CN21-01

Writer's Direct Dial (469) 673-6666
Writer's Direct Facsimile (214) 445-3994
E-Mail Address: Kyle.Chandler@intrepidUSA.com

June 22, 2020

Department of Health
Certificate of Need Program
111 Israel Road SE
Tumwater, WA 98501

Re: Application for Certificate of Need Home Health Care Projects

To whom it may concern:

Please see the attached CON application for Intrepid of Washington, Inc. d/b/a Intrepid USA Healthcare Services. We are requesting certificate of need ("CON") approval for a licensed Home Health Care agency offering Medicare Certified and Medicaid Eligible services to the residents of Stevens County. Along with the application, I have included all necessary attachments corresponding with the application and a check for $24, 666.00 representing the review fee.

Should you have any questions, or need any additional information, please contact me at the information listed above.

Sincerely,

Kyle Chandler
Sr. Compliance Analyst
Intrepid USA Healthcare Services
3220 Keller Springs Road, Suite 108
Carrollton, TX 75006-5911

Washington State Department of Health

FOR DEPARTMENT USE ONLY
Date Stamp Here
Fee Received _____
Check #: _____
Initials_____

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

APPLICATION FOR CERTIFICATE OF NEED HOME HEALTH CARE PROJECTS

Certificate of Need applications must be submitted with a fee in accordance with the instructions on page 2 of this form Application is made for a Certificate of Need in accordance with provisions in Revised Code of Washington (RCW) 70 38 and Washington Administrative Code (WAC) 246-310 adopted by the Washington State Department of Health. I hereby certify that the statements made in this application are correct to the best of my knowledge and belief

Signature and Title of Responsible Officer: Paul M McMullen Chief Operation Officer **Date:** 6 22 2020	**Person To Whom Questions Regarding This Application Should Be Directed:** **Kyle Chandler** **Telephone Number:** 469-673-6666
Legal Name of Applicant: Intrepid of Washington, Inc **Address of Applicant:** 3220 Keller Springs Road, Suite 108 Carrollton, TX 75006 **Telephone Number:** 469-559-5963	**Type of Project (check all that apply):** [ ] New Agency [X] Existing Medicare Certified/Medicaid Eligible Agency Expanding into Different County [ ] Existing Licensed-Only Home Health Agency to Become Medicare Certified/Medicaid Eligible
Project Summary: Certificate of Need ("CON") approval for a licensed Home Health Care agency offering Medicare Certified and Medicaid Eligible services to the residents of Stevens County Intrepid USA Healthcare Services will offer in-home skilled nursing, physical therapy, occupational therapy, speech language pathology, medical social worker, and home health aide services to homebound patients **Estimated capital expenditure: $150,000.00**	

APPLICATION INFORMATION INSTRUCTIONS:

These application information requirements are to be used in preparing a Certificate of Need application The information will be used to evaluate the conformance of the project with all applicable review criteria contained in RCW 70 38 115 and WAC 246-310-210, 220, 230, and 240

NOTE: If this application is approved, the applicant will be expected to provide services to residents in the entire county.

- Home Health applications are county specific. No more than one county per application.
- Include a table of contents for major application sections and appendices.
- Number **all** pages consecutively.
- **Do not** bind or 3-hole punch the application
- Make the narrative information complete and to the point
- Cite all data sources
- Provide copies of articles, studies, etc , cited in the application.
- Place extensive supporting data in an appendix.
- Provide detailed descriptions of assumptions used for **all** projections
- Use **non-inflated** dollars for **all** cost projections
- **Do not** include a general inflation rate for these dollar amounts
- **Do** include current contract cost increases such as union contract staff salary increases You must identify each contractual increase in the description of assumptions in the application
- **Do not** include a capital expenditure contingency

Application Submission:

Number of Copies:
- Submit an **original and an electronic (pdf) version**
- All subsequent submissions associated with this application must be submitted with an **original and an electronic (pdf) version**

To be accepted, the application must include:
- A completed and signed Certificate of Need application face sheet
- The review fee of **$24,666** Make check payable to ***Department of Health***

Send application to.

Mailing Address:

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

Other Than By Mail:

Department of Health
Certificate of Need Program
111 Israel Road SE
Tumwater, Washington 98501

If you have questions, call (360) 236-2955

I. APPLICANT DESCRIPTION:

A Provide the legal name(s) of applicant(s).
Note The term "applicant" for this purpose is defined as any person or individual with a ten percent or greater financial interest in a partnership or corporation or other comparable legal entity that engage in any undertaking which is subject to review under provisions of RCW 70 38

Intrepid of Washington, Inc
3220 Keller Springs Rd , Suite 108
Carrollton, TX 75006-5911
EIN 41-1946917

100% Owned by Intrepid Companies, Inc

Intrepid Companies, Inc
3220 Keller Springs Rd , Suite 108
Carrollton, TX 75006-5911
EIN 41-1946901

100% Owned by Intrepid U S A , Inc

Intrepid U S A Inc
3220 Keller Springs Rd , Suite 108
Carrollton, TX 75006-5911
EIN 41-1684069

100% Owned by Zohar Healthcare, LLC

Zohar Healthcare, LLC
1 Liberty Plaza, 35th Floor
New York, NY 10006-1404
EIN 20-5632385

100% Owned by Snelling Holdings, LLC

Snelling Holdings, LLC
1 Liberty Plaza, 35th Floor
New York, NY 10006-1404
EIN 45-0575591

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

License/Credential Number. HIS.FS.00000346 issued to Intrepid USA Healthcare Service by Washington State Department of Health

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

Intrepid USA Healthcare Service
9715 N Nevada St
Spokane, WA 99218-3412

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

Corporation

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

Intrepid of Washington, Inc

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

Intrepid of Washington, Inc

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

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EIN 41-1946917

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New York, NY 10006-1404
EIN 45-0575591

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

Please see attached Agency Listing.

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

Medicare Certified Coverage: Spokane County
State Licensed Home Health Coverage: Adams, Lincoln, Pend O'Reille, Stevens and Whitman Counties

J. Identify the facility licensure/accreditation status

Intrepid USA Healthcare Services is accredited by Accreditation Commission for Health Care (ACHC) with deemed status.

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

Medicare and Medicaid

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

Susan Ashley, MD – Credential Number MD00025521 – Credential Type: Physician and Surgeon License

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

Please see attached contract for Susan Ashley, MD.

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

1 Total number of home health *visits* per year for the last three years, and

Home Health Aide: 615, MSW: 315, OT 1,749, PT: 6,108, Skilled Nursing 11,022, ST· 285

2 Total number of unduplicated home health *patients* served per year for the last three years

915

II. PROJECT DESCRIPTION

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

A Provide the name and address of the proposed facility.

Intrepid of Washington, Inc. d/b/a Intrepid USA Healthcare Services
9715 N Nevada St.
Spokane, WA 99218-3412

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

Expansion of services area for a licensed Home Health Care agency offering Medicare Certified and Medicaid Eligible services to the residents of Stevens County.

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

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

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

Skilled Nursing for adult and geriatric population in the rural area of Stevens County.

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

N/A

F Provide drawings of proposed project:
1 Single line drawings, *approximately to scale,* of <u>current</u> locations which identify current department and services, and
2 Single line drawings, *approximately to scale,* of <u>proposed</u> locations which identify proposed services and departments, and
3 Total net and gross square feet of project

N/A

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

June 20, 2020

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

Continue expansion to population of Stevens County.

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

1 Clear legal title to the proposed site; or

2. A lease for at least one year with options to renew for not less than a total of three years; or

See attached lease agreement for Intrepid USA Healthcare Services Spokane, WA agency
No new leases will be necessary.

3. A legally enforceable agreement (i e , draft detailed sales or lease agreement, executed sales or lease agreement with contingencies clause) to give such title or such lease in the event that a Certificate of Need is issued for the proposed project. These agreements may be in draft form if all parties identified in the draft agreements provide a signed "Letter of Intent to finalize" the agreement

III. PROJECT RATIONALE

A. Need (WAC 246-310-210)

1. Identify the proposed geographic service area.

Stevens County

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

Data obtained from Health Resources and Services Administration
https://data hrsa.gov/tools/shortage-area/mua-find

MUA/P ID	Service Area Name	Designation Type	Primary State Name	County	Index of Medical Underservice Score	Status	Rural Status	Designation Date	Update Date	
Discipline	MUA/P ID	Service Area Name	Designation Type	Primary State Name	County	Index of Medical Underservice Score	Status	Rural Status	Designation Date	Update Date
Primary Care	3698	Loon Lake Division Service Area	Medically Underserved Area	Washington	Stevens County, WA	59 6	Designated	Non-Rural	5/11/1994	5/11/1994

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

See attach letters of support received

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

Only two home health agencies currently in Stevens County.

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

Unmet home health needs result in an increase in acute care hospitalizations which result in negative long-term rehab potential and lack of patient knowledge of their care.

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

Medicare Certified and Medicaid Eligible services to the adult and geriatric population of Stevens County.

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

Stevens County ZIP Codes: 99126, 99129, 99131, 99137, 99141, 99146, 99148, 99151, 99157, 99167, 99034, 99173, 99101, 99040, 99181, 99109, 99110, 99114

See attached Stevens County ZIP code map

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

N/A

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

A Total number of home health *visits* per year for the first three years; and

Approximately 960 per year.

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

Approximately 360 patients. Stevens county has 45,723 with 23 3% 65 years of age or older (10,653). Any given time, CMS estimates that 15% of the senior population meets criteria for home healthcare (1,597). Fifty percent of seniors needing care do not receive it (798). As a normal course of business, we would expect to ramp up patients on service over time, 15 in the first 3 months, 20 in the next 3 months, 25 in the next three months, then 30 in perpetuity each quarter

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

No additional equipment will be purchased, and no lease will be necessary Will utilize staff from Spokane off and will estimate salaries totaling $150,000.00

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

   One agency only provides IV therapy. Intrepid USA provides a full range of home health services to include physical, occupational, speech therapy as well as skilled nursing services 50% of current Medicare eligible patients who are unable to currently obtain services will have the ability to receive a full range of services.

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

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

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

      Right at Home Spokane is the only other home health agency able to service Stevens County Approximately 360 patients. Stevens county has 45,723 with 23 3% 65 years of age or older (10,653). Any given time, CMS estimates that 15% of the senior population meets criteria for home healthcare (1,597). Fifty percent of seniors needing care do not receive it (798). As a normal course of business, we would expect to ramp up patients on service over time, 15 in the first 3 months, 20 in the next 3 months, 25 in the next three months, then 30 in perpetuity each quarter.

10. Document the manner in which low-income persons, racial and ethnic minorities, women, people with disabilities, and other under-served groups will have access to the services proposed. The department uses the applicant's current or proposed status as a Medicare and Medicaid certified provider of service as part of its evaluation of question.

    Services open to all patients with physician or allowable practitioner orders.

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

    a Admissions policy – See attached policy 2 001
    b Charity care policy – See attached policy 1 057
    c Patient referral policy, if not addressed in admissions policy – See attached Policy 2 001

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

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

       N/A

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

N/A

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

N/A

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

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

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

N/A

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

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

Capital Expenditure based off forecasted need to support Stevens County expansion.

Estimated Capital Expenditure	
Moveable Equipment	
Furniture & Fixtures	$ 25,000
Copiers & Printers	$ 5,000
Computer Hardware	$ 26,000
Telecommunications	$ 12,000
Freight & Delivery Charges	$ 2,000
Total	$ 70,000

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

N/A

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

Please see attached Estimated Operating Revenue and Expenses

Intrepid U S A Healthcare Services
Comparative Consolidated 3 Year CON Budget
Stevens County, WA

	Begin Oct 2020	2021	2022	2023
Revenues				
Episodic Revenue	70,690	1,119,256	1,508,050	1,508,050
Non Episodic Revenue	11,310	179,081	241,288	241,288
Contractual Adjustments	(1,640)	(25,967)	(34,987)	(34,987)
Net Revenues	80,360	1,272,370	1,714,351	1,714,351
Direct Expenses				
Wages, Benefits and Payroll Taxes	33,862	536,152	722,395	722,395
Insurance	2,553	40,416	54,456	54,456
Medical Supplies	819	12,962	17,465	17,465
Contract Labor	0	0	0	0
Travel & Transportation	1,133	17,937	24,168	24,168
Other	1,814	28,717	38,692	38,692
Total Direct Expenses	40,180	636,185	857,176	857,176
Gross Margin	40,180	636,185	857,176	857,176
Gross Margin %	50 00%	50 00%	50 00%	50 00%
Operating Expenses				
Wages, Benefits and Payroll Taxes	22,699	359,397	484,240	484,240
Travel	218	873	873	873
Telecommunications	327	1,310	1,310	1,310
Advertising	25	99	99	99
Supplies	146	586	586	586
Insurance	36	145	145	145
Utilities	115	458	458	458
Postage	6	22	22	22
Bad Debt Expense	1,607	25,447	34,287	34,287
Equipment	118	473	473	473
Corporate Allocations	9,643	152,684	205,722	205,722
Licenses & Permits	140	561	561	561
Professional Fees	619	2,478	2,478	2,478
Other Taxes	439	1,757	1,757	1,757
Other	443	1,774	1,774	1,774
Total Operating Expenses	36,583	548,066	734,786	734,786
Fixed Expenses				
Rent	6,250	25,000	25,000	25,000
Depreciation	0	0	0	0
Total Fixed Expenses	6,250	25,000	25,000	25,000
Operating Profit (Loss)	(2,653)	63,119	97,389	97,389
Operating Profit (Loss) %	-3 30%	4 96%	5 68%	5 68%

Revenue	Expenses
Medicare	Advertising
Medicare Managed Care	Allocated Costs
Medicaid	B & O Taxes
Healthy Options [BHP]	Depreciation and Amortization
Private Pay	Dues and Subscriptions
Third Party Insurance	Education and Training
Other [CHAMPUS, Veterans, etc]	Employee Benefits
Non-operating Revenue [United Way, etc]	Equipment Rental
Deductions from Revenue	Information Technology/Computers, Repairs and Maintenance
(Charity)	Insurance, Payroll Taxes
(Provision for Bad Debt)	Interest, Purchased Services (utilities, other)
(Contractual Allowances)	Legal and Professional
	Licenses and Fees, Rental/Lease
	Medical Supplies, Travel (patient care, other)
	Salaries and Wages (DNS, RN, OT, clerical, etc)
	Postage, Supplies and Telephone/Pagers

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

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

      National Government Services
      P.O. Box 6474
      Indianapolis, IN 46206-6474

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

      N/A

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

   N/A

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

   See attached letter from John Shrieves, Vice President of Finance

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

   N/A

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

Intrepid U S A Healthcare Services
Stevens County Pro Forma Balance Sheet
As of 3/31/2020

	2020	2021	2022	2023
Assets				
Current Assets				
Cash and Cash Equivalents	0	0	0	0
Accounts Receivable	22,385	97,935	144,521	188,632
Inventory	0	0	0	0
Prepaid Expenses	0	0	0	0
Total Current Assets	22,385	97,935	144,521	188,632
Property & Equipment				
Fixed Assets	70,000	70,000	70,000	70,000
Accumulated Depreciation	(3,500)	(17,500)	(31,500)	(45,500)
Net Property & Equipment	66,500	52,500	38,500	24,500
Other Assets				
Deferred Financing Costs	0	0	0	0
Goodwill and Other Intangibles	0	0	0	0
Total Other Assets	0	0	0	0
Total Assets	**88,885**	**150,435**	**183,021**	**213,132**
Liabilites and Stockholders' Equity				
Current Liabilities				
Current Portion LT Debt	0	0	0	0
Accounts Payable	74,891	72,489	4,159	0
Accrued Expenses	3,330	3,496	3,671	3,671
Accrued Payroll and Taxes	13,318	13,984	14,683	14,683
Total Current Liabilities	91,538	89,968	22,512	18,354
Long Term Liabilities				
Capital Leases Payable	0	0	0	0
Other Long Term Liabilities	0	0	0	0
Total Long Term Obligations	0	0	0	0
Stockholders' Equity				
Common Stock	0	0	0	0
Preferred Stock	0	0	0	0
Additional Paid In Capital	0	0	0	0
Treasury Stock	0	0	0	0
Prior Years' Earnings	0	(2,653)	63,119	97,389
Current Years Earnings	(2,653)	63,119	97,389	97,389
Total Stockholders' Equity	(2,653)	60,466	160,509	194,779
Total Liabilities and Stockholders' Equity	**88,885**	**150,434**	**183,021**	**213,133**

Intrepid U S A Healthcare Services
Comparative Consolidated 3 Year CON Budget
Stevens County, WA

	Begin Oct 2020	2021	2022	2023
Revenues				
Episodic Revenue	70,690	1,119,256	1,508,050	1,508,050
Non Episodic Revenue	11,310	179,081	241,288	241,288
Contractual Adjustments	(1,640)	(25,967)	(34,987)	(34,987)
Net Revenues	80,360	1,272,370	1,714,351	1,714,351
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Other	443	1,774	1,774	1,774
Total Operating Expenses	36,583	548,066	734,786	734,786
Fixed Expenses				
Rent	6,250	25,000	25,000	25,000
Depreciation	0	0	0	0
Total Fixed Expenses	6,250	25,000	25,000	25,000
Operating Profit (Loss)	(2,653)	63,119	97,389	97,389
Operating Profit (Loss) %	-3 30%	4 96%	5 68%	5 68%

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

N/A

11 Identify the expected sources of revenue for the applicant's total operations (e g , Medicare, Medicare Managed Care, Medicaid, Healthy Options, Blue Cross, Labor and Industries, etc) for the first three years

of operation, with anticipated percentage of revenue from each source Estimate the percentage of change per year for each payer source

	Begin Oct 2020	%	2021	%	2022	%	2023	%
Revenues								
Episodic Revenue	69,050	86%	1,093,289	86%	1,473,063	86%	1,473,063	86%
Non Episodic Revenue	11,310	14%	179,081	14%	241,288	14%	241,288	14%
Net Revenues	80,360	100%	1,272,370	100%	1,714,351	100%	1,714,351	100%

Episodic Revenue at 86% = Medicare Traditional & Medicare Advantage/PFFS
Non-Episodic Revenue at 14% = All Managed Care/Medicaid/Veteran Administration

We do not forecast Payer mix changing year-over-year.

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

	2017	2018	2019
Revenues			
Home Health and ASL Revenue			
Episodic Revenue	2,894,065	1,948,577	1,144,872
Assisted Living Revenue Subtotal	0	0	0
Non - Episodic Revenue Subtotal	345,507	354,434	195,712
Pediatrics	0	0	0
Professional Services Revenue	0	0	0
Total Gross Home Health	3,239,572	2,303,011	1,340,584
Total Gross Revenue	3,239,572	2,303,011	1,340,584
Sales Adjustments	(102,074)	(85,942)	34,967
Other Revenue	0	0	0
Net Revenues	3,137,499	2,217,069	1,375,552
Direct Expenses			
Direct Wages Subtotal	963,890	808,723	620,379
Sub Cont Subtotal	0	106	0
Total Direct Expense	963,890	808,829	620,379
Gross Margin	2,173,609	1,408,240	755,173
Gross Margin %	69 28%	63 52%	54 90%
Other Direct Expenses			
Benefits Subtotal	214,769	163,040	119,061
Insurance Subtotal	47,596	57,835	55,741
Medical Supplies Subtotal	18,626	17,225	17,877
Other Hospice Patient Related Costs Subtotal	0	0	0
Travel & Transportation Subtotal	49,506	40,546	24,738
Other Subtotal	41,608	40,119	41,731
Total Other Direct Expenses	372,104	318,767	259,148
Total Direct Expenses	1,335,994	1,127,596	879,528
True Gross Margin	1,801,505	1,089,473	496,024
True Gross Margin %	57 42%	49 14%	36 06%

Operating Expenses			
Wages, Benefits and Payroll Taxes Subtotal	482,669	426,556	365,577
Travel Subtotal	10,343	11,808	10,471
Telecommunications Subtotal	23,412	15,108	15,714
Advertising Subtotal	22,480	6,272	1,192
Supplies Subtotal	7,691	8,683	7,029
Insurance Subtotal	1,723	1,568	1,745
Utilities Subtotal	5,299	5,443	5,497
Postage Subtotal	613	567	269
Bad Debt Expense Subtotal	62,750	44,341	27,511
Equipment Subtotal	10,690	4,327	5,679
Other Subtotal	462,541	329,811	226,083
Total Operating Expenses	1,090,211	854,486	666,769
Fixed Expenses			
Interest Subtotal	0	0	0
Rent Subtotal	52,358	46,407	50,539
Depreciation Subtotal	3,029	0	0
Taxes Subtotal	0	0	0
Amortization Subtotal	0	0	0
Other Subtotal			
Total Fixed Expenses	55,387	46,407	50,539
Operating Profit (Loss)	655,907	188,580	(221,284)
Extraordinary Items			
Gain or Loss on Sale of Assets Subtotal	0	0	0
Gain from Debt Restructuring Subtotal	0	0	0
Total Extraordinary Items	0	0	0
Profit (Loss) after Extraordinary Items	655,907	188,580	(221,284)
Add Back			
Interest	0	0	0
Corporate Taxes	0	0	0
Depreciation	3,029	0	0
Amortization	0	0	0
Total Add Back	3,029	0	0
EBITDA	658,936	188,580	(221,284)
Field Allocations	0	0	0
Revenue Cycle Allocations	58,098	43,418	26,920
Regional Directors Allocations	84,015	65,154	40,396
Corporate Allocations	234,387	157,477	98,052
EBITDAM	1,035,436	454,628	(55,917)

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

Spokane Provider (Intrepid of Washington, Inc.) is a Subsidiary of Intrepid U.S.A., Inc. Cash Flows Statement is rolled up to the Parent.

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

Spokane Provider (Intrepid of Washington, Inc.) is a Subsidiary of Intrepid U.S A., Inc. Balance Sheet Statement is rolled up to the Parent

15 For existing providers, provide actual costs and charges per visit broken down by discipline (i.e., RN/LPN, OT, PT, social worker, etc) and by payer source.

Medicare

Type	RevCode	HCPCS	Units	Charge By	Allowed By	Rate
HHA Visit	572	S9122	Hour	Hour	Hour	25 00
RN Visit	551	S9123	Constant	Visit	Visit	120 00
LPN Visit	551	S9124	Constant	Visit	Visit	90 00
PT Visit	421	S9131	Visit	Visit	Visit	130 00
PTA Visit	421	S9131	Visit	Visit	Visit	130 00
OT Visit	431	S9129	Visit	Visit	Visit	130 00
COTA Visit	431	S9129	Visit	Visit	Visit	130 00
ST Visit	441	S9128	Visit	Visit	Visit	130 00
MSW Visit	561	S9127	Visit	Visit	Visit	160 00

Private Insurance

Type	RevCode	HCPCS	Units	Charge By	Allowed By	Rate
HHA Visit	571	G0156	Visit	Visit	Visit	40 00
RN Visit	551	G0299	Visit	Visit	Visit	120 00
LPN Visit	551	G0300	Visit	Visit	Visit	120 00
PT Visit	421	G0151	Visit	Visit	Visit	125 00
PTA Visit	421	G0151	Visit	Visit	Visit	125 00
OT Visit	431	G0152	Visit	Visit	Visit	125 00
COTA Visit	431	G0152	Visit	Visit	Visit	125 00
ST Visit	441	G0153	Visit	Visit	Visit	130 00
MSW Visit	561	G0155	Visit	Visit	Visit	140 00

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

Medicare

Type	RevCode	HCPCS	Units	Charge By	Allowed By	Rate
HHA Visit	572	S9122	Hour	Hour	Hour	25 00
RN Visit	551	S9123	Constant	Visit	Visit	120 00
LPN Visit	551	S9124	Constant	Visit	Visit	90 00
PT Visit	421	S9131	Visit	Visit	Visit	130 00
PTA Visit	421	S9131	Visit	Visit	Visit	130 00
OT Visit	431	S9129	Visit	Visit	Visit	130 00
COTA Visit	431	S9129	Visit	Visit	Visit	130 00
ST Visit	441	S9128	Visit	Visit	Visit	130 00
MSW Visit	561	S9127	Visit	Visit	Visit	160 00

Private Insurance

Type	RevCode	HCPCS	Units	Charge By	Allowed By	Rate
HHA Visit	571	G0156	Visit	Visit	Visit	40 00
RN Visit	551	G0299	Visit	Visit	Visit	120 00
LPN Visit	551	G0300	Visit	Visit	Visit	120 00
PT Visit	421	G0151	Visit	Visit	Visit	125 00
PTA Visit	421	G0151	Visit	Visit	Visit	125 00
OT Visit	431	G0152	Visit	Visit	Visit	125 00
COTA Visit	431	G0152	Visit	Visit	Visit	125 00

ST Visit	441	G0153	Visit	Visit	Visit	130 00
MSW Visit	561	G0155	Visit	Visit	Visit	140 00

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

RN - $65,000, PT - $90,000, OT - $80,000
Will supplement with current staff as needed.

