February 15 and August 15 of each year until maturity. These bonds are subject to early redemption by MHS on or after certain specific dates and at certain specific redemption prices as outlined in each bond agreement.

Principal maturities on long-term debt are as follows:

Year ending December 31:		
2023	$	18,496
2024		21,627
2025		22,704
2026		23,825
2027		46,202
Thereafter		1,811,015
	$	1,943,869

A summary of interest costs is as follows during the years ended December 31, 2022 and 2021:

		2022	2021
Interest cost:			
Charged to operations	$	59,006	50,103
Amortization of bond premiums, discounts, and issuance costs		(2,163)	(2,433)
Capitalized		555	382
	$	57,398	48,052

(16) Commitments and Contingencies

Approximately 43% of MHS employees were covered under collective bargaining agreements as of December 31, 2022. These employees provide nursing, nursing support, pharmacy, imaging, lab, inpatient and outpatient therapies, housekeeping, food, laundry, maintenance, and inventory/distribution services to MHS. Collective bargaining agreements have various expiration dates extending through December 2025.

(Dollars in thousands)

(17) Leases

(a) Lessee

MHS leases various equipment and facilities under noncancelable operating and finance leases. Lease terms for noncancelable operating leases range from 1 to 18 years, and existing leases have expiration dates through 2037. Lease terms for finance leases range from 1 to 21 years, and existing leases have expiration dates through 2040.

The components of lease cost for the years ended December 31, 2022 and 2021 were as follows:

		2022	2021
Operating lease cost	$	36,768	37,283
Finance lease cost:			
Amortization of right-of-use assets		4,745	9,031
Interest on lease liabilities		802	3,402
Total finance lease cost		5,547	12,433
Short term lease cost		1,503	1,578
Variable lease cost		9,138	9,233
Sublease income		(1,727)	(1,662)
Total lease cost	$	51,229	58,865

Other information related to leases as of December 31, 2022 and 2021 was as follows:

		2022	2021
Weighted average remaining lease term (years):			
Operating leases		7.2	6.5
Finance leases		6.0	6.6
Weighted average discount rate:			
Operating leases		4.0 %	4.0 %
Finance leases		4.4	4.4
Operating cash flows from operating leases	$	(35,805)	(36,688)
Operating cash flows from finance leases		(802)	(3,402)
Financing cash flows from finance leases		(4,499)	(8,645)
Right-of-use assets obtained in exchange for new operating lease liabilities		56,322	36,385
Right-of-use assets obtained in exchange for new finance lease liabilities		3,528	11,948

(Dollars in thousands)

Maturities of lease liabilities under noncancelable leases as of December 31, 2022 are as follows:

		Operating leases	Finance leases	Total
For year ended December 31:				
2023	$	35,782	5,623	41,405
2024		31,596	5,400	36,996
2025		28,447	3,351	31,798
2026		26,272	873	27,145
2027		20,794	597	21,391
Thereafter		61,729	4,031	65,760
Total undiscounted lease payments		204,620	19,875	224,495
Less present value discount		(27,596)	(2,419)	(30,015)
Total lease liabilities	$	177,024	17,456	194,480

(b) Lessor

MHS leases a building to the Alliance for South Sound Health, which does business under the name Wellfound Behavioral Health Hospital (Wellfound). Wellfound is a related party owned 50 percent by MHS. The leased building is owned solely by MHS and is the only asset that MHS leases out as a lessor. The lease has a 20-year initial lease term, with four 5-year extension options. Due to the related party nature of the lease, MHS considers it reasonably certain that Wellfound will exercise its four lease renewal options, and as such, treats the lease as a 40-year lease. There is no purchase option stated in the lease contract. MHS has determined that the lease is a sales-type financing lease, since the expected lease term spans a major portion of the useful life of the building. At December 31, 2022, MHS' other assets, net include a net investment in lease of $22,655.

Revenue from leases for the years ended December 31, 2022 and 2021 is as follows:

		2022	2021
Interest income on net investment in finance leases	$	1,032	1,048
Variable lease income		28	28
Total lease income	$	1,060	1,076

(Dollars in thousands)

Future lease payments receivable as of December 31, 2022 are as follows:

Year ended December 31:		
2023	$	1,227
2024		1,227
2025		1,227
2026		1,227
2027		1,227
Thereafter		40,565
Total lease payments to be received		46,700
Less unearned interest income		(24,045)
Net investment in lease	$	22,655

(18) Net Assets with Donor Restrictions

Net assets with donor restrictions are available for the following specified purposes at December 31, 2022 and 2021:

		2022	2021
Healthcare services	$	51,816	57,511
Endowment funds, perpetual trusts and related receivables		78,231	76,079
Purchase of property, plant and equipment		42,001	39,721
Indigent care		2,459	2,167
Health education		1,006	1,264
Total net assets with donor restrictions	$	175,513	176,742

(19) Endowment Funds

MHS' endowments consist of over 100 individual funds established for a variety of purposes. They include both endowment funds with donor restrictions and funds designated without donor restrictions by the board of directors of its foundations to function as endowments (board-designated endowments). Net assets associated with endowment funds, including board-designated endowment funds, are classified and reported based on the existence or absence of donor-imposed restrictions and nature of restrictions, if any.

