CN22-21

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Certificate of Need Application Hospice Agency

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

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

Signature and Title of Responsible Officer Email Address geoffschackmann@vistariver.com	Date: December 30th, 2021 Telephone Number: (480) 495-5474
Legal Name of Applicant: VistaRiver of King County, LLC Address of Applicant: 29100 SW Town Center Loop W Suite 130 Wilsonville, OR 97070	Provide a brief project description [x] - New Agency [ ] - Expansion of Existing Agency Other:__ Estimated capital expenditure: $30,000
Identify the county proposed to be served for this project. Note: Each hospice application must be submitted for one county only. If an applicant intends to obtain a Certificate of Need to serve more than one county, then an application must submitted for each county separately. King County is the proposed county to be served for this project.	

VistaRiver of King County, LLC "VistaRiver"

Certificate of Need Application

To Establish a Medicare Certified and Medicaid Eligible Hospice Agency in King County

December 2021

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VistaRiver's Promise

We know that King County residents are not getting the end-of-life care and experience they need. [1]

At VistaRiver, we believe that everyone deserves a world class experience from the most enlightened caregivers so that they can spend more meaningful time with their loved ones during the moments that matter most.

When patients' and families of King County are not receiving timely access to end-of-life care[2]. We will be there. When need for additional end-of-life services is insufficient. You will find us. We are committed to admitting patients within 24 hours from receipt of a referral.

The need for hospice marks a big change in people's lives. Hospice is about embracing the hope to live as fully as possible in comfort and dignity even in the face of advanced illness. Every moment is a cause for celebration of life and an opportunity to enjoy the time we have left. Hospice is a mission, a calling, and something we are honored to do. We are here to help everyone bring back compassion and joy during the time that matters most.

Whether you need to manage a chronic illness or an advanced-stage disease, VistaRiver Hospice provides patients with the support they need for the highest possible quality of life.

VistaRiver's two guiding principles:

You shouldn't die in pain.
You shouldn't die alone.

The Perfect Visit.
Too many hospices have mistakenly "assumed" that clinicians know how to do a great visit. If we are under this illusion, we can predict that we are not providing as high of quality hospice care as possible. We care deeply about serving the patient and family. The hospice visit is the patients' experience and the family's memory. The Perfect Visit ensures patients and families receive the high-quality and predictable experience they deserve.

More care.
This commitment is why VistaRiver has created a unique staffing model that combines innovative technology, prioritizes timely admissions and time with the patient. Statistics[3] show that too many patients are not receiving visits in their final two days of life. VistaRiver plans to rank among the nation's leaders in daily visits, aiming to provide more care than the national average for hospice providers.

More visits.
In the patient's last seven days, our visits will increase, providing two-and-a-half times more care than the national average. In fact, when we recognize the symptoms that a patient's death is drawing near, we activate additional visits, which allows us to keep a member of the VistaRiver team bedside to support the patient and their family through this final transition.

More services.
VistaRiver offers more services than what is required by CMS. In partnership with Alante Primary Care, a physician group practice opening in Washington 2022, VistaRiver can offer unparalleled transition care services, palliative services, and enhanced hospice services. Increasing hospice utilization via MyCancerJourney is another service that VistaRiver will offer. 85% of cancer patients wished to be involved in treatment decisions[4]. However, patients' preferences for involvement in decision making are variable and are affected by factors such as age, sex, and education[5]. Offering this innovative service, MyCancerJourney, to community providers, patients, and families will help them make more informed decisions about their care options. These services can improve King Counties hospice utilization rate while simultaneously helping those in underserved communities. In addition to providing patients with physical, emotional and spiritual support, VistaRiver offers unique programs like the Gift of a Day, Life Journals, and the Gift of Courage to enrich the patient's final days by celebrating their memories and making new ones.

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[1] Hospice utilization among Medicare decVistaRiver Hospicets in Washington state reached 46% in 2018, just below the national average of 50.7%, according to the National Hospice & Palliative Care Organization (NHPCO).

[2] Short on Staff, Some Hospices Ask New Patients To Wait - The New York Times (nytimes.com)

[3] Teno JM, Plotzke M, Christian T, Gozalo P. Examining Variation in Hospice Visits by Professional Staff in the Last 2 Days of Life. *JAMA Intern Med.* 2016;176(3):364–370. doi:10.1001/jamainternmed.2015.7479

[4],[5] An introduction to patient decision aids *BMJ* 2013; 347 doi: https://doi.org/10.1136/bmj.f4147 (Published 23 July 2013)

How our mission helps King County.
VistaRiver is committed to being at the forefront of the hospice care industry to continually shape the way palliative and hospice care are viewed and administered…so that everyone can expect more.

The VistaRiver brand promise:
VistaRiver offers more to elevate the end-of-life experience in unique ways.
Expect highly attentive, hands-on care. We are always there for you before, during and after the need for end-of-life care.

We, along with the Department of Health, see a clear need for the addition of hospice services in King County. A favorable decision for VistaRiver will result in increased access to care, closing the gap on underserved communities and increasing the overall care and experience the residents of King County will enjoy. Therefore we are we are pursuing the Certificate of Need approval to establish a Medicare certified and Medicaid hospice agency in King County.

Sincerely,

VistaRiver of King County, LLC

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

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

VistaRiver of King County, LLC, applicant, is located at 17201 15th Ave NE Shoreline, WA 98155.

VistaRiver of King County, LLC, is wholly owned by VistaRiver King County HoldCo, LLC. VistaRiver King County HoldCo, LLC is owned by Jeff Baumgarner (16.66%), Jonathan Bliss (16.66%), Geoff Schackmann (16.66%) and Sante Partners, LLC (50%).

Sante Partners, LLC is owned by Mark Hansen (48%), Jacob Schaefer (19.5%) and the remaining are partners with %'s

For the remainder of this application the applicant will be referred to as VistaRiver.

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

VistaRiver of King County legal structure is a Washington State limited liability company. The Unified Business Identifier (UBI) is 608-848-639

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

Geoff Schackmann
Project Manager
29100 SW Town Center Loop W
Suite 130
Wilsonville, OR 97070

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

Geoff Schackmann
Project Manager
29100 SW Town Center Loop W
Suite 130
Wilsonville, OR 97070

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

Please see Appendix 1 for an organizational chart identifying the business structure of the applicants.

6. Identify all healthcare facilities and agencies owned, operated by, or managed by the applicant or its affiliates with overlapping decision-makers. This should include all facilities in Washington State as well as out-of-state facilities. The following identifying information should be included:

- Facility and Agency Name(s)
- Facility and Agency Location(s)
- Facility and Agency License Number(s)
- Facility and Agency CMS Certification Number(s)
- Facility and Agency Accreditation Status
- If acquired in the last three full calendar years, list the corresponding month and year the sale became final
- Type of facility or agency (home health, hospice, other)

Please see Appendix 2 for a list of the existing healthcare facilities and agencies owned, operated by, or managed by the applicant or its affiliates with overlapping decision-makers.

Project Description

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

Not applicable.

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

Not applicable.

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

VistaRiver of King County, LLC
17201 15th Ave NE, Shoreline, WA 98155

4. Provide a detailed description of the proposed project.

VistaRiver Hospice offers the highest quality of hospice and palliative care. We specialize in supporting individuals and families who are facing the physical, emotional, social and spiritual challenges confronted when dealing with terminal and chronic illness. Paramount to our philosophy is to ensure that our patient is experiencing their final passing on their own specified terms — in comfort and with dignity. In our care, our main objective is always to maximize patients' comfort and quality of life during the time that remains.