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

Intrepid USA Healthcare Services is already a Medicare certified provider.
Medicare Provider Number: 50-7109

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

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

	Current FTE		Year 1		Year 2		Year 3	
Staff	FTE	Contracted	FTE	Contracted	FTE	Contracted	FTE	Contracted
RN	6		7		7		9	
LPN	3		5		5		6	
HH Aide	3		3		3		5	
NURSING TOTAL	12		15		15		20	
Admin	1		1		1		1	
Medical Director		1		1		1		1
DNS		1		1		1		1
Business/Clerical	3		4		4		4	
ADMIN. TOTAL	4	2	5	2	5	2	5	2
PT	2	3	3	4	3	4	3	5
OT	1		2		2		3	
Speech Therapist		1		2		2		2
Med Social Work		1		2		2		3
Other (specify)								
PTA	1		2		2		4	
ALL OTHERS TOTAL	4	5	7	8	7	8	10	10
TOTAL STAFFING	20	7	27	10	27	10	35	12

2. Please provide your staff to visit ratio.

Type of Staff	**Staff / Visit Ratio**
Skilled Nursing (RN & LPN)	1 30
Physical Therapist	1 30
Occupational Therapist	1 40
Medical Social Worker	1 100
Speech Therapist	1 20
Home Health Aide	1 35
Other (list)	N/A
Total	1 42 5

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

   In line other area agencies

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

   Existing staff from Spokane agency will be used Will supplement with new hires from Spokane area if unable able to find in Stevens County.

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

   See attached Orientation checklists and policies 1-022.1, 3-002.1.

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

   HH CAHPS and customer satisfaction

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

   Monday – Friday 8 00 am to 5:00 pm, 24/7 RN on Call

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

   N/A

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

   Partnering local hospital systems and continuity.
   Please see attached reference letters.

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

   a) Have any of the applicants been adjudged insolvent or bankrupt in any state or federal court?

No

b) Have any of the applicants been involved in a court proceeding to make judgment of insolvency or bankruptcy with respect to the applicant).

No

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

N/A

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

Please see attached Administrator and Supervising Nurses resume.

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

Please see attached surveys from 2015, 2017 and 2019.

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

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

N/A

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

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

All state and federal regulations as well as billing compliance for the Medicare conditions of participation are followed in addition to the PDGM payment model.
There are no Medicare caps for home health.

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

Services provided will decrease cost of care by preventing hospitalization.

4. If applicable, in the case of construction, renovation, or expansion, capital cost reductions achieved by architectural planning and engineering methods and methods of building design and construction Include

an inventory of net and gross square feet for each service and estimated capital cost for each proposed service Reference appropriate recognized space planning guidelines you have employed in your space allocation activities

N/A

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

N/A

Attachments Index

SECTION I APPLICANT DESCRIPTION

- Letter H: Agency Listing
- Letter M Medical Director Contract

SECTION II: PROJECT DESCRIPTION

- Letter I· Building Lease Agreement

SECTION III A: PROJECT RATIONALE – NEED

- Number 3. Reference Letters and Letters of Support
- Number 5: Stevens County Zip Code Map
- Number 11: 2.001 Admissions Policy, 1.057 Charity Care Policy

SECTION III B: PROJECT RATIONALE – FINANCIAL FEASIBILITY

- Number 4: Formulas for Estimated Operating Revenue and Expenses
- Number 7: Attestation of Funding

SECTION III C: PROJECT RATIONALE – STRUCTURE AND PROCESS (QUALITY) OF CARE

- Number 5 Orientation Check Lists, Policy 1-022.1, Policy 3-002.1
- Number 9: Reference Letters and Letter of Support
- Number 12: Administrator Resume, Supervising Nurses Resume
- Number 13: Surveys from 2015, 2017, 2019

Attachments

SECTION I: APPLICANT DESCRIPTION

- Letter H: Agency Listing
- Letter M: Medical Director Contract

INTREPID USA HEALTHCARE SERVICES

Agency Legal Name	Address	City	State	Zip
F C of Alabama, Inc	2700 Corporate Drive, Suite 200	Birmingham	AL	35242-2733
F C of Alabama, Inc	445 Dexter Avenue, Suite 4050	Montgomery	AL	36104-3867
Intrepid of the Ozarks, Inc	109 9th Street, Bldg 1 P O Box 365	McCrory	AR	72101-0365
F C of Arkansas, Inc	300 S Rodney Parham Suite 14	Little Rock	AR	72205-4774
F C of Arkansas, Inc	183 Arena Road Suite C	Cabot	AR	72023-7920
F C of Arkansas, Inc	306 Salem Road Suite 103	Conway	AR	72034-6376
F C of Arizona, Inc	1 W Wetmore Road Suite 203	Tucson	AZ	85705-0603
F C of Georgia, Inc	2510 Archwood Drive Suite 11 & 12	Albany	GA	31707-6674
F C of Georgia, Inc	650 Scranton Road Suite G+H	Brunswick	GA	31520-1930
F C of Georgia, Inc	140 Lakes Boulevard Suite 211	Kingsland	GA	31548-6814
F C of Georgia, Inc	355 Northside Drive	Valdosta	GA	31602-1861
F C of Georgia, Inc	360 Courtland Avenue Suite A	Homerville	GA	31634-2675
Intrepid of Indiana, Inc	400 Poplar Street, 2nd Floor	Terre Haute	IN	47807-4209
Intrepid of Indiana, Inc	1001 S Bloomington St Suite 101	Greencastle	IN	46135-2292
F C of Indiana, Inc	5250 E U S Highway 36, Suite 1102	Avon	IN	46123-8224
F C of Indiana, Inc	4635 Progress Drive Suite A	Columbus	IN	47201-7825
F C of Kentucky, Inc	2411 Ring Road Suite 106	Elizabethtown	KY	42701-5930
F C of Kentucky, Inc	700 Portland Avenue Suite C	Bardstown	KY	40004-2539
F C of Kentucky, Inc	259 West Walnut Street	Lebanon	KY	40033-1456
F C of Kentucky, Inc	1619 Elizabethtown Road	Leitchfield	KY	42754-9155
Intrepid of the Tri-State, Inc	201 Klutey Park Plaza	Henderson	KY	42420-3345
Intrepid of the Tri-State, Inc	408 East Waverly Street	Morganfield	KY	42437-1106

INTREPID USA HEALTHCARE SERVICES

Agency Legal Name	Address	City	State	Zip
Intrepid of the Tri-State, Inc	920 Frederica Street #1009	Owensboro	KY	42301-3051
Intrepid of Western Kentucky, Inc	1616 Hwy 121 North Suite C	Murray	KY	42071-0016
Intrepid of Western Kentucky, Inc	1025 Paducah Road	Mayfield	KY	42066-3615
Intrepid of Southern Kentucky, Inc	230 Tower Circle	Somerset	KY	42503-3480
Intrepid of Southern Kentucky, Inc	1125 North Main Street, Suite 2	Monticello	KY	42633-2865
Intrepid of Southern Kentucky, Inc	220 Office Park Drive	Columbia	KY	42728-1381
Intrepid of Southern Kentucky, Inc	1820 Scottsville Rd, Suite 203	Bowling Green	KY	42104-3302
Intrepid of Louisiana, Inc	1211 East Laurel Avenue Suite D	Eunice	LA	70535-3705
Intrepid of Louisiana, Inc	343 Tunica Drive West	Marksville	LA	71351-2605
Intrepid of Louisiana, Inc	913 South College Road Suite 104	Lafayette	LA	70503-3060
Intrepid of Golden Valley, Inc	7300 Metro Blvd Suite 625	Edina	MN	55439-2313
Intrepid of Golden Valley, Inc	1500 Clinton Lane Suite H	Northfield	MN	55057-3366
Intrepid of the Twin Cities, Inc	2277 Highway 36 West, Suite 101	Roseville	MN	55113-3804
F C of Missouri, Inc	4305 S National Ave	Springfield	MO	65810-2607
F C of Missouri, Inc	550 N Spring Park Blvd	Mt Vernon	MO	65712-7841
F C of Mississippi, Inc	885 Ferncliff Drive Suites 1 & 3	Southaven	MS	38671-2433
Intrepid of North Carolina, Inc	343 E Six Forks Road Suite 130	Raleigh	NC	27609-7885
NC HHA, Inc	1825 East 51st Street	Ashtabula	OH	44004-6270
F C of Pennsylvania, Inc	3 Lemoyne Drive Suite 101	Lemoyne	PA	17043-1231
F C of South Carolina, Inc	2694 Lake Park Dr First Floor	No Charleston	SC	29406-9826

Agency Legal Name	Address	City	State	Zip
F C of South Carolina, Inc	302 Medical Park Drive Suite 215	Walterboro	SC	29488-5749
Intrepid of Tennessee, Inc	72 Stonebridge Blvd Suite 1	Jackson	TN	38305-2158
Intrepid of Tennessee, Inc	870 West Church Street	Lexington	TN	38351-1741
Intrepid of Tennessee, Inc	315 West Main Street	Brownsville	TN	38012-2530
Intrepid of East Tennessee, Inc	350 Caldwell Street	McMinnville	TN	37110-2032
Intrepid of East Tennessee, Inc	222 Heritage Park Suite # 102	Murfreesboro	TN	37129-1550
Intrepid of East Tennessee, Inc	130 Relco Drive	Manchester	TN	37355-7385
F C of Tennessee, Inc	2763 Summer Oaks Drive Suite 101	Bartlett	TN	38134-2850
F C of Tennessee, Inc	225 North Willow Avenue 3rd Floor	Cookeville	TN	38501-2335
F C of Tennessee, Inc	555 Marriott Drive Suite 315	Nashville	TN	37214-5088
F C of Tennessee, Inc	414 Sweetwater Vonore Road	Sweetwater	TN	37874-3064
F C of Tennessee, Inc	5401 Kingston Pike Building 1, Suite 210	Knoxville	TN	37919-5051
Intrepid of Southeast Texas, Inc	1480 Cornerstone Court	Beaumont	TX	77706-3896
F C of Texas, Inc	3220 Keller Springs Rd Suite 108	Carrollton	TX	75006-5911
Intrepid of West Texas, Inc	3310 West Loop 306	San Angelo	TX	76904-5945
F C of Texas, Inc	4007 Call Field Road Suite D	Wichita Falls	TX	76308-2679
F C of Virginia, Inc	230 Charwood Drive, Suite B	Abingdon	VA	24210-2566
F C of Virginia, Inc	**Physical Address** 2502 South Front Street **Mailing Address:** P O Box 300, Richlands, VA 24641	Richlands	VA	24641-2774
F C of Virginia, Inc	320 Cloverleaf Square Building C, Suite 1	Big Stone Gap	VA	24219-2752
F C of Virginia, Inc	101 West Main Street	Radford	VA	24141-1582
F C of Virginia, Inc	4005 Electric Road Suite 200	Roanoke	VA	24018-8435

INTREPID USA HEALTHCARE SERVICES

Agency Legal Name	Address	City	State	Zip
F C of Virginia, Inc	The Shops at 222 106 Rowe Road #103	Staunton	VA	24401-6714
F C of Virginia, Inc	165 Market Street, Suite 2	Onancock	VA	23417-4233
F C of Virginia, Inc	2430 Southland Drive Suite B	Chester	VA	23831-2354
Intrepid of Washington, Inc	9715 N Nevada St	Spokane	WA	99218-3412

MEDICAL DIRECTOR AGREEMENT

THIS MEDICAL DIRECTOR AGREEMENT (the "Agreement"), made and entered as of the **7th day of January 2019**, by and between **Susan Ashley, MD**, a licensed physician whose primary offices are located at **1431 N. Liberty Lake Rd., Suite B, Lake Liberty, WA 99019** (the "Medical Director") and **Intrepid of Washington, Inc. d/b/a Intrepid USA Healthcare Services**, a home health agency located at **9715 N. Nevada St. Spokane, WA 99218** (the "Agency")

WITNESSETH:

WHEREAS, the Agency is a home health agency which is engaged in the business of providing health care services to patients in their residences in Agency's licensed service area; and

WHEREAS, the Agency desires to engage Medical Director to provide medical director services for the Agency, and Medical Director desires to perform such services, all upon the terms and conditions set forth in this Agreement;

NOW, THEREFORE, in consideration of the mutual premises, promises and covenants contained herein, and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties do mutually covenant and agree as follows:

1. **Services Provided by Medical Director.** Medical Director agrees to serve as the Agency's medical director and to provide the Agency during the Term of this Agreement the services set forth in Exhibit "A" attached hereto, the terms of which are incorporated herein by reference, or such services as may hereafter be agreed upon in writing by and between the parties ("Medical Director Services").

2. **Medical Director's Representations and Warranties.** Medical Director hereby makes the following representations and warranties to the Agency:

   (a) That Medical Director is duly licensed to practice medicine in the **State of Washington,** and is fully capable and qualified, in accordance with good medical practice to provide physician services. Medical Director shall provide evidence of such licensure to Agency upon execution of this Agreement.

   (b) That Medical Director shall, at all times during the Term hereof, have all necessary narcotics and controlled substances numbers and licenses, including, but not limited to a Drug Enforcement Agency number

   (c) That Medical Director is a Medicare and Medicaid participating physician.

   (d) That Medical Director's license to practice medicine and/or board certification in any state has never been suspended or revoked.

   (e) That Medical Director has never been sanctioned by Medicare or Medicaid, other federally funded program, any licensing board or state or local medical society or specialty board.

(f) That Medical Director is not presently conducting, nor in the future shall conduct, his/her medical practice in such a manner as to cause Medical Director to be suspended, excluded, barred or sanctioned under Medicare or Medicaid programs or other federally funded program.


(g) That Medical Director is not an Ineligible Person For purposes of this Agreement, an "Ineligible Person" is an individual or entity who: (a) is currently excluded, debarred, suspended, or otherwise ineligible to participate in the Federal health care programs (Medicare, Medicaid) or in Federal procurement or nonprocurement programs (any other program receiving federal moneys); or (b) has been convicted of a criminal offense that falls within the ambit of 42 U.S.C. §1320a-7(a), but has not yet been excluded, debarred, suspended, or otherwise declared ineligible. The Medical Director shall immediately disclose in writing to Agency should there be a change in Medical Director's Ineligible Person status. A change in status shall be grounds for immediate termination of this Agreement by Agency.

medical director initial

Medical Director agrees and covenants that these representations and warranties are of a continuing nature and further agrees that he/she will immediately notify the Agency if any of the above representations or warranties become inapplicable or become untrue during the Term of this Agreement.

3. **General Qualifications and Obligations.** Medical Director shall at all times: (a) Maintain a general working knowledge of current Medicare, Medicaid, and state and federal licensure regulations as they relate to home health care for patients; (b) Remain up-to-date on the latest developments in home health practice as well as issues related to the care of home health patients in the home environment and duly able to advise Agency on the scope and direction of its programs for patients; (c) Provide services hereunder in conformity with the Agency's Code of Conduct, policies and procedures, applicable standards of any accrediting body, corporate entity, and individual having authority over the Agency, and federal, state, and local laws and regulations, standards, rulings, regulations of the Department of Health and Human Services, and any other federal, state, or local government agency; and (d) Use Medical Director's best and most diligent efforts and professional skills in performing services under this Agreement, and shall perform professional services in accordance with and in a manner consistent with generally accepted medical practices and the standards of the Agency Medical Director shall perform his/her work in accordance with currently approved methods and practices of his/her profession, and shall conform to all applicable Agency policies and the Agency's Corporate Compliance Program and Code of Conduct. In the event of failure to do so, the Agency reserves the right to immediately terminate the services of Medical Director. Further, Medical Director agrees, at the Agency's request, to provide the Agency with such personal information concerning Medical Director as shall be necessary for the Agency to comply with applicable state and federal laws, rules, regulation and/or guidelines, as well as the Agency's policies and the Agency's Corporate Compliance Program.

4. **Compensation for Services.**

4.1. The Agency shall pay Medical Director compensation for Medical Director Services rendered by Medical Director pursuant to this Agreement and for Medical Director's reasonable travel time necessary for the performance of Medical Director Services at the rate of **$185.00** per hour The parties believe that this amount represents the fair market value for administrative medical services performed by physicians in Agency's

geographic service area. Medical Director shall be compensated only for the number of hours during which Medical Director Services and travel time necessary for the performance of Medical Director Services are actually rendered and incurred by Medical Director pursuant to this Agreement ("Fees"). On or before the fifth day of each month during the Term, Medical Director shall submit to the Agency a statement documenting in detail the type, nature, and duration of Medical Director Services provided by Medical Director and travel time necessary for the performance of Medical Director Services during the preceding month

4.2. Medical Director understands that compensation to be paid to Medical Director is solely for the Medical Director Services and travel time necessary for the performance of Medical Director Services described in this Agreement and that Medical Director is not being and shall not be paid to: refer patients; sign orders for Medical Director's patients who are admitted to the Agency or its Affiliated Companies for services, or counsel or promote a business or any other activity that violates any federal and/or state law(s), regulations, rules and/or guidelines. Medical Director shall not be prohibited from referring or sending patients to a home health care agency other than the Agency and/or any of its Affiliated Companies. This Agreement is intended to comply with the Safe Harbor for Personal Service Agreements contained at 42 CFR 1001.952(d) and the personal service exception to the Stark Act. Medical Director agrees that the compensation set out in Paragraph 4 1 shall be the Medical Director's sole compensation for Medical Director Services furnished pursuant to this Agreement.

4.3. In accordance with 42 U.S.C § 1395x(v)(1)(I) and 42 CFR §§ 420.300-420.304, the Medical Director shall keep proper and timely records of the Medical Director Services provided by Medical Director to the Agency and shall provide the Agency with a basis for computation of charges. Medical Director agrees that for the time required by law, but no less than six (6) years after the furnishing of the services described in this Agreement, he/she will make available to the Secretary of the U.S. Department of Health and Human Services, the U.S. Comptroller General, and/or the Agency, and their authorized representatives, this contract and all of Medical Director's books, documents and records necessary to verify the nature and extent of the cost incurred by the Agency for the services provided by Medical Director.

4.4. Medical Director shall not bill patients, carriers, or other insurers for any services provided hereunder to Agency.

5. **Insurance.** Medical Director shall maintain at his/her cost and shall provide to the Agency, at the time of execution of this Agreement, a valid certificate of insurance evidencing minimum professional liability insurance coverage for him/her of $100,000 per occurrence and $3,000,000 annual aggregate covering all services to be provided by Medical Director pursuant to this Agreement. If Medical Director procures "claims made" type coverage as distinguished from "occurrence" type coverage, Medical Director shall insure that he/she provides thirty (30) days prior written notice to the Agency before terminating said insurance. At Medical Director's sole cost and expense, Medical Director shall procure, prior to termination of such insurance and regardless of whether notice is given, and maintain sufficient "tail" coverage to continue and extend coverage complying with this Agreement after the term of the "claims made" policy to ensure coverage of any claims arising hereunder In the event that said insurance is terminated without providing the Agency with thirty (30) days prior written notice and/or the Medical Director fails to procure "tail" coverage as required, Medical Director shall indemnify the Agency

for any non-covered claims. Medical Director's obligation under this Paragraph shall survive any termination of this Agreement

With respect to the insurance required under this Section, Medical Director will provide the Agency with a certificate of insurance which: (1) indicates the general nature of coverage provided; (2) lists all extensions and endorsements; (3) lists Intrepid U.S.A., Inc and its affiliates as additional insured's on the policy; (4) states that coverage is to be primary; and, (5) requires 30 days written notice to Intrepid of cancellation, non-renewal, or of any reduction or limitation of coverage.

6. **Covenants.**

6.1. Affiliated Companies. As used herein, the term "Affiliated Companies" is defined as being any and all companies and/or other entities which, either directly or indirectly, either in whole or in part, own, manage, and/or are owned or managed by the Agency and any and all companies and/or other entities which, either directly or indirectly, either in whole or in part, are related to the Agency as a result of common ownership, common control, and/or common management, and/or other affiliation.

6.2. Confidentiality. During the Term of this Agreement and the performance of Medical Director Services, Medical Director may have access to vital information dealing with all aspects of the Agency. Medical Director acknowledges that such information is a valuable, special, and unique asset of the Agency's business. Such information shall include, but is not limited to: patient lists and information concerning patients; case records, case histories, personnel files, and files concerning patients of the Agency or patients consulted, interviewed, treated or cared for by the Agency; information concerning the contracts of the Agency with hospitals, physicians, or medical suppliers and the relationship of the Agency with such person or entity, and any other information which the Agency deems confidential in relation to the business of the Agency and its Affiliated Companies.

Medical Director agrees that all such information shall belong to, be and remain the sole property of the Agency and shall be used solely for the purpose of providing services under this Agreement and shall not be used for the benefit of Medical Director or any third party(ies). Medical Director realizes that divulgence of the aforementioned information, without prior notice to and consent by the Agency, would cause great harm to the Agency and its Affiliated Companies and agrees that, except as otherwise ordered by a court of law, such information and knowledge cannot be shared, for any reason or purpose, with individuals or entities inside or outside of the Agency, without the Agency's prior written consent

Medical Director agrees that all memoranda, notes, records, reports, drawings, or other writings and documents, equipment, apparatus, products, or materials and the like, including copies thereof, made or compiled by him/her or made available to him/her during the Term of this Agreement, shall be the property of the Agency and shall be delivered to the Agency upon termination of this Agreement or at any other time upon request by the Agency.

6.3 Non-Solicitation. Medical Director agrees that during the period that he/she is providing services hereunder and for a period of one (1) year thereafter, he/she will not, either alone or in concert with others, solicit, entice, induce or encourage: (1) any employee(s) to

leave the employment of the Agency or any of its Affiliated Companies, (2) any patient(s) to discontinue using the Agency's services or the services of any of its Affiliated Companies; (3) any referring physician(s) or other referral sources to discontinue referring patients to the Agency or any of its Affiliated Companies or to switch patients from the Agency or any of its Affiliated Companies to any other home health care agency or company which is not an Affiliated Company, or (4) any existing or proposed transfer arrangement or other community or institutional affiliation to discontinue the affiliation or transfer relationship with the Agency or any of its Affiliated Companies.

6.4 Survival. Medical Director's obligations and agreements set forth in this Paragraph 6 shall survive any termination, for whatsoever reason, of this Agreement

6.5 Remedies in the Event of Breach and Attorney's Fees. The parties recognize that irreparable injury will result to the Agency in the event of a breach of the provisions contained in this Paragraph on the part of Medical Director. In the event that either party breaches or threatens to breach any term of this Agreement, this Agreement may be enforced by temporary restraining order and/or an injunction issued by a court of competent jurisdiction enjoining and restraining any actual or threatened breach of any term of this Agreement and the non-breaching party shall have the right to bring suit for the breach of this Agreement, seeking damages and any other appropriate relief, legal and/or equitable, including a temporary restraining order, preliminary and/or permanent injunctions. Should either party be in breach under this Agreement, the breaching party shall pay all reasonable attorney's fees incurred by the non-breaching party in connection with such breach or the enforcement of any obligations hereunder, or both of them, as determined by a court of competent jurisdiction.

7. **Indemnity.**

7.1 Agency agrees to indemnify, defend and hold Medical Director free and harmless from and against any and all claims, causes of action, judgments, losses, damages, costs, and expenses, including reasonable attorney's fees, arising out of, caused by or resulting from any breach of Agency's obligations herein or any negligent acts or omissions or willful misconduct of Agency, anyone directly employed by the Agency or anyone for whose acts Agency may be liable.

7.2 Medical Director agrees to indemnify, defend and hold Agency free and harmless from and against any and all claims, causes of action, judgments, losses, damages, costs, and expenses, including reasonable attorney's fees, arising out of, caused by or resulting from any breach of Medical Director's obligations herein or any negligent acts or omissions or willful misconduct of Medical Director

8. **Term of Agreement and Cancellation.**

8.1. The initial term of this Agreement shall be for a period of one (1) year commencing as of the date first above written (the "Term"). The term of this Agreement shall be automatically renewed for one (1) year periods thereafter, on the same terms and conditions, up to a maximum of three total years.

8.2. In the event Medical Director at any time breaches any term or provision of this Agreement or fails to fulfill any obligation under this Agreement or is arrested or

convicted (or pleads guilty or nolo contendere) to any felony or other crime involving dishonesty or moral turpitude, the Agency shall have the right to immediately terminate this Agreement without advance notice to Medical Director.