(Dollars in thousands)

The following tables present MHS' endowment net asset composition as well as associated changes therein:

	Board designated without donor restrictions	Funds with donor restrictions	Total
Endowment net assets, December 31, 2020	$ 2,825	42,424	45,249
Investment return:			
Investment income	18	527	545
Net appreciation – realized and unrealized	65	1,289	1,354
Total investment return	83	1,816	1,899
Contributions	—	2,271	2,271
Appropriation of endowment assets for expenditure	(47)	(2,499)	(2,546)
Endowment net assets, December 31, 2021	2,861	44,012	46,873
Investment return:			
Investment income	16	376	392
Net depreciation – realized and unrealized	(85)	(987)	(1,072)
Total investment return	(69)	(611)	(680)
Contributions	—	3,499	3,499
Appropriation of endowment assets for expenditure	(28)	(581)	(609)
Endowment net assets, December 31, 2022	$ 2,764	46,319	49,083

Perpetual trusts that are held and managed by third party trustees are recorded as net assets with donor restrictions on the consolidated balance sheets; however, they are not included as endowment net assets with donor restrictions in the above presentation. Those perpetual trusts totaled $27,650 and $31,008, respectively, as of December 31, 2022 and 2021. Also excluded from the presentation of endowment net assets with donor restrictions above are pledge receivables and other totaling $4,262 and $1,059, respectively, as of December 31, 2022 and 2021.

(a) Funds with Deficiencies

From time to time, the fair value of assets associated with individual donor restricted endowment funds may fall below the level of the original gifts and the amounts of subsequent donations accumulated at the funds. In accordance with generally accepted accounting principles, deficiencies of this nature are reported in net assets with donor restrictions. There were no funds with deficiencies in 2022 or 2021.

(b) Investment Policy – Including Return Objectives and Strategies to Achieve Objectives

The endowment assets are invested in an investment portfolio, which include those assets of donor restricted funds that MHS must hold in perpetuity as well as all other foundation-related investment assets. MHS has adopted an investment policy for the foundation investments that intends to provide income to support the spending policy while seeking to maintain the purchasing power of the endowment assets. To satisfy its long-term rate of return objectives, MHS relies on a total return strategy in which investment returns are achieved through both capital appreciation and interest and dividend income. MHS uses a diversified asset allocation to achieve its long-term return objectives within prudent risk constraints. There are some donor restricted funds that are held separately from MHS' pooled investments. These endowments are invested by donors in manners to provide funding for specific purposes as determined by donors.

(c) Spending Policy

In order to provide a stable and consistent level of funding for programs and services supported by the endowments, the foundations have determined that an annual spending rate of 5% of the endowment's average account value is prudent. In establishing the spending policies, the MHS foundations considered among other things, the expected total return on its endowments, effect of inflation, duration of the endowments to achieve its objective of maintaining the purchasing power of the endowment assets held in perpetuity, as well as to provide additional growth through new gifts and investment returns.

(Dollars in thousands)

(20) Functional Expenses

MHS provides inpatient and outpatient services, physician services, home health services, and fundraising activities. Certain categories of expenses are attributable to programs and support services. These included salaries and wages, depreciation and amortization and other expenses. Costs are allocated based on cost allocation methods depending on the allocable expense, including square footage, time utilization and percentage of gross charges. Expenses related to providing these services are as follows for the years ended December 31, 2022 and 2021:

	2022				
	Program services			Support services	
	Hospitals and related services	Clinics and urgent care centers	Retail and other services	Corporate and support services	Total
Salaries and wages	$ 1,357,838	464,219	93,787	283,421	2,199,265
Employee benefits	133,164	75,536	20,705	68,208	297,613
Supplies	535,376	48,220	70,994	3,880	658,470
Purchased services	135,500	68,800	32,771	159,676	396,747
Depreciation and amortization	87,289	14,878	7,580	31,145	140,892
Interest	40,631	3,715	70	12,426	56,842
Other	281,895	48,356	121,797	89,198	541,246
	$ 2,571,693	723,724	347,704	647,954	4,291,075