VistaRiver is proposing to provide Medicare and Medicaid certified hospice services to King County residents' and their families.'

For us, *hospice is about living*. That is why we provide patients with a comprehensive care plan lead by a dedicated interdisciplinary team. Our teams are made up of:

Physician	Our physicians lead the way to ensure each patient is receiving the proper medications and medical treatments in their care.
Nurse Practitioner	Our nurse practitioners work with our physicians to develop a comprehensive and individualized care plan for each patient.
Registered Nurse (RN)	Our nurses, who are available 24 hours a day 7 days a week, work with patients to execute a plan of care that will make them the most comfortable in hospice.
Certified Nursing Assistant (CNA)	CNAs are the 'guardian angels" that assist with the patient's personal care, as well as emphasize family support.
Dietitians	Our dietitians ensure patients are receiving the nutritional intake that best fits their plan of care.
Social Worker	Our social workers are experts in providing grief, bereavement, and mental health support to the patient and their family and continue to support the family after the patient's passing.
Chaplain	Our chaplains provide the spiritual and emotional support that many patients seek at the end of their lives.
Volunteers	Volunteers enrich our patients' lives by bringing them the things that matter most to them directly to their bedside.
Therapy	Physical, Occupational, and Speech Therapist

VistaRiver will offer hospice and palliative care in a variety of situations. We will serve King County patients no matter where they reside: a skilled nursing facility, assisted or independent living facility, an outpatient clinic, or in their own home. To us, each patient is unique – we tailor our plan of care to each individual patient's needs.

VistaRiver Hospice offers all levels of care. Hospice services are covered by the Medicare Part A Benefit. Medicaid and most private insurance plans ensure that hospice services come at no cost of the patient, and this covers all four levels of hospice care:

- Routine Hospice Care
- Respite Care
- Continuous Care
- General Inpatient Care

Alante Primary Care specializes in physician-based supportive hospice services: transitional care management, hospice care supervision (care plan oversight), home visits, palliative care and support hospice care to improve the quality and outcomes for hospice patients. Appendix 19 provides an in-depth summary into how Alante Health Services will increase access to timely care, decrease costs, and enhance the overall experience residents of King County will enjoy.

VistaRiver will provide hospice and palliative services to King County residents' including physician and clinical services, nursing care, symptom control and pain relief management, respite care, home health aide and homemaker services, physical, speech and occupational therapy, social worker services, dietary counseling, grief and loss counseling. Services may be provided directly or under contract.

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

The agency will be available and accessible to the entire geography of King County. This includes Pediatric patients. The agency will work within the community and with other hospice agencies while VistaRiver develops a pediatric program.

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

Reviewing the most recent King County Hospice CN application cycle will be used to guide this project estimated timeline for project completion.

APPLICATION CHRONOLOGY

Action	AccentCare, Inc.	EmpRes Healthcare Group, Inc.	Pennant Group, Inc.
Letter of Intent Submitted	November 20, 2020	November 24, 2020	November 25, 2020
Application Submitted	December 30, 2020	December 31, 2020	December 31, 2020
Department's pre-review activities: • DOH 1st Screening Letter • Applicant's Responses Received	January 29, 2021 February 25, 2021	January 29, 2021 February 25, 2021	January 29, 2021 February 26, 2021
Beginning of Review	March 15, 2021		
Public Hearing Conducted and End of Public Comment	June 25, 2021		
Rebuttal Comments Due	July 26, 2021		
Department's Anticipated Decision Date	October 11, 2021		
Department's Actual Decision Date with a 30-day Extension	November 4, 2021		

Event	Anticipated Month/Year
CN Approval	November 2022
Design Complete (if applicable)	N/A
Construction Commenced (if applicable)	N/A
Construction Completed (if applicable)	N/A
Agency Prepared for Survey	April 2023
Agency Providing Medicare and Medicaid hospice services in the proposed county.	May 2023

The project's estimated timeline is based on the applicants experience with CN applications, preparing for Joint Commission surveys and being fully operational to provide services.

Hospice services are expected to begin in May of 2023. 2023 will be considered a partial year. The three full calendar years used throughout the remainder of the application are 2024, 2025 and 2026.

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

X Skilled Nursing	X Durable Medical Equipment
X Home Health Aide	X IV Services
X Physical Therapy	X Nutritional Counseling
X Occupational Therapy	X Bereavement Counseling
X Speech Therapy	X Symptom and Pain Management
X Respiratory Therapy	X Pharmacy Services
X Medical Social Services	X Respite Care
X Palliative Care	X Spiritual Counseling
X Other (please describe): Music Therapy, Pet Therapy, We Honor Veterans Program, and Gift of a Day, transitional care	

Services	Employed	Contracted
Skilled Nursing	X	
Home Health Aide	X	
Physical Therapy		X
Occupational Therapy		X
Speech Therapy		X
Respiratory Therapy		X
Medical Social Services	X	
Palliative Care		X
Durable Medical Equipment		X
IV Services		X
Nutritional Counseling		X
Bereavement Counseling	X	
Symptom and Pain Management	X	
Pharmacy Services		X
Respite Care		X
Spiritual Counseling	X	
Medical Director		X

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

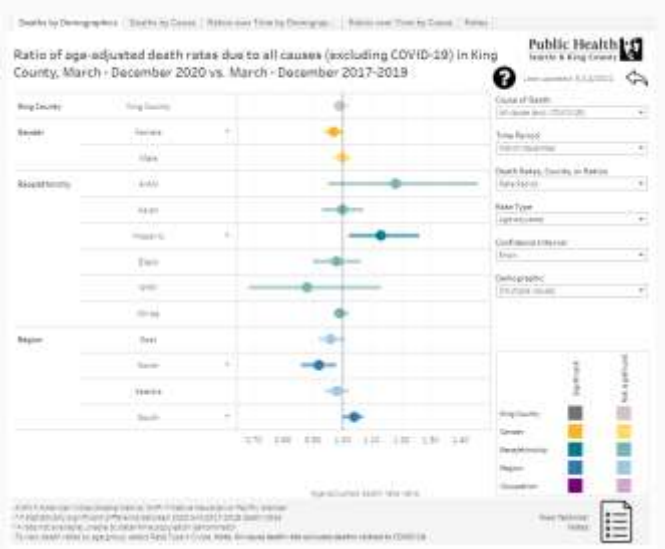
Not applicable.

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

Not applicable.

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

VistaRiver will provide, support, and comfort to those who are facing life limiting illness (6 months or less to live) and elect comfort care instead of curative care. We take a whole-person approach, addressing physical pain as well as emotional and spiritual needs. As such we are committed to serving all patients regardless of age, race, gender, religion, diagnosis, gender expression or orientation. Our commitment to caring for all patients is reflected in our admission and non-discrimination policies. Our charity care policy is available for those who are unable to pay for end-of-life care. VistaRiver will meet the needs of all King County residents, regardless of geography, race or ethnicity, and will operate with a special emphasis on serving traditionally underserved populations.



Source: https://kingcounty.gov/depts/health/data

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

Please see appendix 9

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

VistaRiver of King County, LLC, if approved, will seek accreditation by The Joint Commission.

A. Need (WAC 246-310-210)

VistaRiver of King County, LLC will rely upon and restate the DOH need methodology as listed on the DOH website for King County in 2021.