8.3. Notwithstanding anything contained herein to the contrary, this Agreement may be terminated by either party without cause at any time by giving the other party thirty (30) days advance written notice of termination

8.4 No further compensation or payments pursuant to Paragraph 4 above shall be due or owing subsequent to any termination of this Agreement as provided for herein, except for any compensation or payments which may have been properly due and owing prior to such termination of this Agreement.

9. **Adverse Action.** Notwithstanding anything contained herein to the contrary, in the event either party determines that the performance by any party hereto of any term, covenant, condition or provision of this Agreement (all of the following collectively referred to herein as "Adverse Action"):

(a) Would for any reason violate a statute, regulation, ordinance; or

(b) Would jeopardize the licensure of the Agency or of Medical Director and/or its and/or his/her participation in Medicare, Medicaid, Blue Cross or in any other reimbursement or payment program, or the Agency's accreditation by any state or other recognized accrediting organization, or give rise to an action or sanctions against a party in connection with its licensure, participation in payer programs, or accreditation; or

(c) Is or is likely to be out of compliance with any new federal, state and/or local statute, regulations, guidelines, requirements, or accreditation standard or interpretation thereof, including, but not limited to, Medicare and Medicaid laws, regulations, guidelines or requirements,

then written notice of such Adverse Action shall be given to the other party, the unaffected balance of this Agreement shall remain in full force and effect, and the parties shall immediately enter into good faith negotiations to modify the provision(s) giving rise to the Adverse Action so as to continue to operate on such terms as nearly approximate the terms of this Agreement, without violating or failing to comply with any such statute, rule, regulation, court finding, reimbursement requirement or accreditation standard. If the parties cannot agree on modification(s) within thirty (30) days from the onset of negotiations, either party may terminate this Agreement immediately upon written notice to the other party.

10. **Relationship of Parties.** Medical Director shall at all times be an independent contractor under this Agreement, and not a co-venturer, agent, or employee of the Agency. No action or failure to act by the Medical Director shall in any way obligate or be binding upon the Agency. Medical Director hereby covenants and agrees that he/she shall not represent to any third-party that he is a shareholder, director, officer, agent, or employee of the Agency. Medical Director does hereby acknowledge as an independent contractor that Medical Director shall not be considered as having employee status or as being entitled to participate in any plans, arrangements, or distributions by the Agency pertaining to or in connection with any pension, stock, bonus, profit sharing, or similar benefits for regular employees of the Agency. No party is or shall be responsible for any FICA, FUTA, or income or state withholding taxes under any provision of the Internal Revenue Code of 1986 as amended from time to time, for the other party or such other

party's employees, and each party hereto agrees to be responsible for any such taxes resulting from income derived by it or its employees by reason of this Agreement. Each party agrees not to make any warranty(ies), representation(s), or promise(s) that would either bind the other party or act purportedly on the other party's behalf or authorization without the prior written approval of such other party, except for those transactions specified herein. Medical Director further acknowledges that as an independent contractor, he/she has no claim against the Agency for employees' liability compensation for personal injury, unemployment compensation or otherwise under the laws of any state or the United States. Nothing contained herein shall be construed as giving the Agency control over the manner or method of Medical Director's performance of the Medical Director Services to be provided by Medical Director pursuant to this Agreement.

Medical Director shall further be deemed to be a Business Associate of Agency, and the relationship of the parties hereto shall be governed by the Business Associate Agreement attached hereto and incorporated herein by this reference.

11. **Construction.** This Agreement contains the entire understanding between the parties regarding the subject matter hereof. This Agreement supersedes any and all prior understandings, agreements, representations and other communications between the parties concerning the subject matter hereof, whether written or oral.

12. **Assignment.** Medical Director may not, at any time during the Term hereof, assign, delegate or transfer this Agreement or any right(s), duty(ies) and/or obligation(s) hereunder, whether in whole or in part, unless such assignment is agreed upon, in writing, by both parties prior to such assignment.

13. **Governing Law.** This Agreement is made in accordance with the laws of the State in which the Medical Director Services are rendered and shall be construed, interpreted and governed by the laws of such State. To the extent such waiver is permitted by law, the parties waive trial by jury in any action or proceeding brought in connection with this Agreement and/or Medical Director's services provided hereunder.

14. **Notices.** Any notices required or permitted hereunder shall be sufficiently given if in writing, and hand delivered or sent by registered or certified mail, postage pre-paid, addressed or delivered as follows:

Medical Director:	Susan Ashley, MD 1431 N. Liberty Lake Rd., Suite B Lake Liberty, WA 99019
Agency:	Intrepid USA Healthcare Services 3220 Keller Springs Rd., Suite 108 Carrollton, TX 75006 Attention Compliance Department

or to such other address as shall be furnished in writing by either party; and any such notice shall be deemed to have been given, if hand delivered as of the date of delivery, or if mailed, as provided herein, as of three (3) days after the date mailed.

15. **No Waiver.** No failure or delay of a party to detect, protest, remedy, or enforce its rights due to a breach of any of its rights under this Agreement shall be deemed a waiver of any of the aggrieved party's rights. Any waiver of rights shall occur only by written documents specifying the specific

right waived and the specific circumstance covered by the waiver, and shall be signed by an authorized representative of the party granting the waiver.

16. **Paragraph Headings, Pronouns.** The use of titles to the provisions of this Agreement are for convenience and reference only and such title shall not expressly or by implication, be deemed to modify, limit, define, extend, or construe the terms or provisions of the sections of this Agreement. Any pronouns of this Agreement shall be deemed to include the masculine, feminine, neuter, singular or plural as appropriate.

17. **Severability.** Should any provision, sentence, phrase, and/or word of this Agreement or application thereof to any person and/or circumstance be declared illegal, invalid or unenforceable, then the remainder hereof or the application of such provision, sentence, phrase and/or word to any person and/or circumstance other than those to which it is held invalid shall not be affected thereby and shall remain in full force and effect. In any interpretation of this Agreement, there shall be no presumption against the party drafting this Agreement.

18. **Binding Effect.** This Agreement shall be binding upon, and inure to the benefit of the undersigned parties and their respective representatives, successors, heirs, executors, administrators, legal representatives and assigns, commissioners, directors, officers, shareholders, agents, servants, employees, subsidiaries, parent companies, management companies and/or related and/or affiliated companies, whether related by common ownership, control or otherwise.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed and signed by duly authorized officers and/or representatives as of the day and year first above written.

Intrepid USA Healthcare Services

Signature

John Nix, CFO

Printed Name and Title

1/15/19

Date

Susan Ashley, M.D.

Signature

Susan Ashley

Printed Name and Title

1-14-19

Date

EXHIBIT A
PHYSICIAN SERVICES

The Medical Director shall be responsible for providing the following Medical Director Services, as requested by Agency:

- Serve as chief physician medical advisor to Agency on matters related to Agency medical affairs.
- Attend and actively participate in the Agency's professional advisory committee meetings, which shall meet as frequently as required by applicable state and/or federal law, but not less than annually
- Serve as member of the Agency's community advisory board and attend advisory board meetings.
- Assist the Agency in the development of policies and procedures to meet the requirements of state and federal law, Joint Commission or other accrediting agencies, physician review organizations, and third party payors, including, but not limited to, policies governing the scope of services offered, admissions and discharges, medical supervision, plans of treatment, emergency care, clinical records, personnel qualifications, program evaluation, budget, performance improvement, and marketing plans
- Assist the Agency in maintaining liaison with other health care providers in the Agency's geographic service area and in the Agency's community information program.
- Adhere to all Stark and Medicare anti-kickback guidelines regarding appropriate relationships with and referrals to home care agencies.
- Serve as consultant to Agency in all areas as requested, including but not limited to, scope of services, community needs, clinical practices, medial practices, ethical issues, performance improvement issues, infection control, and incidents/accidents.

The Medical Director may provide the following Medical Director Services upon request by the Agency:

- Review referred cases for determination of appropriate medical action and communicate recommendations to appropriate Agency personnel
- Communicate with referring physicians when deemed appropriate by the Agency.
- Discuss denied cases with peer review organization physician's advisor, Medicare fiscal intermediary or representative as appropriate for the Agency.
- Attend Agency's case conference review meeting
- Be willing to write prescriptions for TB tests and flu vaccines for employees of the Agency as needed.
- Serve as a source of expertise on home care and its appropriate use in the community.
- Assist in the development of, or participation in , staff education programs
- Be willing to assist the Agency with other administrative duties of home care as deemed appropriate.

BUSINESS ASSOCIATE ADDENDUM
TO MEDICAL DIRECTOR AGREEMENT

THIS BUSINESS ASSOCIATE ADDENDUM to the Medical Director Agreement as of even date herewith by and between Intrepid USA Healthcare Services ("Covered Entity") and Medical Director (herein referred to as "Business Associate").

Whereas, Covered Entity (including its affiliated locations) is a health care provider which provides health care services to its patients.

Whereas, Business Associate will provide services to Covered Entity in accordance with 45 C.F.R. 160.103, and as such, may be a "business associate" as that term is defined by HIPAA and in accordance with 42 USCA §17901 *et seq.*

Whereas, in the course of obtaining services from Business Associate, it may be necessary for Covered Entity to, from time to time, provide confidential information to Business Associate, including, but not limited to, medical records, billing records and other information specific to patients to whom Covered Entity provides services.

Whereas, Covered Entity desires to ensure that Business Associate will use and, if necessary, disclose such information only as necessary to provide services to Covered Entity consistent with its engagement by Covered Entity and with applicable legal principles.

Whereas, Covered Entity and Business Associate agree to incorporate into this Agreement any regulations issued with respect to the HITECH Act that relate to the obligations of a business associate and Business Associate recognizes and agrees that it is obligated by law to meet the applicable provisions of the HITECH Act.

NOW, THEREFORE, in consideration of the mutual covenants and agreements contained herein, the adequacy and sufficiency of which is hereby acknowledged, the parties hereto, intending to be legally bound hereby, agree as follows:

1. **Definitions.** For purposes of this Agreement, all capitalized terms not defined herein shall have the meanings defined in the Health Insurance Portability and Accountability Act of 1996 and its regulations promulgated thereunder (45 C.F.R. §§ 160 – 164) as well as applicable provisions of the Health Information Technology for Economic and Clinical Health Act incorporated in the American Recovery and Reinvestment Act of 2009 (H.R.1, "ARRA") and any implementing regulations promulgated thereunder (42 USCA §17901 *et seq*) both as may be amended from time to time.

    a. **"HIPAA"** means the Health Insurance Portability and Accountability Act of 1996 and the federal HIPAA privacy and security regulations at 45 C F.R. parts 160 and 164.

    b. **"HITECH Act"** means the Health Information Technology for Economic and Clinical Health Act as incorporated in the American Recover and Reinvestment Act of 2009 (H.R.1, "ARRA") and any regulations to be promulgated thereunder.

    c. **Individually Identifiable Health Information ("IIHI")** means information that is a subset of health information, including demographic information collected from an individual, and (i) is created or received by Covered Entity, and (ii) relates to the past, present, or future physical or mental health or condition of an individual; the provision of

health care to an individual; or the past, present, or future payment for the provision of health care to an individual and either identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

d. **Protected Health Information ("PHI")** means IIHI (except IIHI in education records covered by the Family Educational Rights and Privacy Act of 1974, as amended, 20 U.S.C. §1232g(a)(4)(B)(iv)) that is (i) transmitted by electronic media, (ii) maintained in any medium described in the definition of electronic media at 45 C.F.R. §162.103, or (iii) transmitted or maintained in any other form or medium.

e. **Electronic Protected Health Information ("EPHI")** means PHI that is (i) transmitted by electronic media, or (ii) maintained in any medium described in the definition of electronic media at 45 C.F.R. §162.103.

2. **Obligations of Covered Entity.**

2.1. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 C.F.R. 164.522 or the HITECH Act, if such restriction affects Business Associate's permitted or required uses or disclosures

2.2. Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by an individual to use or disclose PHI, if such changes affect Business Associate's permitted or required uses and disclosures.

2.3. Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under HIPAA or the HITECH Act if done directly by Covered Entity.

3. **Obligations of Business Associate.**

3.1. Except as otherwise limited in this Agreement, Business Associate shall use and disclose PHI only for the purposes of performing functions, activities, or services for, or on behalf of, Covered Entity or as otherwise set forth in this Agreement, provided that such use or disclosure would not violate HIPAA or the HITECH Act if done directly by Covered Entity.

Notwithstanding the preceding, Business Associate may use PHI received or created pursuant to this Agreement, if necessary for the proper management and administration of Business Associate or to carry out Business Associate's legal responsibilities.

Further notwithstanding the preceding, Business Associate may disclose PHI received or created pursuant to this Agreement, if necessary for the proper management and administration of Business Associate or to carry out Business Associate's legal responsibilities, if (a) the disclosure is required by law or (b) Business Associate obtains from the person or entity to whom or which the PHI is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person or entity and the person or entity agrees to notify Business Associate of any instances of which he, she or it is aware in which the confidentiality of the PHI has been breached

3.2. Business Associate shall not use or further disclose PHI received or created pursuant to this Agreement other than as permitted or required by this Agreement or applicable law.

3.3. Business Associate shall develop, implement, maintain and use appropriate administrative, technical and physical safeguards to prevent use or disclosure of PHI other than as provided for in this Agreement The safeguards will be designed to preserve the integrity and confidentiality of, and to prevent intentional or unintentional non-permitted use or disclosure of Covered Entity's PHI. Business Associate agrees to abide by applicable HITECH regulatory guidance as may be issued subsequently. Pursuant to federal guidance issued as of April 2009, the acceptable methods of securing PHI are encryption and destruction. Access controls and firewalls do not make electronic data secure; redaction of paper documents does not make them secure Business Associate agrees to abide by annual regulatory guidance addressing HITECH provisions

3.4. Business Associate shall promptly report to Covered Entity any use or disclosure of PHI not provided for by this Agreement of which it becomes aware. Business Associate will make the report to Covered Entity's Privacy Department not more than five calendar (5) days after Business Associate learns of any "Breach" of "unsecured Protected Health Information" as these terms are defined by the HITECH Act and any implementing regulations. Business Associate shall cooperate with Covered Entity in investigating the Breach and in meeting the Covered Entity's obligations under the HITECH Act including risk analysis and any other security breach notification laws. Business Associate will provide any and all information reasonably requested by Covered Entity or as required under the HITECH Act or subsequently issued HITECH regulations or regulatory bodies with regard to any such unauthorized use or disclosure. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.

3.5. Business Associate shall ensure that any agents, including a subcontractor, to whom or which it provides PHI, agrees to the same restrictions and conditions that apply to Business Associate hereunder with respect to such information

3.6. Business Associate shall make available to Covered Entity or, as directed by Covered Entity, the individual subject of the PHI, and in the time and manner designated by Covered Entity, PHI in a Designated Record Set in accordance with the provisions of 45 C.F.R. § 164.524, and where applicable, the HITECH Act, and any successor provisions as may be amended from time to time, relating to access of an individual to their PHI.

3.7. Business Associate shall make available PHI in a Designated Record Set for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. §164.526, and any successor provision as may be amended from time to time relating to the rights of individuals to amend their PHI, at the request of Covered Entity or the individual subject of the PHI and in the time and manner designated by Covered Entity.

3.8. Business Associate shall make available, in the time and manner designated by Covered Entity, the information required to provide an accounting of disclosures as would be required for Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528, and any successor provision as may be amended from time to time relating to the rights of individuals to request an

accounting of disclosures of their PHI. Business Associate further shall provide any additional information to the extent required by the HITECH Act and any accompanying regulations.

3.9. To the extent required by law, Business Associate shall make its internal practices, books, and records, if any, relating to the use and disclosure of PHI available to the Secretary of the United States Department of Health and Human Services for the purposes of determining Covered Entity's compliance with 45 C.F.R. §§164.500 – 164.532. Notwithstanding the preceding, Business Associate shall make no such information available if, in its reasonable determination, such action would (a) compromise any right of Covered Entity to keep such information confidential pursuant to applicable law; or (ii) breach any legal obligation by which Business Associate is bound.

3.10. Business Associate shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of any EPHI that the Business Associate creates, receives, maintains, or transmits on behalf of Covered Entity, as required by 45 C.F.R. §§164.302 – 164.318 and as required by the HITECH Act. Business Associate also shall develop and implement policies and procedures and meet the Security Rule documentation requirements as required by the HITECH Act.

3.11. Business Associate shall ensure that any agent, including a subcontractor, to whom it provides EPHI that the Business Associate creates, receives, maintains, or transmits on behalf of Covered Entity agrees to implement reasonable and appropriate safeguards to protect such EPHI.

3.12. Business Associate shall report to Covered Entity any security incident of which it becomes aware.

3.13. Unless otherwise provided under the HITECH Act, Business Associate will maintain all PHI which has been disclosed, and for which Business Associate is accountable for such disclosure pursuant to HIPAA or the HITECH Act, for at least seven (7) years following the date of the accountable disclosure to which such information relates.

4. **Term and Termination.**

4.1. This Agreement shall be effective as of the date first set forth above, and shall terminate when all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in this Agreement. This Agreement may be terminated by Covered Entity immediately upon notice to Business Associate if Covered Entity determines that Business Associate has violated a material term of this Agreement and such breach is not cured or violation ended within the time specified by Covered Entity or if a cure is not possible.

4.2. Either Covered Entity or Business Associate may terminate this Agreement if amendment or addition to 45 C.F.R. Parts 160-164 or the HITECH Act affects the obligations under this Agreement or the party

5. **Destruction of PHI.** Upon termination of this Agreement, Business Associate shall return or destroy all PHI that Business Associate still maintains in any form and retain no copies of such information or, if such return or destruction is not feasible (consistent with law applicable to Business Associate), then Business Associate shall extend the protections set forth in this Agreement to such PHI and limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible. These requirements shall also apply to PHI that is in the possession of Business Associate's subcontractors or agents. Business Associate shall not retain any copies of the PHI unless required to by law

6. **Miscellaneous.**

6.1 This Agreement sets forth the entire understanding and agreement between the parties relating to the subject matter hereof and shall be binding upon the parties and their respective successors, heirs and assigns. All prior negotiations, agreements, and understandings regarding the subject matter hereof are superseded hereby This Agreement shall supplement any other agreements between the parties hereto. To the extent that the terms contained herein are inconsistent with the terms of any other agreements between the parties, the terms of this Agreement shall govern. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity to comply with HIPAA.

6.2 This Agreement may not be amended or revised except in a writing executed by both parties. The parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of HIPAA, the HITECH Act, the regulations promulgated thereunder and applicable state laws.

6.3 This Agreement must be assigned to any legal successor or affiliate of either of the parties hereto.

6.4 This Agreement shall be construed and enforced pursuant to the laws of the State in which Business Associate provides services to Covered Entity.

6.5 The invalidity or unenforceability of any particular provision or part thereof of this Agreement shall not affect the remainder of this Agreement, and this Agreement shall be construed in all respects as if such invalid or unenforceable provision or part thereof had been omitted.

6.6 The respective rights and obligations of Business Associate under this Agreement survive the termination, expiration, or other conclusion of this Agreement or any other agreement between Business Associate and Covered Entity.

6.7 A waiver of any term or provision shall not be construed as a waiver of any other term or provision. Nothing in this Agreement shall be deemed a waiver of any legally recognized claim of privilege available to either party. Any waiver must be in writing executed by the party allegedly making the waiver.

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

6/5/2020

Subject Credential Verification

To Whom It May Concern:

This verifies the status of the Physician And Surgeon License for Ashley, Susan Lynn.

This site is a Primary Source for Verification of Credentials

Credential Number:	MD00028821
Credential Type:	Physician And Surgeon License
First Credential Date:	07/20/1991
Last Renewal Date:	05/28/2020
Credential Status:	ACTIVE
Current Expiration Date:	06/27/2022
Enforcement Action:	No

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

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

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

Attachments

SECTION II: PROJECT DESCRIPTION

- Letter I: Building Lease Agreement

AMENDMENT "TWO" TO LEASE

THIS AGREEMENT, dated for reference purposes only on the 1st day of March, 2018 by and between Denkor Plus LLC, a Washington limited liability company, hereinafter referred to as Landlord, and Intrepid of Washington Inc., a Washington corporation, hereinafter referred to as Tenant, for those certain premises known as 9715 North Nevada Street, Spokane, Washington.

WITNESSETH

WHEREAS, Landlord and Tenant desire to modify the original Lease dated January 20, 2014, and Amendment One to Lease dated March 28, 2014, and the terms thereof, upon the terms, covenants, and conditions herein set forth.

NOW, THEREFORE, for good, valuable, and sufficient consideration by each party hereto to the other paid, receipt of which is hereby mutually acknowledged, Landlord and Tenant do hereby confirm their understanding and agreement as follows:

1. Term: The Term of the Lease shall be extended thirty-eight (38) months, commencing May 1, 2018 and terminating on June 30, 2021.

2. Base Rent:

May 1, 2018 through May 31, 2018	Free Base Rent, NNN due
June 1, 2018 through May 31, 2021	$3,279.00 per month, plus NNN
June 1, 2021 through June 30, 2021	Free Base Rent, NNN due

AGENCY DISCLOSURE. At the signing of this Amendment, Landlord's Broker Jeff Johnson of Black Commercial, Inc. represented the Landlord and Tenant's Broker Mark McLees of Black Commercial, Inc. represented the Tenant. If Tenant's Broker and Landlord's Broker are different salespersons affiliated with the same Designated Broker, then both Tenant and Landlord confirm their consent to that Designated Broker acting as a dual agent. If Tenant's Broker and Landlord's Broker are the same salesperson representing both parties, then both Landlord and Tenant confirm their consent to that salesperson and his/her Designated Broker acting as dual agents. If Tenant's Broker, Landlord's Broker, or their Designated Broker are dual agents, Landlord and Tenant consent to Tenant's Broker, Landlord's Broker and their Designated Broker being compensated based on a percentage of the rent or as otherwise disclosed on an attached addendum. Neither Tenant's Broker, Landlord's Broker or their Designated Broker are receiving compensation from more than one party to this transaction unless otherwise disclosed on an attached addendum, in which case Landlord and Tenant consent to such compensation. Landlord and Tenant confirm receipt of the pamphlet entitled "The Law of Real Estate Agency."

Landlord and Tenant acknowledge disclosure prior to entering into this Amendment that Black Realty Management, Inc., acted as Landlord's Agent solely in the preparation of this Amendment.

ACKNOWLEDGEMENT

STATE OF Texas)
) ss
County of Dallas)

On this 1st day of May, 2018, before me personally appeared **John Nix** to me known to be the **Chief Financial Officer** of **Intrepid of Washington, Inc.**, the Corporation which executed the foregoing instrument, and acknowledged the said instrument to be the free and voluntary act of said Corporation, for the uses and purposes therein mentioned, and on oath stated that he was authorized to execute the said instrument on behalf of said Corporation.

GIVEN UNDER MY HAND AND OFFICIAL SEAL the day and year in this certificate first above written.

(Seal or Stamp)

NOTARY PUBLIC STATE OF TEXAS
KRISTY D STEGER
My Commission Expires
July 16, 2019

Kristy Steger
Notary Public (Signature)
KRISTY STEGER
(Print Name)
Residing at Dallas TX
My appointment expires: 7-16-19

LICENSURE DISCLOSURE. Written disclosure is made that the following parties are licensed real estate brokers in the State of Washington.

a) Landlord: Jeff Johnson and James Hawley are licensed real estate broker(s) in the State of Washington, and are members in the Landlord entity.

b) Tenant: None is a/are licensed real estate broker(s) in the State of Washington in the Tenant entity.

Except as herein extended, modified, supplemented or amended, all of the terms, covenants, and conditions of the original Lease shall remain in full force and effect as heretofore written, and the Lease as extended, modified, supplemented and amended by this Agreement is hereby ratified and confirmed in every respect.

IN WITNESS WHEREOF, Landlord and Tenant, by their respective officers, have caused this Amendment "Two" to Lease to be signed in counterpart originals and/or by originals transmitted via facsimile.

LANDLORD:

Denkor Plus, LLC
a Washington limited liability company

By: _____
Jeffrey K. Johnson
Its: Member

TENANT:

Intrepid of Washington, Inc.,
a Washington corporation

By: _____
John Nix
Its: Chief Financial Officer

Attachments

SECTION III A: PROJECT RATIONALE – NEED

- Number 3: Reference Letters and Letters of Support
- Number 5: Stevens County Zip Code Map
- Number 11: 2.001 Admissions Policy, 1.057 Charity Care Policy

MedBridge at ManorCare Health Services - Spokane
6025 N Assembly, Spokane, WA 99205
509 326 8282
509 326 4790 (Fax)

MedBridge®
Your Bridge From Hospital To Home

May 27, 2020

To Whomever it May Concern:

I would like to express our sincerest recommendation for Intrepid Home Health to serve Stevens County. I have worked alongside Intrepid staff members for the past twelve months at HCR Manorcare.