	2021				
	Program services			Support services	
	Hospitals and related services	Clinics and urgent care centers	Retail and other services	Corporate and support services	Total
Salaries and wages	$ 1,130,560	432,037	65,231	242,817	1,870,645
Employee benefits	128,295	72,692	15,595	61,603	278,185
Supplies	482,058	43,267	66,679	8,753	600,757
Purchased services	132,808	44,695	25,750	145,906	349,159
Depreciation and amortization	70,583	18,057	3,626	34,041	126,307
Interest	40,788	3,936	—	2,946	47,670
Other	293,968	57,179	20,779	114,079	486,005
	$ 2,279,060	671,863	197,660	610,145	3,758,728

(21) Litigation and Regulatory Environment

The healthcare industry is subject to numerous laws and regulations from federal, state, and local governments. These laws and regulations include, but are not limited to, matters such as licensure, accreditation, government healthcare program participating requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Government agencies are actively conducting investigations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in the imposition of significant fines and penalties, significant repayments for patient services previously billed, and/or expulsion from government healthcare programs. Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

MHS is also involved in litigation arising in the normal course of business. After consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect to MHS' financial position.

(22) Subsequent Events

On January 17, 2023, Yakima Valley Memorial Hospital (Yakima) in Yakima, Washington affiliated with MHS. Yakima is a 238 bed hospital as well as operates primary and specialty care clinics in the Yakima Valley region. No consideration was exchanged and MHS became the sole corporate member of Yakima. The unaudited results of operations for the year ended December 31, 2022 is total operating revenue of $521,288 and total deficit of revenue over expenses from operations of $33,211. These unaudited results are not included within the results of operations of MHS for the year ended December 31, 2022 nor are these results indicative of future financial results. MHS is still completing the accounting for the affiliation pending the determination of the fair value of the inherent contribution made.

MHS has evaluated the subsequent events through March 21, 2023, the date at which the consolidated financial statements were issued and has included all necessary adjustments and disclosures.

Exhibit 13

MultiCare Health System Draft Charter of the Health Equity Community Advisory Board

MultiCare Health System
Charter of the Health Equity Community Advisory Board

PURPOSE

The primary objective of the MultiCare Health Equity Community Advisory Board ("HECAB") is to advise MultiCare leadership on strategies to reduce health disparities, address community health needs and identify opportunities for partnership in community to advance equity, diversity, and inclusion shared initiatives.

FUNCTIONAL DUTIES

Members of HECAB are asked to provide feedback to Center for Health Equity and Wellness leadership as well as other MHS leaders on a variety of strategies and initiatives. Specific strategies and programs may include:

1. Health Equity Strategic Plan and Key Performance Indicators
2. Community Health Needs Assessment and Implementation Plans
3. Belonging Strategic Plan and HP Recruitment Strategies
4. Language Access Program and Initiatives
5. Health Equity Action Plans
6. Community Engagement Strategies

COMPOSITION

HECAB shall consist of up to 25 external community persons. Membership criteria includes representatives from organizations that focus on health equity, diversity, inclusion, represent underserved communities, or focus on addressing a priority need identified in the community health needs assessment. We will seek membership from a broad geography that reflects the various communities where MultiCare provide services.

The following internal MHS persons shall serve *ex officio* members of HECAB and are not included in the maximum number of members:

- MultiCare Assistant VP of the Center for Health Equity and Wellness
- MultiCare Leaders of Health Equity and Wellness
- MultiCare VP of Marketing/ Communications
- MultiCare Chief Belonging Officer
- MultiCare President Connected Care
- MultiCare VP of Quality

HECAB membership is voluntary, and a three-year commitment is requested.

Board members may be removed by the MultiCare AVP of the Center for Health Equity and Wellness, with or without cause.

Sub-committees of HECAB may be composed by region or sector, depending on project or need.

STRUCTURE AND MEETING

HECAB will meet at least four (4) times per year, and more frequently as circumstances require. Board members are expected to attend each meeting which will be held virtually. HECAB may invite to any of its meetings other directors, members of MultiCare management, and such other persons as it deems appropriate to carry out its responsibilities.

A designee from the Center for Health Equity and Wellness will preside at each meeting, set the frequency and length of each meeting, and prepare and/or approve an agenda in advance of each meeting. Meeting agendas will be prepared and provided in advance to members, along with appropriate briefing materials. Minutes will be prepared.

SELF-ASSESSMENT AND EVALUATION

The HECAB shall conduct a self-assessment and evaluation at least once every two years. Results of the self-assessment and evaluation will be shared.

AMENDMENTS

This Charter may be amended from time to time by the MultiCare Health System Assistant VP of the Center for Health Equity and Wellness.

Effective as of _____, 2023