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

Certificate of Need Review Criteria

Department of Health 2021-2022 Hospice Numeric Need Methodology
WAC 246-310-290(8)(a)

Step 1:

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

WAC 246-310-290(8)(a)

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

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

Hospice admissions ages 0-64	
Year	Admissions
2018	4,114
2019	3,699
2020	3,679
	average: 3,831

Deaths ages 0-64	
Year	Deaths
2018	14,055
2019	14,047
2020	16,663
	average: 14,922

Use Rates	
0-64	25.67%
65+	60.15%

Hospice admissions ages 65+	
Year	Admissions
2018	26,207
2019	26,017
2020	27,956
	average: 26,727

Deaths ages 65+	
Year	Deaths
2018	42,773
2019	44,159
2020	46,367
	average: 44,433

WAC246-310-290(8)(b)

Step 2:

Calculate the average number of total resident deaths over the last three years for each planning area by age cohort.

0-64				
County	2018	2019	2020	2018-2020 Average Deaths
King	3,284	3,275	4,456	3,665
65+				
King	9,917	10,213	11,186	10,439

WAC246-310-290(8)(c)

Step 3:

Multiply each hospice use rate determined in Step 1 by the planning areas' average total resident deaths determined in Step 2, separated by age cohort.

0-64		
County	2018-2020 Average Deaths	Projected Patients: 25.67% of Deaths
King	3,665	941
65+		
King	10,439	6,279

WAC246-310-290(8)(d)

Step 4:

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

0-64								
County	Projected Patients	2018-2020 Average Population	2021 projected population	2022 projected population	2023 projected population	2021 potential volume	2022 potential volume	2023 potential volume
King	941	1,885,115	1,918,470	1,930,192	1,941,913	958	963	969

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

DOH 290-020 November 2021

65+								
County	Projected Patients	2018-2020 Average Population	2021 projected population	2022 projected population	2023 projected population	2021 potential volume	2022 potential volume	2023 potential volume
King	6,279	310,572	337,771	350,881	363,992	6,829	7,094	7,359

WAC246-310-290(8)(e)

Step 5:

Combine the two age cohorts. Subtract the average of the most recent three years hospice capacity in each planning area from the projected volumes calculated in Step 4 to determine the number of projected admissions beyond the planning area capacity.

County	2021 potential volume	2022 potential volume	2023 potential volume	Current Supply of Hospice Providers	2021 Unmet Need Admissions*	2022 Unmet Need Admissions*	2023 Unmet Need Admissions*
King	7,786	8,057	8,328	**7,830.73**	(44)	226	497

WAC246-310-290(8)(f)

Step 6:

Multiply the unmet need from Step 5 by the statewide average length of stay as determined by CMS to determine unmet need patient days in the projection years.

				Step 6 (Admits * ALOS) = Unmet Patient Days			
County	2021 Unmet Need Admissions*	2022 Unmet Need Admissions*	2023 Unmet Need Admissions*	Statewide ALOS	2021 Unmet Need Patient Days*	2022 Unmet Need Patient Days*	2023 Unmet Need Patient Days*
King	(44)	226	497	**62.12**	(2,759)	14,070	30,899

WAC246-310-290(8)(g)

Step 7:

Divide the unmet patient days from Step 6 by 365 to determine the unmet need ADC.

				Step 7 (Patient Days / 365) = Unmet ADC		
County	2021 Unmet Need Patient Days*	2022 Unmet Need Patient Days*	2023 Unmet Need Patient Days*	2021 Unmet Need ADC*	2022 Unmet Need ADC*	2023 Unmet Need ADC*
King	(2,759)	14,070	30,899	(8)	39	85

WAC246-310-290(8)(h)

Step 8:

Determine the number of hospice agencies in the planning area that could support the unmet need with an ADC of thirty-five.

Application Year

	Step 7 (Patient Days / 365) = Unmet ADC			Step 8 - Numeric Need	
County	2021 Unmet Need ADC*	2022 Unmet Need ADC*	2023 Unmet Need ADC*	Numeric Need?	Number of New Agencies Needed?**
King	(8)	39	85	*TRUE*	*2*

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

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

King County Unmet Need for Hospice Agencies

2023 ADC (Unmet)	# of New Agencies

	Needed
85	2

Source: DOH 2021 Hospice Need Methodology

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

Not applicable.

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

Hospice Services are expected to begin in May 2023. The first full three years are assumed to be 2024, 2025, and 2026. This timeline is based on previous King County Hospice CN application cycles and applicants CN experience.

COUNTY	2023 (partial year)	2024	2025	2026
Total number of admissions	60	153	202	307
Total number of patient days	3744	9608	12649	19250
Projected average daily census	15.3	26.3	34.7	52.7

Additional information underlying the projects three full years of admissions:

- Assumed admissions are based on a conservatives projection of what the operators of VistaRiver have experienced in other start-up agencies.
- 12,775 default patient days / 62.12 ALOS = 205.7 default admissions projected by need methodology for 2023

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

Factors that could restrict patient access to hospice services can be identified by analyzing the county's existing hospice agencies and ADC, relative to the county's population.

The need methodology revels the need for two additional hospice agencies by 2023 with each of the new agencies operating at an average daily census of 35 patients. VistaRiver projects it will reach an ADC of 15.4 for partial year 2023 increasing gradually to an ADC of 46.4 by the end of the third full year, 2026.

	Total					
Hospice Agency Name	Hospice Beneficiary	Died in 2020	Died in Hospice	Hospice Days Sum	Hospice Days Mean	Hospice Days Median
FRANCISCAN HOSPICE 501526	2,947	2,124	1,993	199,891	68	30
EVERGREEN HEALTH HOSPICE CARE 501523	2,341	1,839	1,751	125,056	53	19
PROVIDENCE HOSPICE OF SEATTLE 501515	2,172	1,577	1,484	151,601	70	28
MULTICARE HOSPICE 501508	1,191	930	876	69,765	59	24
KAISER FOUNDATION HEALTH PLAN OF WASHINGTON 501521	712	567	532	38,401	54	26
KINDRED HOSPICE 501541	239	163	150	22,477	94	37
PROVIDENCE HOSPICE AND HOME CARE OF SNOHOMISH CO 501514	167	121	114	9,842	59	16
ENVISION HOSPICE 501544	73	52	48	2,900	40	20
PROVIDENCE SOUNDHOMECARE AND HOSPICE 501511	57	41	38	3,357	59	33

Hospices Serving Beneficiaries Residing in Selected Counties (with 11+ Beneficiaries served)

Custom Report for VistaRiver Hospice using newly released Medicare 2020 Hospice Claims Information - King and Pierce Counties, WA.
4,764 Medicare Certified Hospices Served 1,714,371 Medicare Beneficiaries across 1,832,314 new admissions in the 50 US states and DC during 2020.
* Indicates cells blanked where N<11 (per CMS reporting requirements).
© Hospice Analytics, Inc., 12/23/21.

Table 1: 2020 Medicare Cost Report Data Agencies reporting data for hospice in King County

Department of Health
2021-2022 Hospice Numeric Need Methodology
Admissions - Summarized

Recent approvals showing default volumes:
Olympic Medical Center - Clallam County. Approved in September 2019. Default volumes for 2019-2020
Providence Hospice - Clark County. Approved in 2019. Default volumes in 2019-2020
The Pennant Group - Grays Harbor County. Approved August 2021. No adjustment possible for 2021, adjustment in 2020 as proxy.
Wesley Homes Hospice - King County. Approved in 2015, operational since 2017. 2018 volumes exceed "default" - no adjustment for 2018. Adjustments in 2019.
Envision Hospice - King County. Approved in 2019. Default volumes for 2019-2020
Continuum Care of King - King County. CN issued March 2020. Default volumes for 2020
Empires Healthcare Group - King County. Approved in 2021. No adjustment possible for 2021, adjustment in 2020 as proxy.
Seasons Hospice - King County. Approved in 2021. No adjustment possible for 2021, adjustment in 2020 as proxy.