The team is always available and willing to help with our patients which never ceases to amaze us. Intrepid is able to provide quality services to our patients which lowers the re-hospitalization rate and would highly benefit the patients who reside in rural areas. Intrepid also accepts a wide range of insurance providers which would be beneficial to those in Stevens County as the current home health provider is limited.

For patients currently living in Stevens County, we have been unsuccessful setting up home health services due to availability and staffing, insurance coverage, and not being able to comply with the 48hour Medicare guideline. This has caused patients to return to the hospital, then to the nursing home and in some cases has caused the patient not to be able to return home safely. Finding alternate living arrangements causes stress on patients and their families leading to further decline in health.

Intrepid's office team shows great organizational skills and time management skills so they are able to see patients sooner than the current provider for Stevens County. By expanding the services of Intrepid, this would eliminate the deficit and give patients more options to stay home, stay safe, and remain out of hospitals and skilled nursing facilities.

Sincerely,

The Manorcare Team

Eric Sohn, MD

Joel Brooks, RN Unit Manager

Stephanie Gladden, Social Services Director

NEW Health

PLEASE SEND INFORMATION TO THE CLINIC LOCATION CHECKED BELOW:

- ☐ **Chewelah Community Health Center**
  Phone: 509-935-8424 / Fax: 509-935-8402
- ☐ **Colville Community Health Center**
  Phone: 509-684-1440 / Fax: 509-684-2745
- ☐ **Kettle River Community Health Center**
  Phone: 509-684-5521 / Fax: 509-684-1464
- **Lake Spokane Community Health Center**
  Phone: 509-464-3627 / Fax: 509-466-9517
- ☐ **Loon Lake Community Health Center**
  Phone: 509-233-8412 / Fax: 509-233-2864
- ☐ **Northport Community Health Center**
  Phone: 509-732-4252 /Fax: 509-732-4318
- ☐ **Selkirk Community Health Center**
  Phone: 509-442-3514 / Fax: 509-442-3436
- ☐ **Springdale Community Health Center**
  Phone: 509-258-4234 / Fax: 509-258-4499
- ☐ **Colville Community Dental Clinic**
  Phone: 509-684-1440 / Fax: 509-684-1277
- ☐ **Lake Spokane Community Dental Clinic**
  Phone: 509-464-0002 / Fax: 509-464-2378
- ☐ **Springdale Community Dental Clinic**
  Phone: 509-258-7543 / Fax: 509-258-7524

CONFIDENTIAL FAX

To: Craig Board **FAX #:** 466-9325

From: Sherri

Re: _____

Date: _____ **Pages:** _____ (including this page)

☐ **Urgent** ☐ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **As Requested**

MESSAGE: _____

5/29/20

To Whom it may concern,

I am a referral coordinator for Stevens County. Our population is this county are very under served with home health care due to lack of availability. We have multiple patients needing the service that home health care provides but because of our remote location often our patients have to go without services they so badly need.

It would be so helpful to have greater access to home health care in Stevens county to care for our elderly and ill patients.

Thank you for your consideration in this matter,

Sincerely,

Sherri Nogales, referral coord

MIGUEL SCHMITZ, M.D.
Board Certified Orthopaedic Surgeon
Fellowship Trained in Spine Surgery & Sports Medicine
RYAN SAUNDERS, PA-C
CHASE KAUFMAN, PA-C

June 15, 2020

C/O Craig Board; Patient Advocate
9715 North Nevada
Spokane, Washington 99218

RE: Intrepid Home Health

To Whom It May Concern:

I would like to express my sincerest recommendation for Intrepid Home Health to serve Stevens County. I have worked alongside Intrepid staff members for the past twelve months at Alpine Orthopaedics.

The team is always available and willing to help with our patients which never ceases to amaze me. Intrepid is able to provide quality services to our patients which lowers the rehospitalization rate and would highly benefit the patients who reside in rural areas. Intrepid also accepts a wide range of insurance providers which would be beneficial to those in Stevens County, as the current home health provider is limited. For patients currently living in Stevens County, we have been unsuccessful setting up home health services due to the availability and staffing, insurance coverage, and not being able to comply with the 48-hour Medicare guideline. This has caused patients to return to the hospital, then to the nursing home and in some cases has caused the patient not to be able to return home safely. Finding alternative living arrangements causes stress on patients and their families leading to further decline in health.

Intrepid's office team shows great organizational skills and time management skills, so they are able to see patients sooner than the current provider for Stevens County. By expanding the services of Intrepid, this would eliminate the deficit and give patients more options to stay home, stay safe, and remain out of hospitals and skilled nursing facilities.

Sincerely,

Electronically signed by Miguel A Schmitz, MD
MAS:sja
Dictated but not read

AVALON CARE CENTER - NORTHPOINTE

6/5/2020

To Whom It May Concern,

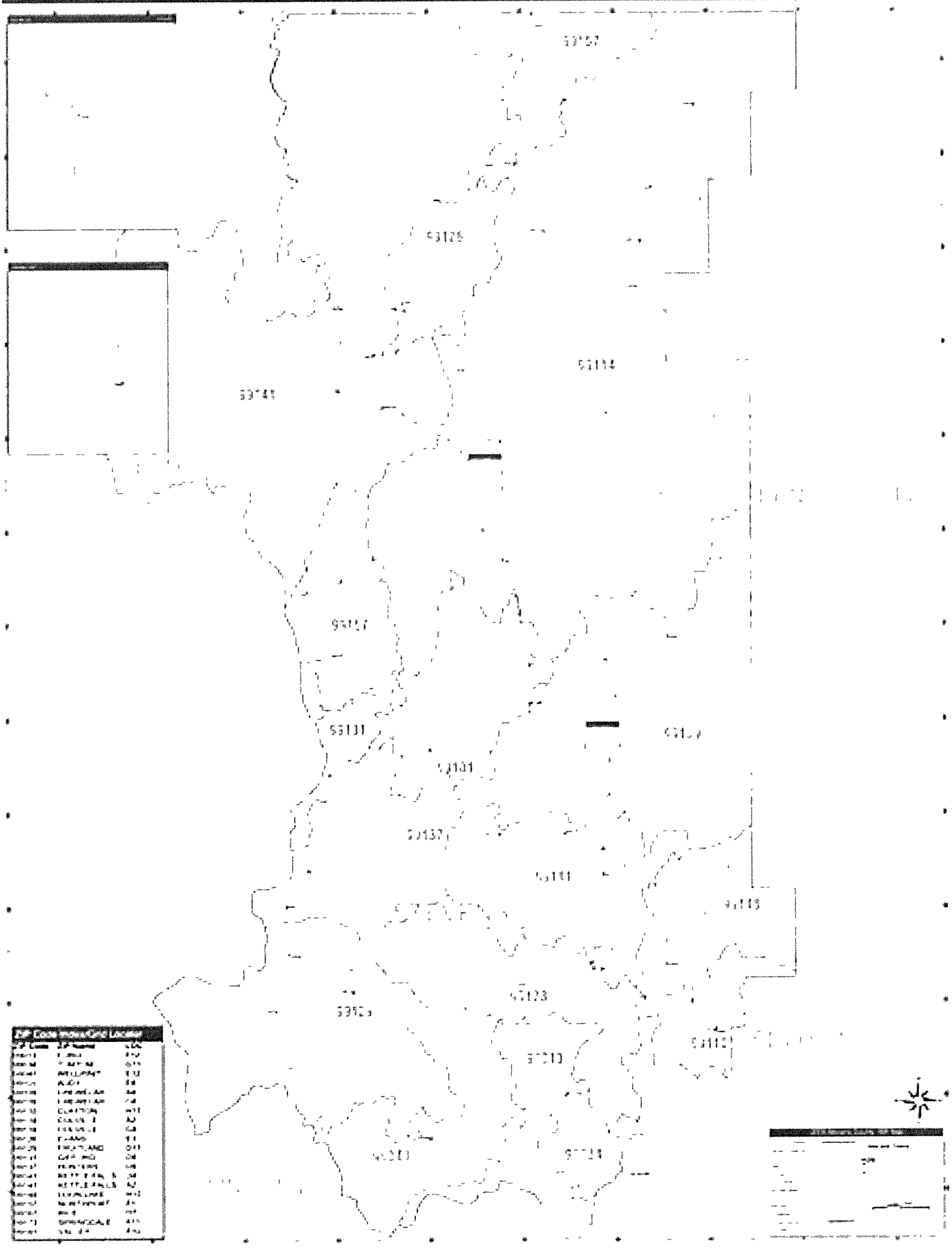
As the Director of Social Services for a large skilled nursing facility in Spokane, WA, I often have residents that reside in Stevens County and return there upon discharge from our facility. Often, these people would benefit greatly in their transition home with the support of home health Too frequently, our residents returning to Stevens County are unable to receive the home health they need as there is currently only one home health agency servicing Stevens County and they are often short staffed, or otherwise unable to accept new patients Granting Intrepid Home Health a Certificate of Need for Stevens County will be extremely helpful in providing access to the quality healthcare the residents of Stevens County need. Thank you for your consideration in this matter.

AVALON CARE CENTER AT NORTHPOINTE

SARA BELZMAN, MSW SSD
SOCIAL SERVICES NORTH

9827 N Nevada St | Spokane WA 99218
P 509 468 7000x3159 | F 509 468 1659
sara.belzman@avalonhealthcare.com

STEVENS COUNTY, WA



Intrepid USA Healthcare Services Policy and Procedure

Policy Name:	**Admission**			**HH5-2A.01; HH5-14A.01**
Section:	**2**	**Care Delivery**	**Policy Number:**	**2.001**
Effective Date:	**September 1, 1999**	**Revision Date:**	**November 2017**	

Policy Statement:

Acceptance of a client for services will be based on a reasonable expectation that the specified needs of the client can be adequately met by the agency Environmental conditions in the home will be conducive to the adequate treatment of the client and the safety of both the staff and client Patients that do not meet the criteria for admission will receive communication regarding the reason for non-admission If applicable, the client will receive a Home Health Change of Care Notice (HHCCN) or Advance Beneficiary Notice of Non-coverage (ABN) in accordance with Medicare's guidelines

The agency will provide services to accepted patients without regard to race, color, diagnosis, sex, sexual orientation, marital status, age, religion, creed, national origin, citizenship status, physical or mental handicap or disability or as otherwise required by state or federal law

Guidelines / Procedures:

1 The agency will not accept patients whose care needs are determined to be beyond the scope of services that can be provided by the agency Services and care will conform to current professional and community standards of practice for the respective discipline(s) Patients will be referred to alternative services, if available, when the agency is unable to meet identified client needs

2 The client must reside within the geographical area served by the agency

3 The agency may accept Medicare, Medicaid (or equivalent state sponsored health plan), private insurance, private pay, worker's compensation, Veterans Administration, and vocational rehabilitation as a primary payment source(s) for home care The agency should not accept any third party liability carrier as a primary payment source This would include, but is not limited to third party auto vehicle insurance carriers and/or personal property carriers Cases of this nature would be accepted contingent upon the patient being listed as self pay and/or subrogated through their medical health carrier

4 All Medicare FFS (traditional) and some Medicare Advantage (check with verification for current requirement) patients require a face to face encounter with the MD who is certifying the need for home care, who is responsible for providing documentation of eligibility for home care This face to face encounter must occur 90 days prior to or within 30 days following the SOC.

5 The agency does not provide care to patients with no third party payor source or without the ability to pay for home care services except as approved by the Regional Directors of Operations and Revenue Cycle Director

Criteria for Admission:

1 Requests for skilled services and orders for care are accepted from physicians who hold a current valid state license The physician's plan of treatment will include orders for all services except housekeeping or companion services unless such orders are required by the state or payor source

2 There is a reasonable expectation that the client's specified needs can be met, including a plan to meet medical emergencies

3 The physician and/or referral source will be notified, at the time of referral, of the requirements related to documentation of the face to face encounter, which must have occurred within the 90 days prior to the start of care or will need to occur within 30 days following the SOC

4 Upon receipt of the referral, the client will be admitted within 48 hours unless otherwise directed by the physician, referral source, client, or payor The reason for the delayed admission will be documented in the clinical record Commercial insurance patients will be admitted/have services initiated within 48 hours of the referral If the authorization for these services has not been obtained within this 48 hour period the agency must contact the physician and obtain an order for the delayed start of care Medicare patients require eligibility status and determination of homebound status

5 It is preferred that each client identify an available, willing and able primary caregiver who is able to oversee the needs of the client in the emergent event that the Company staff is unable to be on-site to provide services

6 If the patient has not had a face to face encounter within the 90 days prior to the SOC date, one will need to be completed within 30 days following the SOC date and the patient will be notified of the requirements of the face to face encounter at the time of admission evaluation, utilizing the "Patient Letter" form and the "Patient Information Face to Face" fact form If a face to face encounter was not performed timely (90 days prior to or 30 days after SOC) follow the Late Face to Face Physician Encounter Process 1 075 The comprehensive assessment will be completed within 5 days

* Agencies will meet requirements regarding the provision of indigent care specified by any license, certification, or contractual requirement

Associated Process(s): 1 075 Late Face to Face Physician Encounter

State Specific Requirements:

Mississippi: All Medicare patients require eligibility status and determination of homebound status

The comprehensive assessment will be completed within 5 days

No. Carolina: The agency ensures available back up staff for patients receiving Community Alternative Placement Program for children and adults with Mental Retardation or Developmental Disabilities (CAP-MR/DD) services when the lack of immediate care poses a threat to the recipient's health and welfare If informal providers and agency back up staff is unavailable, the agency will document who provided services, support, and care in the absence of direct service employee

Texas Agency staff members will implement, enforce and educate, all patients 60 years of age and older regarding the provisions of Human Resources Code, Chapter 102-Rights of the Elderly

Virginia It shall be the responsibility of the health care provider to inform patients of the below provision prior to providing him with health care services, which create a risk of exposure Whenever any health care provider, or any person employed by or under the direction and control of a health care provider, is directly exposed to body fluids of a client in a manner which may, according to the then current guidelines of the Centers for Disease Control, transmit human immunodeficiency virus or hepatitis B or C viruses, the client whose body fluids were involved in the exposure shall be deemed to have consented to testing for infection with human immunodeficiency virus or hepatitis B or C viruses Such client shall also be deemed to have consented to the release of such test results to the person who was exposed

Pennsylvania

Any client who has reason to believe they have been discriminated against with regard to race, color, diagnosis, sex, sexual orientation, marital status, age, religion, creed, national origin, citizenship status, physical or mental handicap or disability or anyone who becomes aware of what he or she believes is such discrimination may contact the Corporate office by phone or e-mail at intrepid@intrepidusa com or may report same to one of the following

US Dept of Labor
Equal Employment Opportunity Commission
1001 Liberty Avenue, Suite 300
Pittsburgh, PA 15222
800-669-4000

Human Rights Commission
Uptown Plaza
2971-E N 7th Street
Harrisburg, Pa 17110-2123
717-787-9784

Act 44 of 2004, signed into law on June 23, 2004 amends the Medical Practice Act to address home health care services ordered for Pennsylvania residents by physicians from another state This revision to the law permits a Pennsylvania home health agency, licensed by Pennsylvania Department of Health under the Health care Pennsylvania upon an order of a physician from another state who holds a license in good standing in the other state and who prescribes home health care services after the physician has performed an in-person physical examination of the patient in the site where the physician is licensed This allows Pennsylvania home health care services to accept prescriptions and orders from out-of-state doctors

Intrepid USA Healthcare Services Policy and Procedure

Policy Name:	Charity Care –Indigent Care			HH5-14A.01
Section:	1	Administrative	Policy Number:	1.057
Effective Date:	April 2012	Revision Date:	April 2014	

Policy Statement:

Any self-pay, uninsured patient who indicates an inability to pay should be screened for charity care using the policy as outlined below Additionally, at the discretion of the Revenue Cycle Director, any insured patient who indicates an inability to pay their liability after the insurance has paid should be screened for charity care only after an attempt to collect has been made Screening for charity care must occur only after all other potential resources have been exhausted The screening process for self pay, uninsured patients will optimally occur at the time of service but may occur anytime during the collection process The agency must utilize the most current Federal Poverty Guidelines in the determination of submitting Charity Care reviews In addition, the agency Administrator alongside with the Regional Director should review the feasibility of care for the uninsured/self pay patient prior to accepting the case Should the patient not meet the guidelines of this policy, the patient would not be considered for the Charity/Indigent Care program

Guidelines / Procedures:

1 DOCUMENTATION REQUIREMENTS

Application
In order to qualify for charity care, a Confidential Financial Statement should be completed The agency Social Worker must assist the patient in completing the form as necessary The Confidential Financial Statement allows for the collection of information Income and documentation requirements are defined below Pending the completion of such application, the patient should be treated as a pending charity care patient in accordance with the agency's policies and the appropriate financial class recorded to reflect this status

Family Members: Patients should be required to provide the number of family members in their household

- **Adults** In calculating the number of family members in an adult patient's household, include the patient, the patient's spouse and/or legal guardian, and all dependents

Income Calculation: Patients should be required to provide their household's yearly gross income

- **Adults:** The term "yearly income" on the Confidential Financial Statement means the sum of the total yearly gross income of the patient and patient's spouse

Income Verification

Patients should be required to verify the income set forth in the Confidential Financial Statement in accordance with the documentation requirements identified below in cases where documentation is available Income documentation may include IRS Form W-2, wage and earnings statement, paycheck stub, tax returns, telephone verification by employer of the patient's income, bank statements, or other appropriate indicators of income

2 The Confidential Financial Statement, as well as any supporting documentation, must be submitted to the Revenue Cycle Department Director who will then determine the amount of discount allowed for the patient's care Once a charity determination has been made, the outcome will be communicated to the patient in writing with notification to the agency as applicable

3 Current published Federal poverty guidelines published each year will be used to determine qualifications for approval Source of information on the guidelines http //aspe hhs gov/poverty

The following will be used to determine approved amounts for self pay/indigent patients,
Up to 10% above Poverty Guidelines – 100% of billed charges
11-15% above Poverty Guidelines – 50% of billed charges

If a patient does not qualify for charitable work, the patient will be notified in writing and will be provided with an option to make monthly payment arrangements consistent with the Company's financial goals.

Should a patient indicate inability to pay their liability after the insurance has paid they would need to submit a request for charitable and/or indigent care by following the same methods as stated above Determination of approval and/or discounted amounts will be taken into consideration based on carrier contracts A letter will be sent to the patient outlining their approval and/or discount amount accepted

Associated Form(s): Application for Charity Care

Attachments

SECTION III B: PROJECT RATIONALE – FINANCIAL FEASIBILITY

- Number 4: Formulas for Estimated Operating Revenue and Expenses

- Number 7: Attestation of Funding

Estimated Operating Revenue and Expenses

Episodic Revenue is calculated off March –May 2020 average HHRG score which is then multiplied by forecasted Patient Census

Non-Episodic Revenue is 14% of Episodic Revenue, our Payor mix

Expenses are set to a run-rate of actual 2019 spend in similar Providers

Direct Wages	% of similar Providers actual 2019 Direct Expenses
Sub Contractor	% of similar Providers actual 2019 Direct Expenses
Direct Wages	
Benefits	% of similar Providers actual 2019 Direct Expenses
Insurance	% of similar Providers actual 2019 Direct Expenses
Medical Supplies	% of similar Providers actual 2019 Direct Expenses
Other Hospice Patient Related Costs	
Travel & Transportation	% of similar Providers actual 2019 Direct Expenses
Other	% of similar Providers actual 2019 Direct Expenses
Direct Expenses	
Wages, Benefits and Payroll Taxes	% of similar Providers actual 2019 Indirect Wages, Benefits, and Payroll Tax
Travel	% of similar Providers actual 2019 Expense
Telecommunications	% of similar Providers actual 2019 Expense
Advertising	% of similar Providers actual 2019 Expense
Supplies	% of similar Providers actual 2019 Expense
Insurance	% of similar Providers actual 2019 Expense
Utilities	% of similar Providers actual 2019 Expense
Postage	% of similar Providers actual 2019 Expense
Bad Debt Expense	2% of Net Revenues
Equipment	% of similar Providers actual 2019 Expense
Licenses & Permits	% of similar Providers actual 2019 Expense
Professional Fees	% of similar Providers actual 2019 Expense
Other Taxes	% of similar Providers actual 2019 Expense
Other	% of similar Providers actual 2019 Expense
Ops Allocation	12% of Net Revenues
Rent Subtotal	Estimated Annual Rent Expense for small office space
Indirect Expenses	

IntrepidUSA
Healthcare & Hospice at Home
3220 Keller Springs Road, Ste #108
Carrollton, Texas 75006
(214) 445-3750

June 1, 2020

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

To whom it may concern.

As you can see from the attached statement we maintain balances that would allow for us to fund the capitalized expenditures out of our current cash levels. All of our deposits go into one of two bank deposit accounts, Bank of Texas account 8095974969 and Bank of Texas account 8095974958 Once the money is available it is then moved to our operating account, Bank of Texas account 3090605363, to support the day to day operations We have attached all three accounts so that you can see that the balances required are being met within the bank accounts

If you have any questions about this, please contact me at your earliest convenience

Sincerely,

John Shrieves
VP of Finance, Interim CFO, Intrepid USA, Inc.