Table 2: King county recent CN approved agencies

King County is served by 14 agencies (9 presented in table 1; 5 agencies receiving CN approval in table 2).

Table 1 shows that three of the operational hospice agencies had average length of stays >62.66 that exceeded the Washington State need methodology length of stay average.

While the many of the hospice agencies are large and established there still exists access to care for many residents relatively compared to the county's population. Although these agencies provide a good service, they don't always have enough resources or staff members to meet all of their patient's needs. This is where new hospice organizations come into play, providing support services that can be tailored specifically towards those who need them.

Staffing will be a factor in the planning area that could restrict access to hospice care. VistaRiver has a plan that addresses this factor head on:

1) Recruiting and retaining qualified healthcare personnel regionally to dedicate to establish, operate and grow

the hospice agency. A core group of qualified healthcare professionals are identified and will be ready to relocate to King County to support this project upon a favorable decision.

2) Partnering with Alante Primary Care to provide transitional care management, Hospice Care Supervision (CPT Code: G0182), 24/7 access to a nurse practitioner, medically necessary home visits, palliative care and supporting the hospice services with dedicated Nurse Practitioners and personalized dedicated software solutions.

Understanding another factor that could restrict access to hospice care is by analyzing and comparing the cause of deaths in King County helps to understand restrict patients access to services.

The top three causes of death in King County are cancer, heart disease, and Alzheimer's Disease. A principal diagnosis of **cancer (29.6 percent)** was the leading diagnosis among Medicare hospice patients, followed by principle diagnosis of circulatory/heart disease (17.4 percent) and dementia (15.6 percent). Routine Home Care accounted for 98.2 percent of care provided according to NHPCO.6 Hospice is underutilized in cancer and non cancer deaths, notably in those with a non-cancer diagnosis (heart disease and dementia). Hospice utilization in King County (45.91%) trails the national average (46.14%).

Using King County demographic information, census data, 2020 Medicare claims data along with the numeric need methodology provides the general description of the types of patients to be served by this project.

- **Hospice Utilization (Medicare Hospice Deaths / Medicare Deaths):**
  - 46.14% 2020 National Hospice Utilization (of beneficiaries who died, died on hospice).
  - 45.47% 2020 Washington State Hospice Utilization.
  - 45.91% 2020 King County Hospice Utilization.

  Washington state and King County hospice utilization rates are all below the national average.

- **Hospice Utilization x Race:** Breaking hospice utilization rates down further by race, we find hospice utilization for Whites in King County to be significantly higher than all other races:
  - 46.96% White
  - 34.93% Hispanic
  - 34.81% Asian
  - 32.00% Black
  - 28.47% North American Native

  This trend for Whites to have higher hospice utilization rates is consistent and long-standing across both Washington state and nationally. Per the hospice utilization definition, this addresses hospice deaths by race.[7]

  We believe that everyone should have access to the end-of-life care they deserve. Racial and ethical disparities in hospice utilization are multi-factorial as observed by a prominent study.[8] VistaRiver will stand out among other hospice providers by it's plans to address this disparity, among others, through it's partnership with MyCancerJourney's innovative health navigator tool which has been shown to help underserved groups, racial and ethnic minorities, in making decisions about their care.

- **Hospice Admissions and Length of Stay x Race:** Consistent with hospice utilization trends above, hospice admissions occur at higher percentages for Whites compared to all other races. Additionally, both mean and median hospice lengths of stay are longer for Whites compared to all other races. These trends hold true for beneficiaries residing in King County as well as Washington state and nationally.

  In summary, VistaRiver is committed to being accessible and available to patients and helping alleviate the restrictions to hospice services in three distinct ways:

  1) Dedicated Quick Response RNs for timely admissions (timely admissions)
  2) Increase hospice utilization through its MyCancerJourney (potentially increasing hospice utilization)
  3) Increased care by way of Alante Primary Care

[6] Hospice Facts & Figures | NHPCO

[7] **Custom Report for VistaRiver Hospice using newly released Medicare 2020 Hospice Claims Information - King and Pierce Counties, WA.**

[8] Racial/Ethnic Disparities in Hospice Utilization Among Medicare Beneficiaries Dying from Pancreatic Cancer - PubMed (nih.gov)

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

Based on the department's need methodology results for two additional hospice agencies in King County this application should not be considered unnecessary duplication of services.

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

VistaRiver of King County, LLC will be available and accessible to the entire planning area of King County.

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

King County's hospice utilization for 2020 was 45.91% which is slightly above the State average of 45.47% yet lags the National Hospice utilization 46.14%.[9]

Breaking hospice utilization rates down further by race, we find hospice utilization for Whites in King County to be significantly higher than all other races:

- 46.96% White
- 34.93% Hispanic
- 34.81% Asian
- 32.00% Black
- 28.47% North American Native

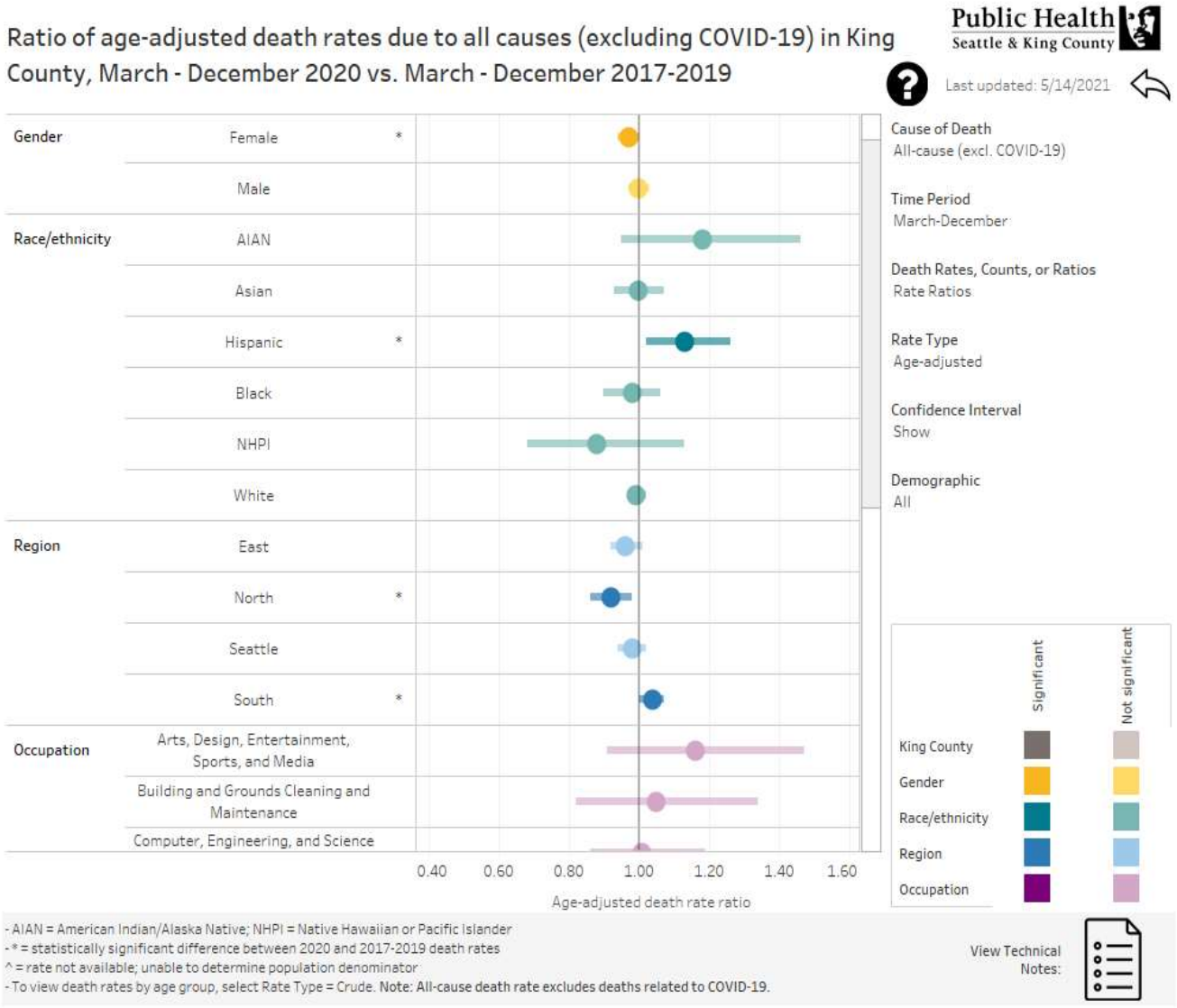
This trend for Whites to have higher hospice utilization rates is consistent and long-standing across both Washington state and nationally. Per the hospice utilization definition, this addresses hospice deaths by race. [10]

"The two leading causes of death in King County each year, going back to the earliest available data from 1999, are cancer and heart disease. No other causes of death come close."[11]

[9] **Custom Report for VistaRiver Hospice using newly released Medicare 2020 Hospice Claims Information - King County, WA.**

[10] **Custom Report for VistaRiver Hospice using newly released Medicare 2020 Hospice Claims Information - King and Pierce Counties, WA.**

[11] COVID-19 has likely passed Alzheimer's as the 3rd leading cause of death in King County | The Seattle Times



Under-served groups in King County include but are not limited to low-income persons, racial and ethnic minorities, women, handicapped persons, and the elderly. VistaRiver is committed to being available and accessible to all under-served groups. We submit the admission policy to demonstrate the overall guiding principles ensuring all residents in King County will have access to end-of-life care.

The follow excerpt from VistaRiver's admission policy states the following:

"…patients would be admitted without regard to race, ethnicity, national origin, age, sex, pre-existing condition, physical, or mental status."

King County has a large and diverse population and understanding the following statistics will help clarify how this project will be available and accessible to underserved groups.

- Hospice Admissions and Length of Stay x Race: Consistent with hospice utilization trends above, hospice admissions occur at higher percentages for Whites compared to all other races. Additionally, both mean and median hospice lengths of stay are longer for Whites compared to all other races. These trends hold true for beneficiaries residing in King County as well as Washington state and nationally.[12]

[12] **Custom Report for VistaRiver Hospice using newly released Medicare 2020 Hospice Claims Information - King and Pierce Counties, WA.**

- Hospice Levels of Care x Race: Because 99%+ of hospice days are billed at the Routine Home Care level of care, there is little differentiation across the four hospice levels of care by race. This is expected, and holds true across beneficiaries residing in King County as well as Washington state and nationally.

- Hospice Locations of Care: Hospice beneficiaries in King County are slightly more likely to receive care at Home and less likely to receive care in other settings compared to Washington state and national averages.

    - 64% Home location of hospice care in King and Pierce Counties
    - 62% Home location of hospice care in Washington state
    - 59% Home location of hospice care Nationally

There were slight differences in all other hospice locations of care, generally falling between Washington state and national averages. Other hospice locations of care include: Assisted Living Residences, Skilled Nursing Facilities, Non-skilled Nursing Facilities, Hospice Inpatient, Hospital Inpatient, Long Term Care Hospital, Psychiatric Inpatient, and Other.

- Hospice Locations of Care x Race: Whites received hospice care slightly less frequently at the Home location of care and more frequently across all other locations of care. All other races were significantly more likely to receive hospice care at Home, and less likely to receive hospice care across all other locations of care.

7. Provide a copy of the following policies:
    - Admissions policy [Appendix 22]
    - Charity care or financial assistance policy [Appendix 23]
    - Patient Rights and Responsibilities policy [Appendix 24]
    - Non-discrimination policy [Appendix 22]

Suggested additional policies include any others believed to be directly related to patient access (death with dignity, end of life, advanced care planning)

8. If there is not sufficient numeric need to support approval of this project, provide documentation supporting the project's applicability under WAC 246-310-290(12). This section allows the department to approve a hospice agency in a planning area absent numeric need if it meets the following review criteria:
    - All applicable review criteria and standards with the exception of numeric need have been met;
    - The applicant commits to serving Medicare and Medicaid patients; and
    - A specific population is underserved; or
    - The population of the county is low enough that the methodology has not projected need in five years, and the population of the county is not sufficient to meet an ADC of thirty-five.

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

The need methodology clearly demonstrates need to support the approval of two new agencies based on the projected unmet demand.

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

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

1. Provide documentation that demonstrates the immediate and long-range capital and operating costs of the project can be met. This should include but is not limited to:

- Utilization projections. These should be consistent with the projections provided under the Need section. **Include all assumptions.**
- Pro Forma revenue and expense projections for at least the first three full calendar years of operation using at a minimum the following Revenue and Expense categories identified at the end of this question. **Include all assumptions.**
- Pro Forma balance sheet for the current year and at least the first three full calendar years of operation. **Include all assumptions**.

VistaRiver of King County, LLC is a new agency. Therefore, the Pro Forma revenue and expense projections cover the first three calendar years of operation, 2023 – 2026 and include all assumptions that are consistent with the representations in the application itself. A 2023 – 2026 Balance Sheet is also provided for the first three, full calendar years of operation include all assumptions. Please see Appendix 27 which includes a pro forma forecast showing operating revenue and expenses for the first three full years of operations and partial year in 2023.

- For existing agencies proposing addition of another county, provide historical revenue and expense statements, including the current year. Ensure these are in the same format as the projections. For incomplete years, identify whether the data is annualized.

Revenue	**Expenses**
Medicare, including Managed Care	Advertising
Medicaid, including Managed Care	Allocated Costs
Private Pay	B & O Taxes
Other, [TriCare, Veterans, LNI, etc.] detail what is included	Depreciation and Amortization
Non-operating revenue	Dues and Subscriptions
	Education and Training
	Employee Benefits
	Equipment Rental
	Information Technology/Computers
Deductions from Revenue:	Insurance
(Charity)	Interest
(Provision for Bad Debt)	Legal and Professional
(Contractual Allowances)	Licenses and Fees
	Medical Supplies
	Payroll Taxes
	Postage
	Purchased Services (utilities, other)
	Rental/Lease
	Repairs and Maintenance
	Salaries and Wages (DNS, RN, OT, clerical, etc.)
	Supplies
	Telephone
	Travel (patient care, other) Other, detail what is included

2. Provide the following agreements/contracts:
    - Management agreement [Not applicable]
    - Operating agreement [Appendix 33]
    - Medical director agreement [Appendix: 11]
    - Joint Venture agreement [Not applicable]

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

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

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

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

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

a. An **executed** purchase agreement or deed for the site.

b. A **draft** purchase agreement for the site. The draft agreement must include a document signed by both entities committing to execute the agreement as submitted following CN approval.

c. An **executed** lease agreement for at least three years with options to renew for not less than a total of two years.

d. A **draft** lease agreement. For Certificate of Need purposes, draft agreements are acceptable if the draft identifies all entities entering into the agreement, outlines all roles and responsibilities of the entities, identifies all costs associated with the agreement, includes all exhibits referenced in the agreement. The draft agreement must include a document signed by both entities committing to execute the agreement as submitted following CN approval.