Attachments

SECTION III C: PROJECT RATIONALE – STRUCTURE AND PROCESS (QUALITY) OF CARE

- Number 5: Orientation Check Lists, Policy 1-022.1, Policy 3-002.1
- Number 9: Reference Letters and Letter of Support
- Number 12: Administrator Resume, Supervising Nurses Resume
- Number 13: Surveys from 2015, 2017, 2019

INITIAL COMPETENCY ASSESSMENT SKILLS CHECKLIST

(Sample for Occupational Therapy Assistant)

Key for Evaluation Method
(to be determined by organization):

Verbal Test	=	**V**
Written Test	=	**W**
Observation	=	**O**
Demonstration	=	**D**
Special Training	=	**ST**

INITIAL COMPETENCY ASSESSMENT SKILLS CHECKLIST— OCCUPATIONAL THERAPIST ASSISTANT

Name _____

Date of Employment _____ Date Completed _____

Self Assessment				Competency for the Occupational Therapist Assistant	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				A. Demonstrates ability to process paperwork and associated functions necessary to facilitate:			
				1 Knowledge of Assessment Process			
				a Assesses response to treatment			
				b Other			
				2 Documentation Skills (accurate, timely, complete, legible)			
				a Progress notes, flow sheets	*		
				b Incident reporting			
				c Other			
				3 Adheres to POC			
				a Reviews POC prior to care	*		
				b Performs services as ordered	*		
				c Documents according to POC	*		
				d Communicates/coordinates as appropriate	*		
				e Other			
				4 Knowledge of Medicare/State Guidelines			
				a Criteria for participation			
				b Skilled reimbursable visit			
				c Other			
				5 Reports and documents key information to Physician, DC planner, Clinician, Pharmacist, Supervisor	*		
				6 Submits written summary reports as indicated	*		
				7 Attends/participates in case conferences as required			
				8 Supply/HME requisition and management			

Self Assessment				Competency for the Occupational Therapist Assistant	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				9 Infection Control Practices			
				a Hand washing	*		
				b Personal protective equipment	*		
				c Exposure control plan	*		
				d Equipment care, as appropriate	*		
				e Other			
				10 Patient home safety			
				11 Other			
				B. Patient Education			
				1 Develops/implement teaching plan			
				2 Evaluates effectiveness of teaching			
				3 Documents patient response			
				4 Other			
				C. Clinical Skills—General			
				1 Vital Signs			
				2 Other			
				D. Skilled Treatments/Interventions			
				1 Teaches ADL/IADL Program			
				2 Work simplification and energy conservation			
				3 Teaches muscle reeducation program			
				4 Perceptual motor training			
				5 Fine motor training/dexterity training/gross motor training			
				6 Neuro-developmental training			
				7 Sensory enhancement (tactile, ocular, gustatory, Olfactory, proprioceptive, auditory, vestibular, kinesthesia)			
				8 Arranges orthotics/splinting			
				9 Arranges adaptive equipment			
				10 Teaches caregiver exercises/activities			
				11 Safety evaluation/environment adaption recommendations			

Self Assessment				Competency for the Occupational Therapist Assistant	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				12 Other			

Comments _____

_____

_____

_____ _____
Employee Signature Date

_____ _____
Supervisor Signature Date

_____ _____
Preceptor(s) Date

_____ _____
Preceptor(s) Date

_____ _____
Preceptor(s)

ADDENDUM 3-002.D

INITIAL COMPETENCY ASSESSMENT SKILLS CHECKLIST

(Sample for the Home Health Aide)

Key for Evaluation Method
(to be determined by organization):

Verbal Test	=	**V**
Written Test	=	**W**
Observation	=	**O**
Demonstration=	**D**	
Special Training	=	**ST**

INITIAL COMPETENCY ASSESSMENT SKILLS CHECKLIST— HOME HEALTH AIDE

Name _____

Date of Employment _____ Date Completed _____

Self Assessment				Competency for the Home Health Aide	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				A. Demonstrates ability to process paperwork and associated functions necessary to facilitate:			
				1 Temperature			
				a Oral	*		
				b Rectal	*		
				c Axillary	*		
				d Digital thermometers			
				e Other			
				2 Pulse (radial)	*		
				3 Respiration	*		
				4 Blood pressure	*		
				5 Bed bath	*		
				6 Shower/tub bath	*		
				7 Nail care	*		
				8 Skin care	*		
				a Recognizing and reporting changes in skin condition			
				9 Oral care	*		
				10 Shampoo	*		
				a Sink			
				b Tub			
				c Bed			
				11 Toileting/Elimination			
				a Urinal			
				b Bedpan	*		
				c Other			

Self Assessment				Competency for the Home Health Aide	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				12 Transfer techniques			
				a Bed to chair	*		
				b Chair to standing	*		
				c Assist with ambulation	*		
				d Other			
				13 Assists with exercise program range of motion			
				14 Assistive devices			
				a Walker	*		
				b Cane	*		
				c Other			
				15 Positioning	*		
				16 Optional Skills			
				a Dry dressings			
				b Ace bandage wrap			
				c Medication reminders			
				d Urinary catheter care			
				e Gastrostomy site care			
				f Observe/record intake and output			
				g Hoyer lift			
				h Enema			
				i Other			
				17 Documentation Skills (legible, timely, accurate and complete)			
				a Progress notes, flow charts	*		
				b Incident reporting	*		
				c Relates to POC	*		
				d Other			
				18 Observation and reporting to			
				a RN/Supervising nurse			
				b Other professional			

Self Assessment				Competency for the Home Health Aide	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				c Other			
				19 Adheres to POC			
				a Reviews POC prior to care	*		
				b Performs services as ordered	*		
				c Documents according to POC	*		
				d Communicates/coordinates if appropriate	*		
				e Other			
				20 Infection Control			
				a Hand washing	*		
				b Proper bag technique	*		
				c Protective equipment	*		
				d Exposure plan	*		
				e Equipment care	*		
				f Other			
				21 Emergency procedures			
				22 Reports and documents patient status information to Physician, DC Planner, Clinician, Pharmacist, Supervisor	*		
				23 Knows Resources, HME, Lab, other services	*		
				24 Submits written summary reports as indicated	*		
				25 Attends case conference as required	*		
				26 Patient safety/falls risk			
				27 Meal preparation			
				a Feeding			
				b Diabetic diet			
				c Low sodium			
				d Low cholesterol/fat			
				28 Light housekeeping			
				29 Linen change/wash clothing			
				30 Other			

(*) Competency evaluation by observing an aide's performance of the task with a patient

The remaining areas may be evaluated through written or oral examination or after observation of a home health aide with a patient

Comments _____

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Employee Signature Date

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Supervisor Signature Date

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Preceptor(s) Date

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Preceptor(s) Date

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Preceptor(s) Date

INITIAL COMPETENCY ASSESSMENT SKILLS CHECKLIST— LICENSED PRACTICAL/VOCATIONAL NURSE

Name _____

Date of Employment _____ Date Completed _____

Self Assessment				Competency for the Licensed Practical/ Vocational Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				A. Demonstrates ability to process paperwork and associated functions necessary to facilitate:	*		
				1 Assess patient response to treatment			
				2 Transfer of Patient	*		
				3 Attends Case Conference	*		
				4 Adheres to POC	*		
				5 Performs services as ordered	*		
				6 Reports and documents key information to physician, DC planner, Case Manager, pharmacist, supervisor	*		
				7 Communicates/coordinates as appropriate with other team members	*		
				8 Coordinates community resources	*		
				9 Documents according to POC			
				a Medicare guidelines for documentation	*		
				b Corrections to the clinical record	*		
				c Accident/incident reports	*		
				d Clinical notes, flow charts	*		
				10 Other			
				a HME requisition and management			
				b Supply requisition and management			
				B. Review of Systems: Demonstrates ability to obtain and document appropriate age specific history/ assessment for patients in the following categories:			
				1 Pulmonary System			
				a Pulmonary Assessment			
				b Tracheostomy care			

Self Assessment				Competency for the Licensed Practical/ Vocational Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				c Oxygen administration			
				d Pharyngeal suction			
				e Use of oral/nasal inhalers			
				f Oxymeter			
				g CPAP			
				h Oxygen mask, nasal cannula, concentrator, portable oxygen			
				i Airway insertion			
				j SVN/Nebulizer treatment			
				k Home ventilator management			
				l Foreign body airway obstruction			
				m Breathing exercises/incentive spirometry			
				n Other			
				2 Cardiovascular System			
				a Cardiovascular assessment			
				b Pulses (apical, radical, femoral, pedal)			
				c Edema assessment and management			
				d Supine and orthostatic blood pressure			
				e NTG use, inhaler use			
				f CPR			
				g Energy conservation techniques			
				h Other			
				3 Neurologic System			
				a Neurologic assessment			
				b Aphasia care			
				c Mental status exam			
				d Seizure precautions			
				e Spinal cord injuries care			
				f Head injury care			
				g Other			

Self Assessment				Competency for the Licensed Practical/ Vocational Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				4 Gastrointestinal System			
				a Gastrointestinal assessment			
				b NG tube insertion/care			
				c Jejunostomy tube care			
				d Gastrostomy tube care			
				e Enteral feedings			
				f Suction machine(s)			
				g Ostomy care			
				h Dysphagia precautions			
				i Impaction removal			
				j Enema			
				k Bowel training			
				l Other			
				5 Genitourinary System			
				a GU assessment			
				b Urinary catheterization insertion and care (male and female)			
				c Irrigation of catheters			
				d Obtaining specimens			
				e Removal of urinary catheter			
				f Care of supra-pubic catheter			
				g Care of urostomy			
				h Bladder training			
				i Nephrostomy tubes			
				j Knowledge of types of catheters and indications for use (straight, indwelling, condom)			
				k Ileostomy care			
				l Incontinence care			
				m GU post op care			
				n Other			
				6 Integumentary/Wounds/Dressings			

Self Assessment				Competency for the Licensed Practical/ Vocational Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				a Assessment of skin/wound			
				b Measurement of wounds			
				c Wound irrigation			
				d Wet to dry dressing(s)			
				e Decubitis care			
				1 Assessment and staging			
				2 Prevention			
				3 Various treatments (hydrocolloid, calcium, alginate, transparent films)			
				4 Documentation/pictures			
				f Ace wrap, case care, compresses			
				g Hemovac			
				h Sterile dressing change			
				i Suture/staple removal			
				7 Musculoskeletal System			
				a Assessment			
				b Range of motion (ROM)			
				c TED hose			
				d Total knee care			
				e Total hip care			
				f Case assessment and care			
				g Devices			
				1 Walker			
				2 Wheelchair			
				3 Transfer board			
				4 Hoyer lift			
				h Pain assessment			
				i Transfers			
				j Other			
				8 Metabolic			

Self Assessment				Competency for the Licensed Practical/ Vocational Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				a Assessment			
				b Diabetic assessment and teaching			
				1 Insulin types and teaching			
				2 Use, care and teaching of glucose monitoring system			
				3 Diet, exercise and sick day teaching			
				4 Signs and symptoms of Hypo-Hyperglycemic reactions			
				5 Foot and skin care			
				c Coumadin therapy			
				d Other			
				9 Behavioral Health			
				a Assessment			
				b Suicide precautions			
				c Psychotropic drugs			
				d Care of the demented patient			
				e Other			
				10 Miscellaneous Skills			
				a Vital signs			
				b Intake and output			
				c Caring for immuno-compromised patients			
				d eye/ear irrigation			
				e Post mortem care			
				f Collection, labeling and delivering laboratory specimens (blood, urine, sputum, wound, stool)			
				C. Medication Administration: Demonstrates ability to administer, monitor and document medications for patients.			
				1 Medication Administration techniques			
				a Oral			

Self Assessment				Competency for the Licensed Practical/ Vocational Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				b Intra muscular			
				c Subcutaneous			
				d Suppositories			
				e Ear, eye, nose drops			
				f Heparin administration			
				g Insulin administration, site rotation			
				h Assessment for side effects, adverse reactions, therapeutic response			
				D. Infection Control			
				1 Hand washing technique	*		
				2 Aseptic technique	*		
				3 Proper bag technique	*		
				4 Safe needle technique	*		
				5 Personal protective equipment	*		
				6 Exposure control plan	*		
				7 TB exposure control plan	*		
				8 Reporting of infections for patient and personnel	*		
				9 Standard precautions	*		
				E. Equipment			
				1 Displays knowledge of the following			
				a Electric bed			
				b Special beds			
				c Alternating pressure mattress			
				d Infusion pumps			
				e Ambulatory infusion devices			
				2 Home Glucose Monitoring			
				a Verbalizes purpose of test	*		
				b Specimen collection	*		
				c Instrument calibration	*		

Self Assessment				Competency for the Licensed Practical/ Vocational Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				d Quality control process	*		
				e Test correctly performed and interpreted	*		
				3 Other			
				F. Safety			
				1 Restraints, indications and policy			
				2 Fire extinguishers			
				3 Emergency preparedness			
				4 Hazardous materials			
				5 Assessment of patient safety risks and home safety			
				G. Patient Education			
				1 Determine patient and family learning needs	*		
				2 Sets measurable objectives	*		
				3 Develops/implements teaching plan	*		
				4 Evaluates effectiveness of teaching	*		
				5 Revises teaching plan based on patient needs	*		
				6 Documents response to teaching	*		
				7 Provides instruction in the following			
				a Emergency care	*		
				b Diet and nutrition	*		

Comments _____

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Employee Signature Date

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Supervisor Signature Date

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Preceptor(s) Date

Preceptor(s) _____ Date _____

Preceptor(s) _____ Date _____

INITIAL COMPETENCY ASSESSMENT SKILLS CHECKLIST

(Sample for the Medical Social Worker)

Key for Evaluation Method
(to be determined by organization):

Verbal Test	=	**V**
Written Test	=	**W**
Observation	=	**O**
Demonstration=	**D**	
Special Training	=	**ST**

INITIAL COMPETENCY ASSESSMENT SKILLS CHECKLIST— MEDICAL SOCIAL WORKER

Name _____

Date of Employment _____ Date Completed _____

Self Assessment				Competency for the Medical Social Worker	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				A. Demonstrates ability to process paperwork and associated functions necessary to facilitate:			
				1 Knowledge of Assessment Process			
				a Health and psychosocial history	*		
				b Development of Problem List	*		
				c Assists in the development of care plan	*		
				d Assesses response to treatment	*		
				e Establishes and revises goals	*		
				f DC planning	*		
				g Conducts complete initial evaluation	*		
				h Other			
				2 Documentation skills			
				a 485, 486, 487			
				b Progress notes, flow charts			
				c Summary report			
				d Incident/variance reporting			
				e Other			
				3 Adheres to POC			
				a Reviews POC prior to care	*		
				b Performs services as ordered	*		
				c Documents according to POC	*		
				d Communicates/coordinates as appropriate	*		
				e Other			
				4 Knowledge of Medicare/State Home Health guidelines			

Self Assessment				Competency for the Medical Social Worker	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				a Criteria for participation			
				b Skilled reimbursable visit			
				c Other			
				5 Reports and documents key information to Physician, DC planner, Clinician, Pharmacist, Supervisor			
				6 Submits written summary reports as indicated			
				7 Attends/participates in case conference as required			
				8 Infection Control Practices			
				a Hand washing	*		
				b Personal protective equipment	*		
				c Exposure control plan	*		
				d Equipment care, as appropriate	*		
				e Other			
				9 Patient home safety			
				10 Other			
				B. Patient Education			
				1 Determines learning needs	*		
				2 Sets objectives	*		
				3 Develops/implements teaching plan	*		
				4 Evaluates effectiveness of teaching	*		
				5 Revises teaching plan	*		
				6 Documents patient response	*		
				7 Other			
				C. Assessment and Evaluation			
				1 Psychosocial assessment (social Hx , living situation, career, hobbies, support systems, decision making, communication difficulties, flexibility, prolonged mental illness/emotional problems, lack of community/caregiver support, family discord, ability to deal with loss)			

Self Assessment				Competency for the Medical Social Worker	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				2 Financial assessment (income, ability to meet needs, management)			
				3 Emotional assessment (response to illness, status, need for care, response to treatment)			
				4 Spiritual assessment (beliefs, practices, religion, role in care)			
				5 Terminal care assessment Ability to cope with death at home, patient/ caregiver receptive to hospice, concurrent life crisis, active grieving process, dependent family members, assistance needed with bringing closure to life			
				6 Other			
				D. Skilled Treatments/Interventions			
				1 Counseling for long range planning and decision making			
				2 Community resource planning and information			
				3 Short-term therapy related to illness			
				4 High risk intervention/patient safety risk			
				5 Arranges for long term care			
				6 Other interventions			
				7 Other			

Comments _____

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Employee Signature Date

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Supervisor Signature Date

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Preceptor(s) Date

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Preceptor(s) Date

_____ _____

Preceptor(s) Date

INITIAL COMPETENCY ASSESSMENT SKILLS CHECKLIST

(Sample for the Occupational Therapist)

Key for Evaluation Method
(to be determined by organization):

Verbal Test	=	**V**
Written Test	=	**W**
Observation	=	**O**
Demonstration=	**D**	
Special Training	=	**ST**

INITIAL COMPETENCY ASSESSMENT SKILLS CHECKLIST— OCCUPATIONAL THERAPIST

Name _____

Date of Employment _____ Date Completed _____

Self Assessment				Competency for the Occupational Therapist	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				A. Demonstrates ability to process paperwork and associated functions necessary to facilitate:			
				1 Knowledge of Assessment Process			
				a Health history and physical exam	*		
				b Development of Problem List	*		
				c Development and revision of care plan	*		
				d Assesses response to treatment	*		
				e Establishes and revises goals	*		
				f DC planning	*		
				g Conducts complete initial evaluation	*		
				h Other			
				2 Documentation Skills (accurate, timely, complete, legible)			
				a 485, 486, 487			
				b Progress notes, flow sheets			
				c Summary reports			
				d Incident reporting			
				e Other			
				3 Adheres to POC			
				a Reviews POC prior to care	*		
				b Performs services as ordered	*		
				c Documents according to POC	*		
				d Communicates/coordinates as appropriate	*		
				e Other			
				4 Knowledge of Medicare/State Guidelines			
				a Criteria for participation			

Self Assessment				Competency for the Occupational Therapist	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				b Skilled reimbursable visit			
				c Other			
				5 Reports and documents key information to Physician, DC planner, Clinician, Pharmacist, Supervisor			
				6 Submits written summary reports as indicated			
				7 Attends/participates in case conferences as required			
				8 Supervision of ancillary Personnel			
				a OTA			
				b HHA			
				9 Supply/HME requisition and management			
				10 Infection Control Practices			
				a Hand washing	*		
				b Personal protective equipment	*		
				c Exposure control plan	*		
				d Equipment care, as appropriate	*		
				e Other			
				11 Patient home safety			
				12 Other			
				B. Patient Education			
				1 Determines learning needs	*		
				2 Sets objectives	*		
				3 Develops/implement teaching plan	*		
				4 Evaluates effectiveness of teaching	*		
				5 Revises teaching plan	*		
				6 Documents patient response	*		
				7 Other			
				C. Clinical Skills—General			
				1 Vital Signs			
				2 Other			

Self Assessment				Competency for the Occupational Therapist	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				D. Assessment and Evaluation			
				1 Mental Status/Cognition (judgment, memory judgment, orientation, sequencing, following directions, problem solving)			
				2 Upper Extremity (ROM, strength, coordination)			
				3 Balance/trunk control			
				4 Ambulation/endurance			
				5 Transfers			
				6 Pain/edema, synergy			
				7 Visual/sensory/perceptual performance			
				8 Functional Findings			
				a Eating/feeding			
				b Dressing			
				c Hygiene			
				d Toileting			
				e Cooking/laundry/cleaning/home skills			
				f Writing/phone use			
				g Leisure interest			
				h Time use and structuring			
				i Medication management			
				j Other			
				9 Architectural barriers/equipment needs/safety			
				10 Other tests or measurements			
				E. Skilled Treatments/Interventions			
				1 Teaches ADL/IADL Program			
				2 Work simplification and energy conservation			
				3 Teaches muscle reeducation program			
				4 Perceptual motor training			
				5 Fine motor training/dexterity training/gross motor training			

Self Assessment				Competency for the Occupational Therapist	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				6 Neuro-developmental training			
				7 Sensory enhancement (tactile, ocular, gustatory, Olfactory, proprioceptive, auditory, vestibular, kinesthesia)			
				8 Arranges orthotics/splinting			
				9 Arranges adaptive equipment			
				10 Teaches caregiver exercises/activities			
				11 Safety evaluation/environment adaption recommendations			
				12 Work capacity evaluation			
				13 Other			

Comments _____

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Employee Signature Date

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Supervisor Signature Date

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Preceptor(s) Date

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Preceptor(s) Date

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Preceptor(s) Date

INITIAL COMPETENCY ASSESSMENT SKILLS CHECKLIST

(Sample for the Physical Therapist)

Key for Evaluation Method
(to be determined by organization):

Verbal Test	=	**V**
Written Test	=	**W**
Observation	=	**O**
Demonstration	=	**D**
Special Training	=	**ST**

INITIAL COMPETENCY ASSESSMENT SKILLS CHECKLIST—PHYSICAL THERAPIST

Name _____

Date of Employment _____ Date Completed _____

Self Assessment				Competency for the Physical Therapist	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				A. Demonstrates ability to process paperwork and associated functions necessary to facilitate:			
				1 Knowledge of Assessment Process			
				a Health history and physical exam	*		
				b Development of Problem List	*		
				c Development and revision of care plan	*		
				d Assesses response to treatment	*		
				e Establishes and revises goals	*		
				f DC planning	*		
				g Conducts complete initial valuation	*		
				h Other			
				2 Documentation Skills (accurate, legible, timely, and complete)			
				a 485, 486, 487			
				b Progress notes, flow charts			
				c Summary report			
				d Incident/Variance reporting			
				e Other			
				3 Adheres to POC			
				a Reviews POC prior to care	*		
				b Performs services as ordered	*		
				c Documents according to POC	*		
				d Communicates/coordinates if appropriate	*		
				e Other			

Self Assessment				Competency for the Physical Therapist	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				4 Knowledge of Medicare/State Guidelines			
				a Criteria for participation			
				b Skilled reimbursable visit			
				c Skilled reimbursable visit			
				d Other			
				5 Reports and documents key information to Physician, DC Planner, Clinician, Pharmacist, Supervisor			
				6 Participates as team member			
				7 Submits written summary reports as indicated			
				8 Attends/participates in case conference as required			
				9 Supervision of Ancillary Personnel			
				a PTA			
				b HHA			
				10 Supply/HME requisition and management			
				11 Infection Control Practices			
				a Hand washing	*		
				b Personal protective equipment	*		
				c Exposure control plan	*		
				d Equipment care, as appropriate	*		
				e Other			
				12 Patient home safety			
				13 Other			
				B. Patient Education			
				1 Determines learning needs			
				2 Sets objectives	*		
				3 Develops/implement teaching plan	*		
				4 Evaluates effectiveness of teaching	*		
				5 Revises teaching plan	*		
				6 Documents patient response	*		

Self Assessment				Competency for the Physical Therapist	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				7 Other			
				C. Clinical Skills—General			
				1 Vital Signs/I&O			
				2 Other			
				D. Assessment and Evaluation			
				1 Cognition/communication			
				2 Musculoskeletal-Skeletal (ROM, posture, deformity)			
				3 Pain (location, intensity, relief)			
				4 Neuro-Muscular Function (motor control, strength, coordination, tone, reflexes)			
				5 Sensation			
				6 Endurance			
				7 Functional Findings			
				a Bed mobility			
				b Gait			
				c Transfers			
				d Equipment management			
				8 Environmental eval/architectural barriers			
				9 Other tests or measurements			
				E. Skilled Treatments/Interventions			
				1 Perform therapeutic exercises			
				a Active			
				b Passive			
				c Strengthening and endurance			
				d Other			
				2 Transfer Activities			
				3 Mobilization			
				a Bed mobility			
				b Gait training			

Self Assessment				Competency for the Physical Therapist	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				c Other			
				4 Use of Physical agents			
				a Ultrasound			
				b Hot/cold packs			
				c TENS\FES			
				d Massage			
				e Other			
				5 Prosthetic Training			
				a Care of prosthesis			
				b Stump conditioning			
				c Other			
				6 Assistive Devices			
				a Fit/adjustment			
				b Gait training			
				c Safety			
				d Other			
				7 Fabricates orthotic device, instructs in use			
				8 Management and evaluation of the patients care plan			
				9 Other			

Comments _____

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Employee Signature Date

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Supervisor Signature Date

Preceptor(s) Date

Preceptor(s) Date

Preceptor(s) Date

INITIAL COMPETENCY ASSESSMENT SKILLS CHECKLIST

(Sample for the Physical Therapy Assistant)

Key for Evaluation Method

(to be determined by organization):

Verbal Test	=	**V**
Written Test	=	**W**
Observation	=	**O**
Demonstration=	**D**	
Special Training	=	**ST**

INITIAL COMPETENCY ASSESSMENT SKILLS CHECKLIST—PHYSICAL THERAPIST ASSISTANT

Name _____

Date of Employment _____ Date Completed _____

Self Assessment				Competency for the Physical Therapist Assistant	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				A. Demonstrates ability to process paperwork and associated functions necessary to facilitate:			
				1 Knowledge of Assessment Process			
				a Assesses response to treatment			
				b Other			
				2 Documentation Skills (accurate, legible, timely, and complete)			
				a Progress Notes, flow charts	*		
				b Incident/Variance reporting	*		
				c Other			
				3 Adheres to POC			
				a Reviews POC prior to care	*		
				b Performs services as ordered	*		
				c Documents according to POC	*		
				d Communicates/coordinates as appropriate	*		
				e Other			
				4 Knowledge of Medicare/State Guidelines			
				a Criteria for participation			
				b Skilled reimbursable visit			
				c Other			
				5 Reports and documents key information to Physician, DC planner, Clinician, Pharmacist, Supervisor	*		
				6 Participates as team member	*		
				7 Submits written summary reports as indicated	*		
				8 Attends/participates in case conference as required	*		

Self Assessment				Competency for the Physical Therapist Assistant	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following.					
YES	NO	YES	NO				
				9 Supply/HME requisition and management			
				10 Infection Control Practices			
				a Hand washing	*		
				b Personal protective equipment	*		
				c Exposure control plan	*		
				d Equipment care, as appropriate	*		
				e Other			
				11 Patient home safety			
				12 Other			
				B. Patient Education			
				1 Develops/implement teaching plan			
				2 Evaluates effectiveness of teaching			
				3 Documents patient response			
				4 Other			
				C. Clinical Skills—General			
				1 Vital Signs/I&O			
				2 Other			
				D. Skilled Treatments/Interventions			
				1 Perform therapeutic exercises			
				a Active			
				b Passive			
				c Strengthening and endurance			
				d Other			
				2 Transfer Activities			
				3 Mobilization			
				a Bed mobility			
				b Gait training			
				c Other			
				4 Use of Physical agents			

Self Assessment				Competency for the Physical Therapist Assistant	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				a Ultrasound			
				b Hot/cold packs			
				c TENS\FES			
				d Massage			
				e Other			
				5 Prosthetic Training			
				a Care of prosthesis			
				b Stump conditioning			
				c Other			
				6 Assistive Devices			
				a Fit/adjustment			
				b Gait training			
				c Safety			
				d Other			
				7 Fabricates orthotic device, instructs in use			
				8 Other			