VistaRiver of King County, LLC is located at Laurel Cove Community at 17201 15th Ave NE Shoreline, WA 98155. Appendix 25 provides a draft lease agreement.

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

Table 21 provides the estimated capital expenditure associated with the project. VistaRiver of King County, LLC is located at Laurel Cove Community so there is no building remodel, fixed equipment or moveable equipment costs associated with the project. Minor equipment such as laptops and cell phones are expected to be supported by current inventory.

Item	Cost
a. Land Purchase	$
b. Utilities to Lot Line	$
c. Land Improvements	$
d. Building Purchase	$
e. Residual Value of Replaced Facility	$
f. Building Construction	$
g. Fixed Equipment (not already included in the construction contract)	$
h. Movable Equipment	$
i. Architect and Engineering Fees	$
j. Consulting Fees	$
k. Site Preparation	$
l. Supervision and Inspection of Site	$
m. Any Costs Associated with Securing the Sources of Financing (include interim interest during construction)	
1. Land	$
2. Building	$
3. Equipment	$
4. Other	$
n. Washington Sales Tax	$
Total Estimated Capital Expenditure	**$**

Start-up Assets	
Working Capital	$1,490,172
Inventory	$0
Other Current Assets	$0
Land	$0
Equipment	$0
Structures	$0
Furniture	$6,500
Computers	$2,000
Printer	$500
Telephone	$828
	$0
	$0
	$0
Other Long-term Assets	$0
Total Start-up Assets	**$1,500,000**

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

The owners of VistaRiver King County Holdco, LLC are jointly responsible for the capital costs equally.

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

Start-up costs are estimated to be less than $30,000 to cover working capital requirements. Located at Laurel Cove will reduce the costs of outreach and administration during the certification process.

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

The ownership of VistaRiver King County HoldCo, LLC are jointly responsible for the capital costs.

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

As noted in this application, King County hospices are under capacity stress, a current need for two new hospices; resulting in shorter lengths of stay and limited outreach as shown by admissions. VistaRiver Hospice being located at Laurel Cove can operate with great economies of scale without large patient volumes that could affect new King County hospices and additional staffing is minimized due to the economies of scale. This addition of capacity should reduce future capacity stress for King County hospices while not reducing current volumes. This will give other newly approved hospices an opportunity to catch up with the current volume of patients.

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

With minimal capital, start-up, and operational costs of $30,000 the project's impact on King County's health care services is not unreasonable. Hospice care has been shown to offer cost benefits to patients and families with reduced end-of-life expenses. This proposal seeks to address the scarcity of hospice agencies in King County while also increasing access for those who need it most. Over time this will reduce the cost of end-of life care which will be beneficial for all parties involved including patients and their loved ones.

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

The numbers in the payer mix table below are averages based on experience

Payer Mix	Percentage of Gross Revenue	Percentage by Patient
Medicare	89%	89%
Medicaid	6%	6%
Other Payers (list in individual lines) PP, 3rd Party, VA	5%	5%
Total	100%	100%

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

Not applicable.

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

$6,000 for furniture, $2,000 for computers, $500 for printer and $828 for telephone.

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

The members of VistaRiver King County HoldCo, LLC have cash reserves more than $1,500,000 sufficient to support the start-up cash flow requirements establishing, operating and maintain the new hospice agency in King County. Appendix 30 provides a receipt of funds available in excess of $3,000,0000. Additionally joint letter of financial commitment, appendix 31, from the members of VistaRiver King County HoldCo, LLC. The source of the funds is from cash reserves exclusively ear marked for this project.

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

Not Applicable.

15. Provide the most recent audited financial statements for:
- The applicant, and
- Any parent entity responsible for financing the project.

Appendix 10 provides the most recent audited financial statements for the applicant and any parent entity responsible for financing the project.

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

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

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

ADMINISTRATIVE/OFFICE PERSONNEL

	2023	2024	2025	2026
Administrative Staff Count				
ED / Director of Patient Care Svcs	1.0	1.0	1.0	1.0
Assistant Director of Clinical Svcs	0.0	0.0	0.0	0.0
Clinical Supervisor	0.0	0.4	1.4	1.9
Intake/Scheduling	1.0	1.0	1.0	1.1
Community Patient Coordinator	1.0	1.1	1.4	1.8
Total Administrative Staff	3.0	3.5	4.8	5.8
Salary Per Position				
Administrator	$ 150,000	$ 150,000	$ 150,000	$150,000
ED / Director of Patient Care Svcs	$ 150,000	$ 150,000	$ 150,000	$150,000
Assistant Director of Clinical Svcs	$ 85,000	$ 85,000	$ 85,000	$85,000
Clinical Supervisor	$ 83,232	$ 83,232	$ 83,232	$83,232
Intake/Scheduling	$ 41,600	$ 41,600	$ 41,600	$41,600
Community Patient Coordinator	$ 75,000	$ 75,000	$ 75,000	$75,000
Payroll Per Position (Count x Salary)				
Administrator	$0	$0	$0	$0
ED / Director of Patient Care Svcs	$150,000	$150,000	$150,000	$150,000
Assistant Director of Clinical Svcs	$0	$0	$0	$0
Clinical Supervisor	$0	$33,986	$117,912	$156,060
Intake/Scheduling	$41,600	$41,600	$42,589	$45,614
Community Patient Coordinator	$75,000	$79,332	$102,018	$137,062
Total Admininstrative/Office Payroll	**$266,600**	**$304,918**	**$412,519**	**$488,736**

FIELD STAFF PERSONNEL

	2023	2024	2025	2026
Field Staff Count				
Hospice Aides	1.6	2.4	3.4	4.6
SW	1.0	1.1	1.4	1.9
Spiritual Care	0.3	0.4	0.6	0.8
Physician	0.1	0.2	0.3	0.4
Admissions Dedicated RN (Quick Response	1.0	1.5	2.0	2.7
Bereavement	0.4	0.6	0.8	1.1
Volunteer	0.4	0.6	0.8	1.1
RN	1.6	2.4	3.4	4.6
LPN	0.8	1.2	1.6	2.2
Total Field Staff	7.1	10.4	14.4	19.3
Salary Per Position				
Hospice Aides	$37,440	$37,440	$37,440	$37,440
SW	$72,800	$72,800	$72,800	$72,800
Spiritual Care	$72,800	$72,800	$72,800	$72,800
Physician	$260,000	$260,000	$260,000	$260,000
On-Call	$93,600	$93,600	$93,600	$93,600
Admissions	$93,600	$93,600	$93,600	$93,600
Bereavement	$72,800	$72,800	$72,800	$72,800
Volunteer Coordinator	$52,000	$52,000	$52,000	$52,000
RN	$93,600	$93,600	$93,600	$93,600
LPN	$68,640	$68,640	$68,640	$68,640
Payroll Per Position (Count x Salary)				
Hospice Aides	$59,340	$91,001	$127,319	$171,054
SW	$72,800	$77,004	$102,614	$134,689
Spiritual Care	$21,302	$32,667	$45,704	$61,404
Physician	$32,967	$50,556	$70,733	$95,030
0	$0	$0	$0	$0
Admissions Dedicated RN (Quick Response	$89,010	$136,502	$190,979	$256,580
Bereavement	$27,692	$42,467	$59,416	$79,825
Volunteer	$19,780	$30,334	$42,440	$57,018
RN	$148,350	$227,504	$318,298	$427,634
LPN	$52,219	$80,081	$112,041	$150,527
Total Field Staff Payroll	**$471,241**	**$688,036**	**$957,502**	**$1,283,233**

TOTAL PERSONNEL BREAKDOWN

	2023	2024	2025	2026
Total Personnel	**10.1**	**13.8**	**19.2**	**25.1**
Total Payroll	**$790,061**	**$1,073,036**	**$1,482,061**	**$1,922,497**
Payroll/Revenue	**99.49%**	**52.65%**	**55.24%**	**47.08%**

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

Not Applicable.

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

Assumptions are listed in appendix 26

The assumptions used to project the number and types of FTEs identified for this project are based on the experience of the applicants as well as previous successful King County CN Hospice applications.

A staff to patient ratio is used to project the number and types of FTE for this application for the first three full years.

Staff Count Per Position	ADC / Caseload
Administrator	100
ED / Director of Patient Care Svcs	100
Assistant Director of Clinical Svcs	75
Clinical Supervisor	30
Intake/Scheduling	50
Community Patient Coordinator	30
Hospice Aides	12
SW	30
Spiritual Care	65
Physician	150
Admissions Dedicated RN (Quick Response)	20
Bereavement	50
Volunteer	50
RN	12
LPN	25

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

The staffing ratios are adequate for the number of patients and visits project based on the experience of the applicant operating hospice agencies, industry standards and compared to CN applications that have been submitted and approved.

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

Bhupinder Walia, MD whose professional license number, MD60211392, is the proposed medical director under contract. The medical director contract is attached in Appendix xx.

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

Not applicable as the medical director is under contract.

7. Identify key staff by name and professional license number, if known. If not yet known, provide a timeline for staff recruitment and hiring (nurse manager, clinical director, etc.)

Key Staff and Clinical Discipline are included. Each are in the process of obtaining their Washington licensure and will transfer to the area to support this new agency fully. The expected time line, based on a favorable CN decision, allows us to complete the necessary accommodations and licensure for the staff that will support this project.

1) Shannon Hoff, RN – Executive Director
2) Cathe Day, RN – Clinical Leader
3) Katie Swett, RN
4) Ashley Davis, RN
5) Toni Jefferson, RN

6) Rhonda VanNess, RN
7) Sif Gunnardottier-Locken, RN

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

Not applicable.

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

Recruitment and retention are a strength of VistaRiver. One of the greatest challenges any of the applicants and current hospice companies is going to have is recruiting and retaining qualified healthcare and management professionals. It is well documented that clinician burn out combined with an already strained labor market create significant barriers.

Our strength lies in the fact that we have been successful recruiting and retaining qualified healthcare professionals in competitive and strained labor markets.

- Traditional recruitment methods include: job fair, posting adverts on major recruitment websites, and posting jobs adverts in discipline specific job board websites.

- Hosting monthly "Day In the Life" opportunities for interested candidates to observe, ask questions and understand the various roles and responsibilities of hospice clinicians.

- Staffing company contracts

- Referral staff bonus programs

- Dedicated recruitment team

- Equity opportunity based on tenure and performance

A group of highly trained and well qualified healthcare personnel and management that will establish and operate this project.

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

The hours of operations are as follows:

Office Hours: 8:00am-5:00pm
On-Call: Two dedicated team members will be available and accessible 24 hours a day for seven days per week.

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

The applicant will assess customer satisfaction and quality improvement for the agency by using the following methods:

1) Assigning the Job Responsibilities of the Performance Improvement Coordinator
2) QAPI Policy
3) Hiring and assigning 3rd party contracted customer satisfaction

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

Not applicable.

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

Not applicable.

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

VistaRiver of King County, LLC, as a new provider, expects to following ancillary or support agreements to take place:

- Hospital: VistaRiver will establish agreements local hospitals (i.e. Harborview, VA, Seattle Medical) for GIP.
- Respite Care: VistaRiver will work with SNFs in King County.
- Long Term Care facilities: VistaRiver will work with SNFs located in King County.
- Pharmacy Benefit Manager: VistaRiver has an agreement with BetterRX
- Home Medical Equipment and Specialty Pharmacy Services: Will establish DME contract with Bellevue Healthcare
- Occupational Therapy, Physical Therapy, and Speech Therapy: VistaRiver will contract with local Home Health agencies within King County or contract directly with the respective disciplines.
- Oncology Cancer Center: VistaRiver Hospice will develop working relationships with cancer programs in King County.
- Primary Care Clinics: VistaRiver Hospice will focus on developing working relationships with federally qualified health care clinics such as Sea Mar, Health point, International Community Health Services and County Doctor Clinics and as part of its outreach to dual eligibility Medicare beneficiaries. It will also use its regular outreach activities with primary care clinics throughout Seattle and the rest of King County, initially relying on relationships developed with physicians in its home health and SNF operations.

The relationships demonstrate that VistaRiver Hospice has the capabilities to meet the service demands for the project. Once the project is approved, VistaRiver Hospice will work to make any necessary adjustments or amendments to the agreements in order to provide the fullspectrum of hospice services in King County.

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

Not Applicable

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

No changes are expected as a result of this project.

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

The list of healthcare facilities with which the agency anticipates it would establish working relationships with is referenced in question 14.

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

a. A criminal conviction which is reasonably related to the applicant's competency to exercise responsibility for the ownership or operation of a hospice care agency; or

b. A revocation of a license to operate a health care facility; or

c. A revocation of a license to practice a health profession; or

d. Decertification as a provider of services in the Medicare or Medicaid program because of failure to comply with applicable federal conditions of participation.

No facility or practitioner associated with this application has a history of any actions listed above.

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

The proposed project will promote continuity in the provision of health care services in King County, and not result in an unwarranted fragmentation of services.

Washington State (45.47%) and King County (45.91%) hospice utilization rates are all below the national average (46.14%). This alone further underscores the numeric need for either existing hospices in King County to increase activity or need for another hospice provider.

VistaRiver has sufficient supply of qualified staff for the project, including both health personnel and management personnel located in Washington State and Oregon State that will fully support the proposed King County hospice project if given a favorable decision. Furthermore, VistaRiver is confident that it's unique shared equity business model helps to recruit and retain the necessary qualified health and management personnel to support the projected growth of the agency. The dedicated resources to recruit and retain the qualified health personnel both within King County as well as more broadly is a strength of the applicant's resources as well as another reason that it can confidently state this application will not result in an unwarranted fragmentation of services.

The proposed hospice services by the applicant, which include MyCancerJourney and Alante Primary Care, will address the existing need for two additional hospice agencies in King County while increasing hospice utilization in underserved groups[13]. The services provided by VistaRiver in both MyCancerJourney and Alante Primary Care will promote continuity in the provision of health care.