Comments _____

_____

_____

_____ _____

Employee Signature Date

_____ _____

Supervisor Signature Date

_____ _____

Preceptor(s) Date

_____ _____

Preceptor(s) Date

_____ _____

Preceptor(s) Date

INITIAL COMPETENCY ASSESSMENT SKILLS CHECKLIST—REGISTERED NURSE

Name _____

Date of Employment _____ Date Completed _____

Self Assessment				Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				A. Demonstrates ability to process paperwork and associated functions necessary to facilitate:	*		
				1 Admission to organization			
				a Initiates assessment form	*		
				b Initiates care plan based on assessment	*		
				c Knowledge of nursing process	*		
				d Health history/physical exam	*		
				e Development of problem list and care planning	*		
				f Conducts complete initial evaluation	*		
				2 Transfer of patient	*		
				3 Care coordination/discharge planning	*		
				a Care planning	*		
				b Case conference	*		
				c 60 day summary	*		
				d Case management	*		
				e Adheres to POC	*		
				f Reports and documents key information to physician, DC planner, Case Manager, pharmacist, supervisor	*		
				g Coordinates community resources	*		
				4 Documentation			

Self Assessment				Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				a Medicare guidelines for documentation	*		
				b Corrections to the clinical record	*		
				c Accident/incident reports	*		
				d Clinical notes, flow charts	*		
				5 Other			
				a Supervision of ancillary personnel			
				b Supply requisition and management			
				B. Review of Systems: Demonstrates ability to obtain and document appropriate age specific history/ assessment for patients in the following categories:			
				1 Pulmonary System			
				a Pulmonary Assessment			
				b Tracheostomy care			
				c Oxygen administration			
				d Pharyngeal suction			
				e Use of oral/nasal inhalers			
				f Oxymeter			
				g CPAP			
				h Oxygen mask, nasal cannula, concentrator, portable oxygen			
				i Airway insertion			
				j SVN/Nebulizer treatment			
				k Home ventilator management			
				l Foreign body airway obstruction			
				m Breathing exercises/incentive spirometry			
				n Other			
				2 Cardiovascular System			

Self Assessment				Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				a Cardiovascular assessment			
				b Pulses (apical, radical, femoral, pedal)			
				c Edema assessment and management			
				d Supine and orthostatic blood pressure			
				e NTG use, inhaler use			
				f CPR			
				g Energy conservation techniques			
				h Other			
				3 Neurologic System			
				a Neurologic assessment			
				b Aphasia care			
				c Mental status exam			
				d Seizure precautions			
				e Spinal cord injuries care			
				f Head injury care			
				g Other			
				4 Gastrointestinal System			
				a Gastrointestinal assessment			
				b NG tube insertion/care			
				c Jejunostomy tube care			
				d Gastrostomy tube care			
				e Enteral feedings			
				f Suction machine(s)			
				g Ostomy care			
				h Dysphagia precautions			
				i Impaction removal			
				j Enema			

Self Assessment				Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				k Bowel training			
				l Other			
				5 Genitourinary System			
				a GU assessment			
				b Urinary catheterization insertion and care (male and female)			
				c Irrigation of catheters			
				d Obtaining specimens			
				e Removal of urinary catheter			
				f Care of supra-pubic catheter			
				g Care of urostomy			
				h Bladder training			
				i Nephrostomy tubes			
				j Knowledge of types of catheters and indications for use (straight, indwelling, condom)			
				k Ileostomy care			
				l Incontinence care			
				m GU post op care			
				n Other			
				6 Integumentary/Wounds/Dressings			
				a Assessment of skin/wound			
				b Measurement of wounds			
				c Wound irrigation			
				d Wet to dry dressing(s)			
				e Decubitis care			
				1 Assessment and staging			
				2 Prevention			
				3 Various treatments (hydrocolloid, calcium alginate, transparent films)			

Self Assessment				Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				4 Documentation/pictures			
				f Ace wrap, cast care, compresses			
				g Hemovac			
				h Sterile dressing change			
				i Suture/staple removal			
				7 Musculoskeletal System			
				a Assessment			
				b Range of motion (ROM)			
				c TED hose			
				d Total knee care			
				e Total hip care			
				f Cast assessment and care			
				g Devices			
				1 Walker			
				2 Wheelchair			
				3 Transfer board			
				4 Hoyer lift			
				h Pain assessment			
				i Transfers			
				j Other			
				8 Pain assessment and management			
				a Conducts pain evaluation which includes location, onset, intensity, duration, alleviating factors	*		
				b Utilizes a pain rating scale to collect data	*		
				c Knowledgeable about types of pain (neuropathic, visceral, bone, smooth muscle, psychologic)	*		
				d Knowledgeable about drug therapies indication and dosing			

Self Assessment				Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				1 NSAIDS	*		
				2 Steroids	*		
				3 Benzodiazepines	*		
				4 Tricylic antidepressants	*		
				5 Anticonvulsants	*		
				6 Narcotics	*		
				7 Other			
				e Non-pharmacologic methods			
				1 Relaxation (guided imagery, meditation, massage)	*		
				2 Psychologic (biofeedback, therapy)	*		
				3 Neurologic (TENS)	*		
				4 Ice/heat	*		
				f Patient/family teaching			
				1 Drug use, side effects	*		
				2 Management of constipation	*		
				3 Addiction vs tolerance	*		
				4 Other			
				9 Metabolic			
				a Assessment			
				b Diabetic assessment and teaching			
				1 Insulin types and teaching			
				2 Use, care and teaching of glucose monitoring system			
				3 Diet, exercise and sick day teaching			
				4 Signs and symptoms of Hypo-Hyperglycemic reactions			
				5 Foot and skin care			

Self Assessment				Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				c Coumadin therapy			
				d Other			
				10 Behavioral Assessment			
				a Psychosocial Status			
				b Suicide precautions			
				c Psychotropic drugs			
				d Care of the demented patient			
				e Other			
				11 Miscellaneous Skills			
				a Vital signs			
				b Intake and output			
				c Caring for immuno-compromised patients			
				d Eye/ear irrigation			
				e Post mortem care			
				f Collection, labeling and delivering laboratory specimens (blood, urine, sputum, wound, stool)			
				g Concepts of death and dying			
				1 Normal vs abnormal	*		
				2 Cultural attitudes toward death	*		
				3 Values of patient/family	*		
				4 Denial and coping mechanisms	*		
				5 Grief and family, children and others	*		
				6 Anticipatory grief	*		
				7 Other			
				C. Medication Administration: Demonstrates ability to administer, monitor and document medications for patients.			

Self Assessment				Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				1 Medication Administration Techniques			
				a Oral			
				b Intra muscular			
				c Intravenous-bolus/push			
				d Subcutaneous			
				e Total Parenteral Nutrition			
				f Suppositories			
				g Ear, eye, nose drops			
				h Heparin administration			
				i Insulin administration, site rotation			
				j Assessment for side effects, adverse reactions, therapeutic response			
				2 Intravenous Therapy			
				a Technique and care of			
				1 Venipuncture			
				2 Butterfly			
				3 Over the needle catheter			
				4 Regulation of IV flow rate, use of infusion pumps			
				b Other			
				3 Central Venous Access Devices			
				a Drawing blood from			
				b Site care			
				c Flushing			
				d Cap change			
				e Needleless system			
				f Other			
				D. Infection Control			
				1 Hand washing technique	*		

Self Assessment				Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				2 Aseptic technique	*		
				3 Proper bag technique	*		
				4 Safe needle technique	*		
				5 Personal protective equipment	*		
				6 Exposure control plan	*		
				7 TB exposure control plan	*		
				8 Reporting of infections for patient and personnel	*		
				9 Standard precautions	*		
				E. Equipment			
				1 Displays knowledge of the following			
				a Electric bed			
				b Special beds			
				c Alternating pressure mattress			
				d Infusion pumps			
				e Ambulatory infusion devices			
				2 Home Glucose Monitoring			
				a Verbalizes purpose of test	*		
				b Specimen collection	*		
				c Instrument calibration	*		
				d Quality control process	*		
				e Test correctly performed and interpreted	*		
				3 Other			
				F. Safety			
				1 Restraints, indications and policy			
				2 Fire extinguishers			
				3 Emergency preparedness			
				4 Hazardous materials			

Self Assessment				Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				5 Assessment of patient safety risks and home safety			
				G. Patient Education			
				1 Determine patient and family learning needs	*		
				2 Sets measurable objectives	*		
				3 Develops/implements teaching plan	*		
				4 Evaluates effectiveness of teaching	*		
				5 Revises teaching plan based on patient needs	*		
				6 Documents response to teaching	*		
				7 Provides instruction in the following			
				a Emergency care	*		
				b Diet and nutrition	*		
				c Medications	*		
				1 Route, dosage, frequency, side effects, adverse reactions, safe storage, labeling, indications, drug/food interactions, home monitoring program, therapeutic blood levels	*		
				8 Provides instruction about advance directives and patient rights			
				9 Other			

INITIAL COMPETENCY ASSESSMENT SKILLS CHECKLIST

(Sample for the Speech–Language Pathologist)

Key for Evaluation Method
(to be determined by organization):

Verbal Test	=	**V**
Written Test	=	**W**
Observation	=	**O**
Demonstration=	**D**	
Special Training	=	**ST**

INITIAL COMPETENCY ASSESSMENT SKILLS CHECKLIST— SPEECH–LANGUAGE PATHOLOGIST

Name _____

Date of Employment _____ Date Completed _____

Self Assessment				Competency for the Speech—Language Pathologist	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				A. Demonstrates ability to process paperwork and associated functions necessary to facilitate:			
				1 Knowledge of Assessment Process	*		
				a Health history and physical exam	*		
				b Development of problem list	*		
				c Development and revision of care plan	*		
				d Assesses response to treatment	*		
				e Establishes and revises goals	*		
				f DC planning	*		
				g Conducts complete initial evaluation	*		
				h Other			
				2 Documentation Skills (accurate, timely, complete and legible)			
				a 485, 486, 487			
				b Progress Notes, flow charts			
				c Summary reports			
				d Incident reporting			
				e Other			
				3 Adheres to POC			
				a Reviews POC prior to care	*		
				b Performs services as ordered	*		
				c Documents according to POC	*		
				d Communicates/coordinates as appropriate	*		
				e Other			
				4 Knowledge of Medicare/ State Guidelines			
				a Criteria for participation			

Self Assessment				Competency for the Speech—Language Pathologist	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				b Skilled reimbursable visit			
				c Other			
				5 Reports and documents key information to Physician, DC planner, Clinician, Pharmacist, Supervisor			
				6 Participates as team members			
				7 Submits written summary reports as indicated			
				8 Attends/participates case conferences as required			
				9 Supervision of Ancillary Personnel			
				a HHA			
				10 Supply/ HME requisition and management			
				11 Infection Control Practices			
				a Hand washing	*		
				b Personal protective equipment	*		
				c Exposure control plan	*		
				d Equipment care, as appropriate	*		
				e Other			
				12 Patient home safety			
				13 Other			
				B. Patient Education			
				1 Determines learning needs	*		
				2 Sets objectives	*		
				3 Develops/implements teaching plan	*		
				4 Evaluates effectiveness of teaching	*		
				5 Revises teaching plan	*		
				6 Documents patient response	*		
				7 Other			
				C. Clinical Skills—General			
				1 Vital Signs/I&O			
				2 Other			

Self Assessment				Competency for the Speech—Language Pathologist	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				D. Assessment and Evaluation			
				1 Verbal expression			
				2 Auditory comprehension			
				3 Non-verbal expression			
				4 Graphic expression			
				5 Reading comprehension			
				6 Speech intelligibility			
				7 Visual comprehension			
				8 Voice			
				9 Prosody			
				10 Latency of response			
				11 Cognitive function			
				12 Arithmetic skills			
				13 Oral/motor/vegetative functions			
				14 Functional skills			
				a Loss of food/drooling			
				b Bolus control			
				c Transit time			
				d Swallowing reflex			
				e Cough/choke			
				f Vocal quality—post intake			
				g Pocketing /stasis			
				15 Other tests			
				E. Skilled Treatments/Interventions			
				1 Speech articulation disorder			
				a Dysarthria (oral-motor exercises, auditory/visual sounds, words, cues, self-monitoring)			
				b Apraxia (auditory, tactile, visual cues with/without mirror, speech, melody, rhythm practice)			

Self Assessment				Competency for the Speech—Language Pathologist	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				2 Language Disorder Aphasia (multisensory stimulation, auditory comprehension strengthening, picture/word board/ gestures)			
				3 Dysphagia (oral sensitivity training, positioning, swallowing, diet, exercises, safety program, compensation techniques)			
				4 Rhythm (voicing control, breath steam)			
				5 Voice Disorder (Compensatory techniques, vocal hygiene, prosthesis-artificial larynx, palatal lift)			
				6 Hearing deficit (evaluate and referral)			
				7 Teach non-oral communication skills (sign, board, electric or mechanical, gestural)			
				8 Other interventions/teaching			
				9 Other			

Comments _____

_____

_____

_____ _____

Employee Signature Date

_____ _____

Supervisor Signature Date

_____ _____

Preceptor(s) Date

_____ _____

Preceptor(s) Date

_____ _____

Preceptor(s) Date

ORIENTATION
Policy No. 1-022.1

PURPOSE

To provide guidelines for the orientation process

POLICY

All personnel will be required to attend an orientation program upon employment and at the time of reassignment The goal of orientation will be to inform and instruct new personnel regarding Intrepid USA Home Health's mission, policies and procedures, benefits (if applicable), the performance appraisal process, competency testing, as well as individual responsibilities and relationships to other personnel

All personnel will demonstrate knowledge and proficiency in skills appropriate to their assigned responsibilities during the orientation period

All clinical personnel prior to being assigned to care must present documentation of current CPR certification CPR certification must be renewed per American Heart Association guidelines

(See "Competency Based Orientation" Policy No 3-002)

PROCEDURE

1 The orientation content for all personnel will include the following as applicable and appropriate to the care and service provided

   A General company orientation including the organization's mission/philosophy, policy and procedures, environmental safety program, etc

   B Review of organizational chart and lines of authority and responsibility

   C Hours of work

   D Job related responsibilities (job description), including orientation to equipment, if applicable

   E Care and services provided by the organization

   F Baseline skills assessments as applicable to job classification

   G Infection prevention and control within the organization and the home care setting

   H Performance standards

I Confidentiality of organization and patient information/HIPAA regulations

J Documentation requirements (record keeping and requirements)

K OSHA compliance

L Medical Device Reporting/Incident Reporting

M Equal Employment Opportunity Act

N Ethical issue identification and resolution including conflict of interest, professional boundaries, etc

O Sexual Harassment Act

P Compensation and benefits information (salary/wages, benefits, etc)

Q *Unemployment and workers' compensation*

R Malpractice coverage, as applicable

S Collective bargaining information, as applicable

T Drug testing

U Family/State Medical Leave Act

V Cultural Diversity and communication barriers

W Client/Patient Rights including Advance Directives

Note Intrepid USA Home Health should review rights and responsibilities of the patient, including, but not limited to, patient complaint procedures and how staff will access language services and auxiliary aids

X Standards of Conduct and Ethical Issues

Y Quality (Performance) Improvement Plan and activities

Z Compliance Plan and employee compliance responsibilities

AA Emergency Management Plan

BB Handling of patient complaints/grievances

CC If applicable, conveying of charges for care/services and OASIS requirements

2 The orientation process, for all personnel will consist of both didactic and field supervision Observation visits will be made by an appropriate supervisor to assess the skills demonstrated by new or reassigned personnel as well as reinforce the information presented during classroom time

3 The orientation process for contract personnel will consist of the following

A For contract personnel, the contracted organization will have one (1) member of the organization that has been oriented to Intrepid USA Home Health policies, procedures, and information presented during orientation That individual will be responsible for orienting other contract personnel from that organization to Intrepid USA Home Health

B For personnel the organization individually contracts with, a preceptor will be assigned during the orientation process

4 During the orientation process, the supervisor will be responsible for evaluating the knowledge and skills of the personnel being oriented Any areas of concern will be brought to the immediate attention of the new personnel Appropriate guidance/monitoring will be provided or additional training recommended, if needed

5 Assigned personnel will orient newly assigned personnel or volunteers to their responsibilities and to the patient needs when changes in patient assignment occur The following will be included as appropriate

A Patient needs including physical, psychosocial, and environmental aspects of care and service

B Personnel responsibilities

C Specific care and services to be provided

6 Orientation of new and reassigned personnel may include verbal or written instructions Orientation may be provided in the patient's home

7 Orientation of current employees assigned to new job classifications will include

A Lines of authority and responsibility

B Hours of work

C Job responsibilities

D Skills assessment as applicable to the specific job classification

E Documentation responsibilities

8 A Personnel Orientation Checklist (See "Personnel Orientation Checklist" Addendum 1-022 A) will be completed for all new personnel New personnel will sign and date when their orientation has been completed

9 The supervisor will sign and date the checklist when new personnel have completed all the required activities

10 The probationary period will be 90 days, during which time the orientation process may be extended if the supervisor, or employee feels it is warranted

COMPETENCY BASED ORIENTATION
Policy No. 3-002.1

PURPOSE

To evaluate skills and experience upon hire using a standard tool

POLICY

The organization ensures that the competency of all personnel is assessed on hire, prior to providing care to organization patients

GUIDELINES

Orientation is intended to prepare the employee to perform the duties of a new role with a competent level of skill Competency Based Orientation (CBO) is a method of learning which stresses performance of competencies which relate directly to the employee's job description There is flexibility in the time and sequence of the orientation activities

A preceptor(s) will be assigned to each orientee The primary role of the preceptor(s) is to facilitate the learning and socialization of the new employee during the orientation program

PRECEPTOR OBJECTIVES

1 Present information needed to function in the home health agency

2 Observe specific tasks to assure satisfactory performance of essential duties and procedures

3 Identify problems and additional learning needs as early as possible in the orientation process

ORIENTEE OBJECTIVES

1 Assess the Physical and Functional characteristics, Psychosocial characteristics, past and current medical history, current medication and treatments, patient/family educational needs, discharge planning needs, and environmental and/or equipment needs of each patient assigned

2 Plan care for each patient based on medical plan, standards of patient care and practice, and standards of performance

3 Implement care according to the discipline specific medical plan of care, standards of patient care, and standards of nursing practice, and standards of performance

4 Evaluate the effect of discipline specific interventions

5 Exhibit professional behavior

6 Provide high quality of service in all aspects of job performance

COMPETENCY ORIENTATION SKILLS CHECKLIST GUIDELINES

1 Organization personnel are given the appropriate job category Orientation Checklist during the orientation process

2 Organization personnel rate their knowledge and abilities in the various procedures routinely performed in the course of their jobs on the self-assessment position of the checklist

3 If organization personnel work in a specialized area (i e , Infusion Therapy) they must complete the Basic Inventory plus the specialty Orientation Skills Checklist (Example registered nurse who does IV therapy completes the Basic Registered Nurse and Infusion Nurse)

4 The method to evaluate each indicator will be documented on the checklist

When the Competency Orientation Skills Checklist is completed, it is reviewed by the preceptor and the Clinical Supervisor Additional training and education is performed as indicated until competence is demonstrated

MIGUEL SCHMITZ, M.D.
Board Certified Orthopaedic Surgeon
Fellowship Trained in Spine Surgery & Sports Medicine
RYAN SAUNDERS, PA-C
CHASE KAUFMAN, PA-C

June 15, 2020

C/O Craig Board; Patient Advocate
9715 North Nevada
Spokane, Washington 99218

RE: Intrepid Home Health

To Whom It May Concern:

I would like to express my sincerest recommendation for Intrepid Home Health to serve Stevens County I have worked alongside Intrepid staff members for the past twelve months at Alpine Orthopaedics.

The team is always available and willing to help with our patients which never ceases to amaze me. Intrepid is able to provide quality services to our patients which lowers the rehospitalization rate and would highly benefit the patients who reside in rural areas. Intrepid also accepts a wide range of insurance providers which would be beneficial to those in Stevens County, as the current home health provider is limited. For patients currently living in Stevens County, we have been unsuccessful setting up home health services due to the availability and staffing, insurance coverage, and not being able to comply with the 48-hour Medicare guideline. This has caused patients to return to the hospital, then to the nursing home and in some cases has caused the patient not to be able to return home safely. Finding alternative living arrangements causes stress on patients and their families leading to further decline in health.

Intrepid's office team shows great organizational skills and time management skills, so they are able to see patients sooner than the current provider for Stevens County By expanding the services of Intrepid, this would eliminate the deficit and give patients more options to stay home, stay safe, and remain out of hospitals and skilled nursing facilities.

Sincerely,

Electronically signed by Miguel A Schmitz, MD
MAS:sja
Dictated but not read

AVALON CARE CENTER - NORTHPOINTE

6/5/2020

To Whom It May Concern,

As the Director of Social Services for a large skilled nursing facility in Spokane, WA, I often have residents that reside in Stevens County and return there upon discharge from our facility. Often, these people would benefit greatly in their transition home with the support of home health Too frequently, our residents returning to Stevens County are unable to receive the home health they need as there is currently only one home health agency servicing Stevens County and they are often short staffed, or otherwise unable to accept new patients Granting Intrepid Home Health a Certificate of Need for Stevens County will be extremely helpful in providing access to the quality healthcare the residents of Stevens County need. Thank you for your consideration in this matter.

AVALON CARE CENTER AT NORTHPOINTE

SARA BELZMAN, MSW SSD
SOCIAL SERVICES NORTH

9827 N Nevada St | Spokane WA 99218

P 509 468 7000x3159 | F 509 468 1659

sara.belzman@avalonhealthcare.com

MedBridge at ManorCare Health Services - Spokane
6025 N Assembly, Spokane, WA 99205
509 326 8282
509 326 4790 (Fax)

MedBridge®
Your Bridge From Hospital To Home

May 27, 2020

To Whomever it May Concern:

I would like to express our sincerest recommendation for Intrepid Home Health to serve Stevens County. I have worked alongside Intrepid staff members for the past twelve months at HCR Manorcare.

The team is always available and willing to help with our patients which never ceases to amaze us. Intrepid is able to provide quality services to our patients which lowers the re-hospitalization rate and would highly benefit the patients who reside in rural areas. Intrepid also accepts a wide range of insurance providers which would be beneficial to those in Stevens County as the current home health provider is limited.

For patients currently living in Stevens County, we have been unsuccessful setting up home health services due to availability and staffing, insurance coverage, and not being able to comply with the 48hour Medicare guideline. This has caused patients to return to the hospital, then to the nursing home and in some cases has caused the patient not to be able to return home safely. Finding alternate living arrangements causes stress on patients and their families leading to further decline in health.

Intrepid's office team shows great organizational skills and time management skills so they are able to see patients sooner than the current provider for Stevens County. By expanding the services of Intrepid, this would eliminate the deficit and give patients more options to stay home, stay safe, and remain out of hospitals and skilled nursing facilities.

Sincerely,

The Manorcare Team

Eric Sohn, MD

Joel Brooks, RN Unit Manager

Stephanie Gladden, Social Services Director

NEW Health

PLEASE SEND INFORMATION TO THE CLINIC LOCATION CHECKED BELOW:

- ☐ **Chewelah Community Health Center**
  Phone: 509-935-8424 / Fax: 509-935-8402
- ☐ **Colville Community Health Center**
  Phone: 509-684-1440 / Fax: 509-684-2745
- ☐ **Kettle River Community Health Center**
  Phone: 509-684-5521 / Fax: 509-684-1464
- **Lake Spokane Community Health Center**
  Phone: 509-464-3627 / Fax: 509-466-9517
- ☐ **Loon Lake Community Health Center**
  Phone: 509-233-8412 / Fax: 509-233-2864
- ☐ **Northport Community Health Center**
  Phone: 509-732-4252 /Fax: 509-732-4318
- ☐ **Selkirk Community Health Center**
  Phone: 509-442-3514 / Fax: 509-442-3436
- ☐ **Springdale Community Health Center**
  Phone: 509-258-4234 / Fax: 509-258-4499
- ☐ **Colville Community Dental Clinic**
  Phone: 509-684-1440 / Fax: 509-684-1277
- ☐ **Lake Spokane Community Dental Clinic**
  Phone: 509-464-0002 / Fax: 509-464-2378
- ☐ **Springdale Community Dental Clinic**
  Phone: 509-258-7543 / Fax: 509-258-7524

CONFIDENTIAL FAX

To: Craig Board **FAX #:** 466-9325

From: Sherri

Re: _____

Date: _____ **Pages:** _____ (including this page)

☐ **Urgent** ☐ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **As Requested**

MESSAGE: _____

CONFIDENTIALITY NOTICE

This facsimile transmission is intended only for the addresses named above. It contains information that is privileged, confidential or otherwise protected from use and disclosure. If you are not the intended recipient, you are hereby notified that any review, disclosure, copying or dissemination of this transmission or the taking of any action in reliance on its contents, or other use is strictly prohibited. If you have received this information in error, please notify us by telephone immediately so that we can arrange for its return to us.

Thank you for your cooperation.

NEW Health Programs Association

5/29/20

To Whom it may concern,

I am a referral coordinator for Stevens County. Our population is this county are very under served with home health care due to lack of availability. We have multiple patients needing the service that home health care provides but because of our remote location often our patients have to go without services they so badly need.

It would be so helpful to have greater access to home health care in Stevens county to care for our elderly and ill patients.

Thank you for your consideration in this matter,

Sincerely,

Sherri Nogales, referral coord

Lisa M Smith

37214 N Prescott rd
Deer Park, WA 99006
Cell 360-580-1867
nurschelle@gmail com

Professional Summary

Eleven years of experience in Home Health with nine of those years in a Management position Seeking a position in the home health field to increase my knowledge and advance my experiences in the Home health arena

Licenses

Registered Nurse in the state of Washington

Skill Highlights

- Geriatric treatment knowledge
- leadership skills and ability to educate
- creatively
- management of operations financially
- and clinically
- Committed to compliance reporting
- skilled in assessments
- skilled in medication administration and
- reconciliation
- Broad medical terminology knowledge
- skilled in reading and performing within a budget
- skilled in reviewing oasis
- skilled in performing chart audits
- ability to multitask

Professional Experience

April 23, 2018

IntrepidUSA Healthcare Services

Responsible for planning, developing and directing the programs, services, activities and employees of the agency consistent with company policies. Accountable for agency's revenue and profit performance, adhere to company systems and compliance with State and Federal regulations Oversees implementation, maintenance and compliance with performance improvement activities; including the Corporate Compliance Program, chairs the home care agency's Professional Advisory Board and acts as the Privacy Officer Continually assesses the needs of internal and external employees and the customer to meet and exceed their expectations The Administrator is also responsible for continual growth and the profitability of the agency

June 2007 to March 2018

LHC Assured Home Health
Field Nurse
Aberdeen- June 2007- April 2009
Director of Nursing
Aberdeen- April 2009-November 2014
Spokane November 2014-Present
Performed Oasis, Chart audits, Reviewed 485 assessments, educated staff on compliance and quality issues, Managed office to work within budgets set for us Managed staffing, promoted team work, manage financials, evaluate staff performance, perform joint visits, prepare offices and staff for joint commission and state surveys, create and perform action plans for JC and state

August 2004 -June 2007

Grays Harbor Health and Rehab
Aberdeen, WA
MDS Coordinator-LPN
Left to pursue career in home health after completing my RN college degree

January 1995-August 2005

Grays Harbor Family Practice Center
Hoquiam, WA
LPN
Left to further my education and obtain my RN degree

July 1992-January 1995

Grays Harbor health and Rehab
Aberdeen, WA
LPN
Left for an office position that was more flexible with raising children

September 1988-July 1992

Grays Harbor Health and Rehab
Aberdeen, WA
CNA
Did not leave, continued to work as an LPN after I received my license

Education and Training

2007 **Grays Harbor Community College**
Aberdeen, WA, USA Nursing
ADN

1992 **Grays Harbor Community College**
Aberdeen, WA, USA Nursing
LPN

Provider Credential Search

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

Access to high volumes of Provider Credential Search data is available at our open data portal It gives users a variety of searching, filtering, and data exporting options We implemented this system to better serve our high-volume customers

Search Results

Select the credential number of the record you wish to view

Credentials Found (1)

NEW SEARCH

Credential	Last Name	First Name	MI	Credential Type	Credential Status	Year of Birth	CE Due Date	Enforcement Action
RN00171463	Smith	Lisa	M	Registered Nurse License	ACTIVE	1969	06/09/2020	No

Kristin Youmans

Cheney, WA 99004
kyoumans1966@gmail com
509-559-5191

To continue to work as a skilled Registered Nurse, learning new talents along the way and making a difference in our world

Work Experience

Registered Nurse Case Manager

Sunshine Home Health - Spokane, WA
March 2016 to Present

managing primarily West Plains area, South Hill, downtown.
Manage patient load to include direct patient care (diabetic education, med/pain management, body system/physiology education, wound care, IV/PICC line management, blood draws)
Oversight of bath aides and LPN's. Working directly with MD to bring in therapies as appropriate (PT, OT, ST, MSW, RD) Participation with team in case conferences

Registered Nurse Case Manager

Veterans Administration - Spokane, WA
January 2016 to March 2016

Worked on Primary Care Team triaging phone, educating pts
to disease management; facilitating other therapies as appropriate, oversight of LPN

Registered Nurse Care Transition Coordinator

Sacred Heart Medical Center - Spokane, WA
October 2015 to January 2016

Worked with Providence Medical Hospitalist
Group assuring continuity of care after discharge Arranged consults for patients with various teams, obtained PCPs and appointments as required, and assured correct medication filled at home.

Registered Nurse hired

St. Luke's Rehabilitation Institute - Spokane, WA
November 2012 to May 2015

for part time day shift. Assigned to Spinal Care unit and trained on Traumatic Brain Injury and Stroke units as well Responsible for diabetic management, IV
therapy, tube feeding, rehab nursing and wound care, intermittent catheters, bowel programs
Worked with patients with cardiac diseases, as well orthopedic issues including BKAs and spinal cord injuries Worked closely with NACs, Therapists and MDs for optimal patient care

Registered Nurse

Shriner's Children's Hospital - Spokane, WA
February 2013 to October 2014

on call as well as Night shift charge nurse responsible for preop and postop

pediatric population with orthopedic issues Care included epidural monitoring, art line monitoring as well as IV therapy, drains, chest tubes, medication dispensation Worked closely with house anesthesiologists and MDs for optimal care

Registered Nurse on Medical/Oncology unit

Holy Family Hospital - Spokane, WA
May 2014 to August 2014

Broad range of processes with emphasis on Med- Surg. Worked closely with New Vision program utilizing methadone tapers and CIWA protocol for addicts Emphasis on oncology patients with neutropenic precautions, IV therapy and PCA
management

Registered Nurse/Case Manager of West Plains area

Family Home Care/GENTIVA - Spokane, WA
February 2012 to December 2012

Cheney, Medical Lake, Airway Heights, Reardan Duties to include creating care plans, Oasis documentation for Medicare
Assessments, IV care, wound assessments/treatments, medication reconciliation and management, disease management/instructions to include diabetic education, COPD, cardiac
diseases and PT/INR monitoring, Orthopedic injury management, wound vacs, as well as palliative/ hospice care Work extensively with other professionals in disciplines such as PT, ST,
OT, HHA and MSW to provide holistic care Close communication with MD and writing orders.

Licensed Practical Nurse

Cheney Care Center - Cheney, WA
March 2010 to July 2012

Duties to include medication administration, wound treatments, blood draws, UA dipsticks, glucose and insulin monitoring, IV management, computer charting,
delegating, patient safety Extensive work with Alzheimer's patients

Nurse-Delegated duties, personal

Private Duty Care - Spokane, WA
May 2004 to March 2010

care/ADL's, housekeeping/meal-preparation, and companionship.

Educational Assistant

Cheney School District - Cheney, WA
September 2001 to April 2009

working with special needs/autistic elementary student.
Health Assistant maintaining health room filing, computer data-entry, vision/hearing screening, scoliosis screening, medication administration, epi-pen use, diabetic management, asthma management Monitored student with hydrocephalus and student with ileostomy.
Triaged school children, administering first aid as needed Health and safety-related instruction to classrooms

Certified nursing assistant

The Ark Family Home - Harrington, WA
May 1996 to June 2001

CNA, managing needs of 6 elderly residents

Private Duty Care - Spokane, WA
January 1988 to April 1996

CNA to patient who had suffered massive stroke and required total care, suctioning, diabetic management, tube feeding management, O2 therapy,

ST Luke's Extended Care - Spokane, WA
March 1987 to August 1989

CNA with emphasis in physical therapy and rehabilitation nursing.

Southcrest Nursing Home - Spokane, WA
April 1986 to May 1987

CNA working extensively with acute care patients requiring tracheotomy care.

Education

Bachelor of Science in Nursing
Western Governor's University
March 2015 to November 2015

Associate in Applied Science in Applied Science
Spokane Community College
January 2009 to December 2011

Pre Nursing
Spokane Falls Community College
April 2008 to December 2009

Liberal Arts Studies
Western Washington University/Eastern Washington University
September 1984 to January 1991

Nursing Licenses

RN

Skills

RN, Home Health, Care Management, RN, Care Management, Hospital, Home Care, Case Management, Medication Administration

Certifications and Licenses

BLS, ACLS

CPR

Additional Information

Volunteered in Guatemala two separate occasions for cleft palate surgeries and clinic work with indigenous population

Please note resume seems to have uploaded in a strange fashion; I do have a hard copy.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
PO Box 47852 • Olympia, Washington 98504-7852

January 9, 2015

Katherine Hassler
Intrepid Healthcare Services
9715 N. Nevada
Spokane WA, 99218

This packet contains information regarding the recent Medicare Survey of Intrepid Healthcare Services by the Washington State Department of Health Your Medicare Survey # 507109 was completed on January 8, 2015.

During the survey, **deficient practice** was found in the areas listed on the attached Statement of Deficiencies report(s). Enclosed are directions and due dates for completing the Plan of Correction to address those deficient practices. The Plan of Correction must be completed and returned to the address below, within ten days of your receipt of this letter. Due date **January 22, 2015**

Please carefully complete the Plan of Correction – the instructions are stated on pages 1 and 2 in the right column of the report. Be sure that each correction you write includes **ALL** four necessary elements as described in the instructions. **Plans of Correction missing vital information may be returned as incomplete and unacceptable.** Please make certain that signatures and initials are recorded on the report itself as bstated in the Plan of Correction instructions. **The Plan of Correction must clearly state**:

The regulation number and/or the tag number for EACH tag/deficiency. EACH tag must have its own specific Plan of Correction.

HOW the deficiency will be corrected
WHO is responsible for making the corrections
WHAT will be done to prevent reoccurrence and monitor for compliance
WHEN will the corrections be completed

Also enclosed is a patient/client and or personnel record list. This item is for your information only, and no response is required.

During licensing surveys, the Department of Health provides technical assistance to give you information to improve Intrepid Healthcare Services practices. Technical assistance is educational or informational. It is not a deficiency, and no response is required. During the recent survey, DOH staff provided technical assistance in these areas:

1) Recommend development of policy and procedure for wound care and congestive heart failure for licensed staff to maintain continuity of care for all patients.

2) Ensure all care plans are specific to each patient.

Please feel free to have staff contact me if there are questions regarding the survey process, deficiencies cited, or completion of the Plan(s) of Correction I may be reached at (509) 329-2176

I want to extend a special thanks to you for coordinating and facilitating all of the activities during the survey process.

Sincerely,

Suzanne Kinchen
DOH office of Inspections and Investigations
16201 E Indiana Ave Suite # 1500
Spokane Valley, Wa 99216

Enclosures: Statement of Deficiencies; Patient/Client List; Personnel List

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	507109	A BUILDING _____ B WING _____	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTREPID USA HEALTHCARE SERVICES	9715 NORTH NEVADA STREET SPOKANE, WA 99218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS During the standard on-site survey conducted January 5-8, 2015, at Intrepid USA Healthcare Services Home Health, Department of Health survey staff reviewed all the appropriate Medicare Conditions of Participation set forth in 42 CFR Part 484. The Department survey staff found Intrepid USA Healthcare Services Home Health in substantial compliance with all the applicable Conditions except those deficiencies described on the following pages The survey was conducted by Suzanne Kinchen, RN MPH Suzanne Kinchen, RN, MPH WA State Department of Health Office of Investigations and Inspections 16201 E Indiana Ave, Suite #1500 Spokane Wa, 99216 509-329-2176	G 000	A Plan of Correction (POC) is due no later than 1/22/15. The POC can either be written on this document (Statement of Deficiencies - Form 2567 - right column) or documented in a separate letter on agency letterhead with each deficiency ' s prefix tag number separately stated and addressed An acceptable Plan of Correction must include the following. 1. HOW the deficiency (state the deficiency prefix tag number - shown in left column of this document) will be or was corrected. 2 WHAT monitors will be put in place to assure continuing compliance 3 WHO is responsible for the Correction, and 4 WHEN (in far right column on this form) each deficiency will be corrected Correction for condition -level deficiencies cannot take longer than 45 days. Correction for standard level deficiencies (non Condition-level deficiencies) cannot take longer than 60 days	[redacted]

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 1/14/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility If deficiencies are cited, an approved plan of correction is requisite to continued program participation

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G 000	Continued From page 1	G 000	without the surveyor's approval PLEASE SEND PLAN OF CORRECTION AND A SIGNED and INITIALED COPY OF THIS REPORT TO ADDRESS ON THE LEFT SIDE	
G 121	484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. This STANDARD is not met as evidenced by Disclosure statements During the survey conducted on January 5-8, 2015, it was determined that the agency failed to comply with the following applicable state laws WAC 246-335-065 Personnel, contractor, and volunteer policies. The applicant or licensee must establish and implement policies and procedures regarding the following: (12) Washington state patrol criminal background inquiries and disclosure statements under RCW 43 43.830 through 43 43 845 for the administrator, director of clinical services or supervisor of direct care services per WAC 246-335-025 (1)(c), 246-335-030(3), and 246-335-035 and personnel, contractors, volunteers, students, and any other individual associated with the licensee having direct contact with children under sixteen years of age, people with developmental disabilities or vulnerable adults Based on record review and an interview with the	G 121	The Administrator will assure that agency and its staff will comply with accepted professional standards and principles that apply to professionals furnishing services in a home health agency by reviewing the Washington Disclosure Statement WAC 246-335-065 with all personnel, contractors, volunteers, students or any other individuals associated with the Intrepid Home Health Agency having direct contact with children under sixteen people with developmental disabilities or vulnerable adults prior to hire to meet the requirements of WAC 246-335-065 and RCW 43 43 830 through 4343845. The Administrator or designee will monitor for compliance by reviewing 100% of all personnel files to assure that the correct Disclosure Statement has been given to all employees The Administrator will monitor for ongoing compliance by reviewing 10% of all personnel files quarterly	2/8/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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G 121	Continued From page 2 administrator, the agency failed to ensure disclosure statements under RCW 43.43 830 through 43 43 845 were signed by all personnel reviewed Six of 6 direct care personnel in the sample had not completed a disclosure statement (Employees A-F) Findings Review of personnel records on 1/8/15 revealed that the following direct care personnel had not completed a disclosure statement Employee A - date of hire 5/6/13 Employee B - date of hire 5/3014 Employee C - date of hire 11/29/11 Employee D - date of hire 8/7/14 Employee E - date of hire 3/25/14 The administrative staff verified these findings on 1/8/15	G 121		
G 158	484 18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine This STANDARD is not met as evidenced by Based on review of patient records and interview with agency staff, the agency failed to document the reason(s) and/or notify the physician for the delays in providing "secondary" (services ordered after an initial assessment is completed by the primary discipline) professional services for 3 (#4, 6, and 11) of 12 patients whose records were	G 158	The Administrator will assure that all care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy or podiatric medicine by providing in-service and education to all clinical staff who provide services to patients on the following topics 1. Review Policy 2 004 Physician Orders and Policy 2 022 Plan of Care and discuss the importance of following the POC as ordered by the MD, 2. Review and discuss how to identify and when to report changes in patient condition and possible need for change in plan of Continued on page 4 of 8	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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G 158	Continued From page 3 reviewed and had orders for therapy, home health aide or social work services ("secondary" services). Failure to provide timely "secondary" professional services places the patient at risk of compromise to functional or mental health/social service status Findings include The agency policy " Care Coordination " noted that " the initial visit by the secondary disciplines will be performed within 48 hours of admission When there is a delay in services, the physician should be notified The below citations are included due to delays beyond the 48 hours noted in the agency policies. 1 Patient # 4 was admitted to service on 12/13/14 by a registered nurse Diagnoses included aftercare for a traumatic injury The Plan of Treatment for the certification period 12/13/14-2/10/15 included orders for Physical Therapy (PT) for 2 times a week for 9 weeks starting 12/13/14, for " therapeutic exercises, home exercise program and other therapy orders " Therapy did the first visit on 12/17/15 Patient #4's clinical record was reviewed on 1/7/15 and revealed that as of the date of the clinical record review, there were no reason(s) documented nor any record of notification to the physician for a delay in the physical therapy (4 day delay) which had been ordered 2 Patient # 6 ' s start of care was 12/5/14 The patient's primary diagnosis included Congestive Heart Failure (CHF). Review of the patient's record on 1/7/15 noted the plan of care had a home health aide ordered 2 times a week for 9 weeks to assist the patient with personal care as	G 158	care to the physician, 3 Review Policy 2.016 Documentation Practices and 2 010 Clinical Records referring to accurate and complete documentation of MD orders and care provided, 4 Review Policy 2 017 Missed Visit on documenting and reporting missed visits to the Physician and Policy 2 005 Care Coordination, by introducing and orienting the staff the needs of each client assigned that may be required in meeting the client's needs. The Administrator or designee will monitor for compliance by weekly reviews of current episode Physician Orders and Plans of Care to assure they are accurate in meeting the patient's needs and will review 100% of current episode nurse notes for 30 days for accurate and complete documentation then graduate the nurses off 100% review as the charting improves and is deemed in compliance. The Administrator or designee will also monitor visit frequency of current episode Physician Orders/POC for a period of 30 days to assure they are accurate in meeting the patient's needs. The Administrator or designee will then monitor for ongoing compliance by reviewing 10% of current episode patient records quarterly	2/8/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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G 158	Continued From page 4 the spouse was unable to perform the tasks Review of the patient ' s record on 1/6/15, noted that the home health aide had not seen the patient until 12/15/14 (10 days after the physician order). There was no documentation in the patient ' s record as to why the visits were delayed and/or notification to the physician of the delay in treatment 3 Patient # 11 ' s start pf care was 11/22/14 The patient's primary diagnosis included Congestive Heart Failure (CHF) On 12/17/14 a Resumption of Care (ROS) was completed after a hospitalization On the ROS, physical therapy was to do an evaluation and resume services with an effective date of 12/15/14 Review of the patient ' s record noted that physical therapy had not done an evaluation or resumption of services as of 1/8/15 (more than 25 days) The administrative staff verified these findings on 1/8/15.	G 158		
G 175	484 30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates appropriate preventative and rehabilitative nursing procedures This STANDARD is not met as evidenced by. Based on a review of patient records and interview with agency staff, the agency failed to initiate appropriate cardiac management on the plan of treatment and monitor weights as ordered for 3 of 4 patients (4, 6 & 11) with a diagnosis of congestive heart failure (CHF) and failed to notify	G 175	The Administrator will ensure that the registered nurse initiates appropriate preventative and rehabilitative nursing procedures are being completed by reviewing the guidelines and procedures of Policy 2.022 Plan of Care and the importance of following the plan of treatment as ordered by the Physician, Policy 2.005 Care Coordination, by introducing and orienting the staff the needs of Continued on page 6 of 8	

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G 175	Continued From page 5 the physician of weight variations per physician orders Failure to monitor weight for CHF patients places the patients at risk of exacerbation of CHF symptoms such as difficulty breathing or strain on heart function Findings include 1. Patient # 6 ' s start of care was 12/5/14 The patient's primary diagnosis included Congestive Heart Failure (CHF). Review of the patient's record on 1/7/15 noted the plan of care had physician orders to assess /perform/instruct patient/caregiver to get weighed every week and if there was a variation of 5 pounds to notify the physician The order noted the patient ' s weight should be between 250-255 pounds Review of the patient ' s record noted a weight of 250 pounds noted on the admission paperwork dated 12/5/14 There were no further weights documented in the patient ' s record On 1/6/15 the surveyor went on a home visit with the licensed nurse The surveyor asked the licensed nurse why weights had not been done for this patient The licensed nurse stated the patient was unsteady on his/her feet and his/her spouse was not comfortable weighing her/ him At that time the licensed nurse weighed the patient and the weight was 223 pounds (down 27 pounds in 4 5 weeks) Record review noted the licensed nurse visited the patient once a week, home health aide visited the patient 2 times a week, and physical therapy visited the patient 2 times a week. There were 5 opportunities a week for licensed staff to obtain weights on the patient as ordered	G 175	each client assigned. This review will encompass orientation to the plan of care and physician's orders, as well as any demonstration or training related to new equipment, procedures and/or treatments that may be required in meeting the client's needs; and Policy 2.016 Documentation Practice to assure that clinical activities are completed on the day it was provided. The Administrator will continue to monitor by reviewing a 100%of the Plan of Care and nurses notes for 30 days and then monitor for ongoing compliance by reviewing 10% of current Plan of Care and Nurses Notes quarterly.	2/8/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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INTREPID USA HEALTHCARE SERVICES	9715 NORTH NEVADA STREET SPOKANE, WA 99218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 175	Continued From page 6 2. Patient # 11 ' s start of care was 12/17/14. The patient's primary diagnosis included Congestive Heart Failure (CHF). Review of the patient's record on 1/7/15 noted the plan of care had physician orders to assess /perform/instruct patient/caregiver to get weighed every week and if there was a variation of 5 pounds to notify the physician Review of Patient # 11 ' s record on 1/7/15 noted there was a weight on 11/22/14 of 292 pounds The patient was admitted to the hospital for a bladder infection and a resumption of care was completed on 12/17/15 There were no further weights recorded in the patient ' s record as of the last survey date of 1/8/15 3. Patient # 4 ' s start of care was 12/13/14 The patient's diagnosis included Congestive Heart Failure (CHF). Review of the patient's record on 1/7/15 noted the plan of care had physician orders to assess /perform/instruct patient/caregiver to notify the physician if there was a weight variation of 5-10 pounds. Review of the patient ' s record noted a weight was obtained on 12/13/14 There were no further weights documented in the record to date 1/8/15. Per an interview with administrative staff on 1/8/15, the agency had a Congestive heart failure (CHF) protocol sheet with specific instructions that was given to all patients with heart failure However there was no documentation the licensed nurses provided education specific to the patient ' s plan of care for interventions related to CHF Per administrative staff, there was no policy or procedure for the management of CHF.	G 175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	507109	A. BUILDING _____ B. WING _____	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTREPID USA HEALTHCARE SERVICES	9715 NORTH NEVADA STREET SPOKANE, WA 99218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 175	Continued From page 7 The administrative staff verified these findings on 1/8/15	G 175		

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
PO Box 47852 • Olympia, Washington 98504-7852

RECEIVED 1/27/15

January 22, 2015

Katherine Hassler
Intrepid Healthcare Services
9715 N. Nevada
Spokane WA, 99218

Dear Ms Hassler:

The Department of Health survey team has reviewed and accepted your plan of correction for deficiencies found during your facility's Medicare survey #507109 of January 8, 2015.

No further action is necessary at this time.

Thank you very much.

Sincerely,

Suzanne Kinchen
DOH office of Inspections and Investigations
509-329-2176
16201 E Indiana Ave Suite # 1500
Spokane Valley, Wa 99216

intrepid®
HEALTHCARE SERVICES
A Home Health Company
9715 N Nevada St
Spokane, WA 99218
Phone 509 • 466 • 0954
Fax 509 • 466 • 9325
www intrepidusa com

December 26, 2017

Suzanne Kinchen
DOH Office of Inspections and Investigations
16201 E Indiana Ave Suite # 1500
Spokane Valley, WA 99216
509-329-2176

Dear Ms. Kinchen,

Please find enclosed the Plan of Correction (POC) based upon your findings of your survey of our Home Health Agency provider # 50-7109 IntrepidUSA at 9715 N. Nevada St. Spokane, WA 99218 beginning December 11, 2017. I believe this POC meets the criteria you set forth and addresses the deficient findings of your survey of our branch.

Please feel free to contact me with any questions you may have.

Respectfully,

Brynne M. Malone
Administrator
Provider # 50-7109
509-466-0964
9715 N Nevada St.
Spokane, WA 99218

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	507109	A. BUILDING _____ B. WING _____	12/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTREPID USA HEALTHCARE SERVICES	9715 NORTH NEVADA STREET SPOKANE, WA 99218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS During the STANDARD on-site survey conducted December 11-13, 2017 at Intrepid USA Healthcare Services Home Health, Department of Health survey staff reviewed all the appropriate Medicare Conditions of Participation set forth in 42 CFR Part 484. The Department survey staff found Intrepid USA Healthcare Services Home Health in substantial compliance with all the applicable Conditions except those deficiencies described on the following pages. The survey was conducted by Suzanne Kinchen, RN MPH Suzanne Kinchen, RN, MPH WA State Department of Health Office of Investigations and Inspections 16201 E Indiana Ave, Suite #1500 Spokane Wa, 99216 509-329-2176	G 000	A Plan of Correction (POC) is due no later than 12/29/2017. The POC can either be written on this document (Statement of Deficiencies - Form 2567 - right column) or documented in a separate letter on agency letterhead with each deficiency ' s prefix tag number separately stated and addressed. An acceptable Plan of Correction must include the following. 1. HOW the deficiency (state the deficiency prefix tag number - shown in *left* column of this document) will be or was corrected 2. WHAT monitors will be put in place to assure continuing compliance 3. WHO is responsible for the Correction, and 4. WHEN (in far right column on this form) each deficiency will be corrected. Correction for condition -level deficiencies cannot take longer than 45 days. Correction for standard level deficiencies (non Condition-level deficiencies) cannot take longer than 60 days	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: By M. Malone — TITLE: Administrator — (X6) DATE: 12/23/17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	507109	A BUILDING _____ B WING _____	12/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTREPID USA HEALTHCARE SERVICES	9715 NORTH NEVADA STREET SPOKANE, WA 99218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	Continued From page 1	G 000	without the surveyor's approval PLEASE SEND PLAN OF CORRECTION AND A SIGNED and INITIALED COPY OF THIS REPORT TO ADDRESS ON THE LEFT SIDE.	
G 158	ACCEPTANCE OF PATIENTS, POC, MED SUPER CFR(s): 484 18 Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine This STANDARD is not met as evidenced by Based on review of patient records, policy and procedures and interview with agency staff, the agency failed to document the reason(s) and/or notify the physician for the delays in providing "secondary" (services ordered after an initial assessment is completed by the primary discipline) professional services for 2 of 12 patients (#4 and #12) whose records were reviewed and had orders for therapies and home health aide Failure to provide timely "secondary" professional services places the patients at risk of compromise to functional/social service status Findings include: The agency policy "Care Coordination" noted, "the initial visit by the secondary disciplines will be	G 158	The Administrator will assure that all care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy or podiatric medicine by providing in-service and education to staff who provide services to patients on the following topics 1 Policy 2 005 Care Coordination process to notify physician regarding patient needs and changes to POC Policy 2 016 Documentation Practices on accuracy of documentation of services compl-ted 2 Review Policy 2 010 re Clinical Records referencing complete and accurate documentation of MD orders and care provided 3 Review policy 2 017 regarding Missed Visits and reporting to Physician The Administrator or designee will monitor for compliance by reviewing all current physician orders of active patients to ensure physician orders The Administrator or designee will monitor for ongoing compliance by reviewing 10% of current patient medical records each quarter for six months	01/05/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	507109	A. BUILDING _____ B. WING _____	12/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTREPID USA HEALTHCARE SERVICES	9715 NORTH NEVADA STREET SPOKANE, WA 99218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 158	Continued From page 2 performed within 48 hours of admission. When there is a delay in services, the physician should be notified " 1 Patient #4 was admitted to service on 10/24/17 by a registered nurse. Diagnoses included heart failure, diabetes and respiratory disease The Plan of Treatment for the certification period 10/24/17- 12/22/17 included orders for Occupational Therapy (OT) to evaluate and treat Therapy did the first visit on 10/27/17, which is beyond 48 hours after admission a. Patient #4's clinical record was reviewed on 12/13/17 and revealed that as of the date of the clinical record review, there were no reason(s) documented nor any record of notification to the physician for a delay in the occupational therapy (4 day delay) which had been ordered 2. Patient #12's start of care was 11/10/17 The patient's primary diagnosis included high blood pressure and diabetes Review of the patient's record on 12/13/17 noted the plan of care had a home health aide ordered 2 times a week for 8 weeks to assist the patient with personal care, and physical/occupational therapy to evaluate and treat a. Review of the patient's record on 12/13/17, noted that the home health aide did not see the patient until 11/21/17 (9 days after the physician order) The Physical therapist did not see the patient until 11/21/17 (9 days after the physician order), and the Occupational therapist did not see the patient until 11/28/17(19 days after the physician order) There was no documentation in	G 158	The Physcians for patients # 4 and # 12 will be notified that IntrepidUSA Staff did not follow the Plan of Care signed by the Physcian regarding these two patients.	01/05/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	507109	A. BUILDING _____ B. WING _____	12/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTREPID USA HEALTHCARE SERVICES	9715 NORTH NEVADA STREET SPOKANE, WA 99218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 158	Continued From page 3 the patient's record as to why the visits were delayed and/or notification to the physician of the delay in treatment The administrative staff verified these findings on 12/13/17 at 2 00 PM This is a repeat deficiency from 2015	G 158		
G 170	SKILLED NURSING SERVICES CFR(s) 484 30 The HHA furnishes skilled nursing services in accordance with the plan of care. This STANDARD is not met as evidenced by. Based on a review of patient records and interview with agency staff, the agency failed to monitor weights as ordered for 2 of 4 patients (#6 & #9) with a diagnosis of congestive heart failure (CHF) and failed to notify the physician of weight variations per agency protocols for CHF Failure to monitor weights for CHF patients places the patients at risk of exacerbation of CHF symptoms such as difficulty breathing or strain on heart function Findings include· 1 Patient #6's start of care was 09/01/17 The patient's primary diagnosis included new onset Congestive Heart Failure (CHF) Review of the patient's record on 12/12/17 noted the plan of care had physician orders to assess /perform/instruct patient/caregiver on fluid management The agency protocol given to the	G 170	The Administrator will ensure that the Home Health Agency furnishes skilled nursing services in accordance with the Plan of Care by In-Service all skilled nursing staff who are providing services to patients by the following actions The Nursing Staff will be educated on 1 Follow POC 2 CHF protocol with focus on weight gain and reporting to physician. 3 The requirement to report changes in patient condition to physician including the possible need for a change in plan of care to MD 4 Review policies 2.002 and 2 022 Plans of Care and Patient Assessment and Reassessment.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	507109	A BUILDING _____ B WING _____	12/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTREPID USA HEALTHCARE SERVICES	9715 NORTH NEVADA STREET SPOKANE, WA 99218

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G 170	Continued From page 4 patient and instructed by the registered nurse was to notify the nurse if a weight gain of 3 pounds and notify the physician of a weight gain or loss of more than 5 pounds a Review of the patient's record noted a weight of 200 pounds on 11/20/17 and 210 pounds on 11/28/17 (10-pound weight gain) There was no documentation the physician was notified. 2. Patient #9's start of care was 12/17/14 The patient had diagnosis that included Congestive Heart Failure (CHF) Review of the patient's record on 12/13/17 noted the plan of care had physician orders to assess /perform/instruct patient to get weighed every morning and if there was a variation of 2 pounds in a day or 5 pounds in a week to notify the physician. Review of Patient #9's record on 12/13/17 noted on 11/24/17 there was an admission weight of 115 pounds There was no there weights until 12/11/17 (17 days) at which time the patient weighed 120 pounds Per an interview with administrative staff on 12/13/17, the agency had a Congestive Heart Failure (CHF) protocol sheet with specific instructions that was given to all patients with heart failure. However there was no documentation the licensed nurses provided education specific to the patient's plan of care for interventions related to CHF. Per administrative staff, there was no policy or procedure for the management of CHF	G 170	Staff members who did not follow plan of care had individual education with supervisor regarding the deficiency The Administrator or designee will monitor ongoing compliance by weekly reviews of all Plans of Care for CHF patients to ensure the POC are accurate in meeting patients needs against Visit Notes for accurate and complete documentation of patient weights and informing the physician when weight gain is 2 lbs in a day or 5 lb.s in a week for a period of 1 month Will review 10% of patient charts quarterly. Patients # 6 and # 9 the physician will be notified of patients weight gain.	01/05/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	507109	A BUILDING _____ B WING _____	12/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G 170	Continued From page 5 The administrative staff verified these findings on 12/13/17 at 2:00PM This is a repeat deficiency from 2015	G 170		

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
PO Box 47852 • Olympia, Washington 98504-7852

Brynne Malone
Intrepid Healthcare Services
9715 N Nevada
Spokane WA, 99218

The Department of Health Inspection Surveyor has reviewed and accepted your plan of correction dated 12/26/2017 for deficiencies found during your facility's Medicare #507109 Recertification survey 12/13/2017

No further action is necessary from your agency, however the department reserves the right to pursue enforcement action for any repeat and/or uncorrected deficiencies."

Sincerely,

Suzanne Kinchen
DOH office of Inspections and Investigations
16201 E Indiana Ave Suite # 1500
Spokane Valley, Wa 99216
509-329-2176

PLAN OF CORRECTION

Organization Intrepid of Washington, Inc | Company ID 72832 | Application ID 25932

Address 9715 N Nevada St, Spokane, WA | Date Generated 10/07/2019

Services Reviewed HHA, MSS, OT, PT, SN, ST | Date of Survey 09/25/2019 | Surveyor Michele Rutledge

INSTRUCTIONS:

- The standards to be addressed are already listed in the first column, the rest should be filled out accordingly Please see the sample below
- For Home Health and Hospice, date of compliance for Condition of Participation (CoP) standard-level and ACHC deficiencies must be within 30 calendar days from receipt of Summary of Findings (SOF) and date of compliance for condition-level deficiencies must be within 10 calendar days from receipt of the SOF
- For Private Duty and Behavioral Health, date of compliance for ACHC deficiencies must be within 30 calendar days from receipt of Summary of Findings (SOF)
- For corrective action measures that require chart audits, please be sure to include the percentage of charts to be audited, frequency of the audit, and target threshold Ten records or 10% of daily census (whichever is greater) on **at least a monthly basis** is required until threshold is met Include actions for continued compliance once threshold is met
- Do not send any Protected Health Information (PHI) or other confidential information with the POC or when submitting evidence to your Account Advisor
- If you need any assistance, contact your Account Advisor

SAMPLE: Below is a sample on how to correctly fill out your POC

Standard	Plan of Correction (Specific action taken to bring standard into compliance)	Date of Compliance (Date correction to be completed)	Title (Individual responsible for correction)	Process to Prevent Recurrence (Describe monitoring of corrective actions to ensure they effectively prevent recurrence)	POC Compliant (ACHC internal use only)	Evidence Required (ACHC internal use only)	Evidence Approved (ACHC internal use only)	Comments (ACHC internal use only)
HH5-3A, §484 60	Staff will be in-serviced on how to document a complete and individualized plan of care that specifies the care and services necessary to meet the patient's needs	mo/dd/yr	Clinical Manager	Audit 10% of all active patients to ensure the plan of care is individualized, complete and addresses the care and services necessary to meet the needs of the patient for at least 5 weeks Target threshold is 95% Once threshold is met, will continue to audit 10% of all patient records quarterly	ACHC INTERNAL USE ONLY (LEAVE THIS AREA BLANK)			
HH4-2C 01	Appropriate staff will be in-serviced on requirements of the initial TB screening and annual verification	mo/dd/yr	Administrator	100% of newly hired, direct care personnel records will be audited within 30 days of hire for evidence that an initial baseline TB screen using TST or BAMT was completed Threshold is 100% compliance Once threshold is met, 50% of direct care personnel records will be audited annually				

HOME HEALTH HOSPICE PRIVATE DUTY

PLAN OF CORRECTION (POC)

ACHC

ONCE COMPLETED PLEASE EMAIL THIS FORM TO THE ATTENTION OF YOUR ACCOUNT ADVISOR

Organization Intrepid of Washington, Inc

Standard	Plan of Correction (Specific action taken to bring standard into compliance)	Date of Compliance (Date correction to be completed)	Title (Individual responsible for correction)	Process to Prevent Recurrence (Describe monitoring of corrective actions to ensure they effectively prevent recurrence)	POC Compliant (ACHC internal use only)	Evidence Required (ACHC internal use only)	Evidence Approved (ACHC internal use only)	Comments (ACHC internal use only)
HH4-1A 02	All personel files will be audited for reference checks Education of policy 3 013 provided to Office Manager and Clinical Supervisor that all new hires will have reference checks performed by CS/BOM/ADM prior to submitting an offer to hire	11/06/2019	BOM, Clinical Supervisor and Administrator	BOM to audit new hire paperwork on all new hires prior to offer submission BOM to perform monthly audit until 100% threshold met and then 10% quarterly ongoing	Yes	No	N/A	
HH2-2A	Addendum to Patient rights statement added to the admission handbook to include the Washington state specific patient rights that were not included in the admission handbook to be reviewed with Patients going forward Education provided on policy 2 009 to staff during the 10/3/19 staff meeting that these specific rights addendum will be reviewed along with the admission book Going forward it will be the admitting clinicians responsibility to provide to the patient with the addendum has been printed Staff provided copies to hand out to all current patients on their next visit	11/06/2019	ADM, BOM, SS2, and admitting clinician	ADM/BOM will review all Washington State specific Patient bill of Rights annually to ensure that the correct information is included with the admission packet	Yes	No	N/A	10/11/19- Process to prevent recurrence is a regular review of the patient rights statement to ensure all required componen t. Suggest annually Record review is not necessary for this standard 10/20/19- Corrected

PLAN OF CORRECTION

Standard	Plan of Correction (Specific action taken to bring standard into compliance)	Date of Compliance (Date correction to be completed)	Title (Individual responsible for correction)	Process to Prevent Recurrence (Describe monitoring of corrective actions to ensure they effectively prevent recurrence)	POC Compliant (ACHC internal use only)	Evidence Required (ACHC internal use only)	Evidence Approved (ACHC internal use only)	Comments (ACHC internal use only)
HH2-4B	End Harm Flyer printed out and placed into admission book Admitting clinicians educated on policy 2 009 at the Staff meeting on 10/3/19 on the new flyer to review with the patient at SOC and the documentation that will need to be included in the Admission statement	11/6/2019	ADM/BOM and all admitting clinicians	ADM/BOM will review all Washington State specific abuse and neglect hotline number on the End Harm Flyer annually to ensure that the correct information is included with the admission packet	Yes	No	N/A	10/11/19- Process to prevent recurrence is to review admission packet for all required elements regularly, suggest annually Patient record review not necessara y for this standard. 10/20/19- Corrected
HH7-3B (484 102(b)(1), E-0017)	Education on policy 1 029 provided to staff at 10/3/2019 meeting that all patients at SOC will have an Emergency plan of care established and brought to office for filing Oasis staff educated that this EPA will be reviewed at any subsequent Recert or ROC to ensure it is still correct and documented in chart at the time	11/6/2019	ADM/BOM Clinical Supervisor All Oasis clinicians	ADM/ BOM/CS to monitor 100% of new admission per month until threshold of 100% compliances is met that the form was completed and copy provided to office Monitoring will continue at 10% quarterly ongoing	Yes	Yes	Yes	

PLAN OF CORRECTION (POC)

Standard	Plan of Correction (Specific action taken to bring standard into compliance)	Date of Compliance (Date correction to be completed)	Title (Individual responsible for correction)	Process to Prevent Recurrence (Describe monitoring of corrective actions to ensure they effectively prevent recurrence)	POC Compliant (ACHC internal use only)	Evidence Required (ACHC internal use only)	Evidence Approved (ACHC internal use only)	Comments (ACHC internal use only)
HH5-6A (484 110(a)(6)(i), G1022)	Education on policy 2 011 provided to staff on 10/3/2019 that going forward a DC/TX summary will be added as a stand alone summary along with all all DC/TX oasis Staff instructed that they may document reference to the additional DC/TX summary Staff educated that this is to ensure we have a completed DC/TX summary to fax to MD within the required timeframe of 5 business days for a DC summary and 2 days for a Transfer	11/6/2019	ADM/BOM Clinical Supervisor All Oasis clinicians	ADM / BOM to monitor 100% of discharged patient charts per month until 100% threshold compliance has been met that the DC/TX summaries were faxed to MD within the required timeframe Monitoring will continue at 10% quarterly ongoing	Yes	Yes	Yes	
HH5-3A (484 60(a)(2), G574)	Education on the POC policy 2 022 to ensure that individual plan of care is established with all required elements including all pertinent diagnosis, patients mental, psychosocial and cognitive status, types of services, supplies, and equipment, Frequency and duration, prognosis, Rehab potential , functional limitations, activities permitted and nutritional requirements Also to be included will be physician ordered or agency established parameters of when to notify the physician and reason for PRN order	11/6/2019	ADM/CS/Field staff	ADM / CS to monitor 100% POC created for SOC/ROC/RC and subsequent physician orders per month until 100% compliance threshold has been met Monitoring will continue at 10% quarterly ongoing	Yes	Yes	Yes	

PLAN OF CORRECTION

Standard	Plan of Correction (Specific action taken to bring standard into compliance)	Date of Compliance (Date correction to be completed)	Title (Individual responsible for correction)	Process to Prevent Recurrence (Describe monitoring of corrective actions to ensure they effectively prevent recurrence)	POC Compliant (ACHC internal use only)	Evidence Required (ACHC internal use only)	Evidence Approved (ACHC internal use only)	Comments (ACHC internal use only)
HH5-11A (484 75(b)(3), G710)	Education provided at staff meeting on 10/3/2019 with review for initiation and following orders of POC and physician orders referring to policies 2 022 and 2 004 Educated staff that a physicians order must be obtained prior to initiation of care	11/6/2019	ADM/CS/Field staff	ADM / CS to monitor 100% of visit note documentation per month until 100% compliance threshold has been met Monitoring will continue at 10% quarterly ongoing	Yes	Yes	Yes	
HH4-11H (484 80(a)(1), G754)	Per new COP guideline HHA will have all areas of competency checked off successfully prior to being allowed to work in the field with any patients Current HHA will be have successful competency check off on all task prior to continuing to see patient	11/06/2019	Clinical Supervisor /ADM	Clinical Supervisor will do joint visits with all newly hired HHA and complete entire competency checklist prior to assigning any patients to the HHA ADM/BOM will monitor 100% HHA personel files and competencies monthly until 100% compliance threshold met Monitoring will continue at 10% quarterly ongoing	Yes	Yes	Yes	10/11/19- Process to prevent recurrence needs to include number/percentage of personnel record review to be completed and it what time frame Initial audits should be for at least 1 month 10/20/19- Corrected

November 5, 2019

FOR PROVIDERS
BY PROVIDERS.

Intrepid of Washington, Inc , DBA Intrepid USA Healthcare Services
Mr Robert Parker
9715 N Nevada Street
Spokane, WA 99218-3412

Branch Listing.
N/A

Dear Mr. Robert Parker:

On behalf of Accreditation Commission for Health Care (ACHC), I am pleased to inform you that Intrepid of Washington, Inc has been ***approved for accreditation*** for Home Health with a recommendation for initial Deemed Status. The services approved are Home Health Aide Services, Medical Social Services, Occupational Therapy Services, Physical Therapy Services, Speech Therapy Services, Skilled Nursing Services. Your accreditation is effective October 15, 2019 through October 15, 2022

By achieving ACHC Accreditation, your company demonstrates its commitment to delivering the highest quality of products and services by complying with ACHC Accreditation Standards and the Centers for Medicare & Medicaid Services' (CMS) Conditions of Participation (CoPs). Maintaining accreditation is contingent upon ongoing compliance with the above requirements during your accreditation period

ACHC has submitted your regulatory paperwork to the appropriate state and regional offices The CMS Regional Office (RO) will then make the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13

ACHC has approved your Plan of Correction (POC) received on October 15, 2019 related to the deficiencies found during your on-site survey, and has concluded that all deficiencies have been resolved Please remember to submit your evidence of compliance supporting your POC within 60 days of the date of your initial survey decision letter

Again, congratulations to Intrepid of Washington, Inc. for being awarded accreditation. It is an achievement of which your organization can be proud, and one that reflects your dedication to meeting standards that facilitate quality in the provision of care.

If you have any questions, please contact your Account Advisor Rachael Herring

Sincerely,

Susan Mills, RN

Susan Mills, RN
Clinical Director

ACHC FOR PROVIDERS. BY PROVIDERS

November 5, 2019

CMS Central Office
CMS R10 - Seattle
State of Washington

RE·
Intrepid of Washington, Inc., DBA Intrepid USA Healthcare Services
Mr. Robert Parker
9715 N Nevada Street
Spokane, WA 99218-3412

Program Type. HH
CCN#. 507109
AOID#: 7283203

Survey Type. Initial
Survey Dates September 25, 2019 - September 26, 2019
Accreditation Dates: October 15, 2019 - October 15, 2022
Accreditation Decision· Full
Plan of Correction Received Date· October 15, 2019

Accreditation Commission for Health Care (ACHC) has ***approved*** Intrepid of Washington, Inc for the Home Health program with a recommendation for initial Deemed Status Services approved are Home Health Aide Services, Medical Social Services, Occupational Therapy Services, Physical Therapy Services, Speech Therapy Services, Skilled Nursing Services

ACHC received an acceptable Plan of Correction for any standard-level or ACHC deficiencies found during your survey. ACHC is recommending initial Deemed Status effective October 15, 2019 through October 15, 2022. The Centers for Medicare & Medicaid Services Regional Office (RO) makes the final determination regarding Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13.

Branch Listing
N/A

Sincerely,

Susan Mills, RN

Susan Mills, RN
Clinical Director

Attachments. ACHC Summary of Findings
CMS-1572
CMS-1515

CERTIFICATE OF ACCREDITATION

ACCREDITATION COMMISSION FOR HEALTH CARE CERTIFIES THAT.

Intrepid of Washington, Inc.
d/b/a Intrepid USA Healthcare Services
SPOKANE, WASHINGTON

HAS DEMONSTRATED A COMMITMENT TO PROVIDING QUALITY CARE AND SERVICES TO CONSUMERS THROUGH COMPLIANCE WITH ACHC'S NATIONALLY RECOGNIZED STANDARDS FOR ACCREDITATION AND IS THEREFORE GRANTED ACCREDITATION FOR THE FOLLOWING:

HOME HEALTH

FROM *October 15, 2019* THROUGH *October 15, 2022*

PRESIDENT & CHIEF EXECUTIVE OFFICER

CHAIRMAN OF THE BOARD OF COMMISSIONERS

ACCREDITATION COMMISSION FOR HEALTH CARE
ACHC

BANK OF TEXAS

A division of BOKF, NA
P.O. Box 29775
Dallas, TX 75229-0775
Member FDIC

PRIMARY ACCOUNT
[redacted]

Statement Period:
05-01-20 to 05-31-20

Direct Inquiries To:
Comm'l Client Svcs
866-407-4147

www.bankoftexas.com

[redacted]

INTREPID USA INC
OPERATING ACCOUNT
3220 KELLER SPRINGS RD STE 108
CARROLLTON TX 75006

COMMERCIAL CHECKING

ACCOUNT: [redacted]

Statement Period from 05-01-20 through 05-31-20

$	Starting Balance	[redacted]	
+	49 Deposits		
-	697 Checks & Withdrawals		
-	Service Fees		
=	Ending Balance		53,668.23

+ DEPOSITS

Date	Amount
[redacted]	

FOR ACCOUNT BALANCING PROCEDURES, IMPORTANT INFORMATION AND ADDRESS CHANGES SEE REVERSE SIDE

[redacted]

BANK OF TEXAS

A division of BOKF, NA
P.O Box 29775
Dallas, TX 75229-0775
Member FDIC

PRIMARY ACCOUNT
[redacted]

Statement Period:
05-01-20 to 05-31-20

Direct Inquiries To:
Comm'l Client Svcs
866-407-4147

www.bankoftexas.com

[redacted]

INTREPID USA INC
NON GOV DEPOSIT ACCOUNT
3220 KELLER SPRINGS RD STE 108
CARROLLTON TX 75006

COMMERCIAL CHECKING

ACCOUNT: [redacted]

Statement Period from 05-01-20 through 05-31-20

$	Starting Balance	[redacted]
+ 1378	Deposits	
- 9	Checks & Withdrawals	
-	Service Fees	
=	Ending Balance	432,250.05

DEPOSITS

Date [redacted]

[redacted]

BANK OF TEXAS
A division of BOKF, NA
P O Box 29775
Dallas, TX 75229-0775
Member FDIC

PRIMARY ACCOUNT
[redacted]

Statement Period:
05-01-20 to 05-31-20

Direct Inquiries To:
Comm'l Client Svcs
866-407-4147

www.bankoftexas.com

[redacted]

INTREPID USA INC
GOV DEPOSIT ACCOUNT
3220 KELLER SPRINGS RD STE 108
CARROLLTON TX 75006

COMMERCIAL CHECKING

ACCOUNT: [redacted]

Statement Period from 05-01-20 through 05-31-20

$	Starting Balance	[redacted]
+	848 Deposits	
-	14 Checks & Withdrawals	
-	Service Fees	
=	Ending Balance	2,133,542.74

DEPOSITS

Date	Amount
[redacted]	

[redacted]

Patient and staff List

Staff

A. Amy Rodney
B. B. Timothy Kline
C. Kirsten Hatton
D. Maren Engh
E. Julie Mondrick

Patient list