- **Hospice Utilization x Race:** Breaking hospice utilization rates down further by race, we find hospice utilization for Whites in King County to be significantly higher than all other races:
  - 46.96% White
  - 34.93% Hispanic
  - 34.81% Asian
  - 32.00% Black
  - 28.47% North American Native

This trend for Whites to have higher hospice utilization rates is consistent and long-standing across both Washington state and nationally. Per the hospice utilization definition, this addresses hospice deaths by race.

- **Hospice Admissions and Length of Stay x Race:** Consistent with hospice utilization trends above, hospice admissions occur at higher percentages for Whites compared to all other races. Additionally, both mean and median hospice lengths of stay are longer for Whites compared to all other races. These trends hold true for beneficiaries residing in King County as well as Washington state and nationally.

Proactive outreach into the underserved communities along with the innovative MyCancerJourney and Alante Primary Care partnerships will help to reach and improve the utilization of hospice care.

As stated above VistaRiver will seek accreditation from The Joint Commission which provides reasonable assurance that the services to be provided through the proposed project will be provided in a manner that ensure safe and adequate care to the public to be served and in accord with applicable federal and state laws, rules and regulations.

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

Hospice Workforce Concerns: Barb Hansen, Executive Director of the Washington State Hospice & Palliative Care Organization, shared concerns about the hospice workforce in Washington state – mostly due to COVID-19 and the Public Health Emergency. VistaRiver has sufficient qualified health and management personnel ready to support the project. None of the staff will disrupt the existing service area's health care system and as such has an appropriate relationship to the service area's existing health care system as required in WAC 246-310-230

[13] MyCancerJourney

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

Facility or Agency Name	Location	License #	CMS Certification #	Acquired <3 calendar years, yes, list the coresponding month and year the sale became final, N/A	Type of facility or agency
Clearbrook Inn	2333 Schold Place NW	2147	N/A	N/A	ALF
	Silverdale, WA 98383				
Country Meadows	12169 Country Meadows Lane NW	N/A	N/A	N/A	ILF
	Silverdale, WA 98383				
Laurel Cove Community	17201 15th Avenue NE	2389	N/A	N/A	ALF/MC
	Shoreline, WA 98155				
Northwoods Lodge	2321 NW Schold Place	1589	505484	N/A	SNF
	Silverdale, WA 98383				
The Ridge	1501 NW Tower View Circle	2231	N/A	N/A	MC
	Silverdale, WA 98383				
Aleca Home Health	1220 20th St SE, Suite 310	Pending	Pending	Dec. 2021	HH
	Salem, OR 97302				
Aleca Home Health	2400 NW Schold Place	Active WDOH License, but no #		Feb. 2020	HH
VistaRiver Hospice - Portland	29100 SW Town Center Loop W Suite 130	16-1085	38-1574	NA	Hospice
	Wilsonville, OR 97070				

22. If information provided in response to the question above shows a history of condition-level findings, provide clear, cogent and convincing evidence that the applicant can and will operate the proposed project in a manner that ensures safe and adequate care, and conforms to applicable federal and state requirements.

No none condition-level findings have been found on any of the facilities or agencies owned or operated by the applicant.

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

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

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

VistaRiver evaluated the following alternatives:

1) Do Nothing
2) Purchase or acquire an existing hospice license
3) Pursue establishing a new Hospice serving King County

Each of the above alternatives were evaluated using the following decision criteria:

1) Does it address the unmet hospice need in King County (availability)
2) Is it financially viable (cost)
3) Would it increase access to care (efficiency)

Evaluating the first alternative, do nothing or status quo, would fail to address the fundamental unmet hospice need. This alternative is rejected as a viable alternative.

Evaluating the second alternative, purchase or acquire an existing hospice license, also does not address the fundamental unmet hospice need. This alternative is also rejected and not considered a viable alternative.

The third alternative, pursue establishing a CN approved Medicare certified and Medicaid hospice agency, is the only viable option. The third alternative is viable as it 1) addresses the unmet hospice need in King County 2) is financially viable and 3) would increase King County residents' access to end-of-life care.

Based on the above criteria and analysis of each criterion, the conclusion is clear. The best option that will result in addressing the unmet hospice need is to seek CN approve to establish a new Medicare Certified and Medicaid eligible hospice agency to serve King County residents.

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

Comparing the project – establishing a new Medicare certified and Medicaid eligible hospice in King County – with the two alternatives are listed below:

Do Nothing or Status Quo	
1) Patient Access to Health Services	It is evident that doing nothing does not improve access to hospice agencies, meaning there are no advantages. The disadvantage of taking no action is it does not address King County's need for more hospice agencies; therefore, this option does not address the access to care problem that exists.
2) Quality of Care	When it comes to the quality of our care, there is no advantage to taking no action. The disadvantage of not doing anything would be driven by shortages in access points for hospice services, which would tighten with time and have adverse impacts on the quality of care.
3) Cost and Operating Efficiency	This option would have no impacts on costs, but there are disadvantages to it. The disadvantage is that it would not improve cost efficiencies.
4) Staffing Impacts	There are no advantages from a staffing perspective.
5) Legal Considerations	None
Conclusion:	This alternative was rejected. It does not do anything to address the unmet hospice need in King County.

Purchase or acquire an existing hospice license	
1) Patient Access to Health Services	An acquisition may not add additional capacity for hospice services.
2) Quality of Care	The advantage is that this option could increase quality and care in King County. There are no clear disadvantages.
3) Cost and Operating Efficiency	The cost to acquire a license could prove to be considerable.
4) Staffing Impacts	The advantage for staffing are that staff from regionally available exist and can serve the immediate needs of the marketplace.
5) Legal Considerations	Considerable time and cost could be associated with the legal process
6) Conclusion:	This alternative is rejected because it is potentially too costly as well as does not help improve the access to care timely.

Pursue establishing a new Hospice serving King County		
7)	Patient Access to Health Services	This project is a step in the right direction towards making health care more accessible. It will help improve access to care across King County, and there have been no disadvantages associated.
8)	Quality of Care	This project is intended to improve quality of care in King County, and there are no disadvantages or flaws.
9)	Cost and Operating Efficiency	VistaRiver Hospice will be able to leverage fixed costs such as the lease and operational expenses by spreading these fixed costs across the hospice and palliative care. It also has minimal operating expenditures during its initial startup period, before it achieves volume that covers fixed and variable cost.
10)	Staffing Impacts	This project will create new jobs that benefit King County. These new jobs also provide paths for staff who are dedicated to efficient delivery of hospice services, and there are no disadvantages. VistaRiver and Sante have a proven track record of hiring and retaining quality staff.
11)	Legal Considerations	The advantage of VistaRiver Hospice of King County staff is that they will have the ability to serve more residents from King County. More people will be able to receive quality hospice services, which means a higher quality for those who do. The disadvantage is that it requires CN approval and takes time and money in order to pursue this endeavor.
12)	Conclusion:	This alternative was selected as it addresses the unmet need for additional hospice agencies in King County.

The 2021 need methodology identified unmet need of an 85 patient ADC requiring two new hospice agencies.

3. If the project involves construction, provide information that supports conformance with WAC 246-310-240(2):

- The costs, scope, and methods of construction and energy conservation are reasonable; and
- The project will not have an unreasonable impact on the costs and charges to the public of providing health services by other persons.

Not applicable as the project does not involve construction.

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

`With the approval of VistaRiver's proposed project, residents in King County would have additional access to hospice services. Analyzing the 2020 Medicare Annual Hospice Claims Data for King County gives valuable insight into how VistaRiver innovations in the delivery of health services will promote greater quality assurance and cost effectiveness.

- **Hospice Utilization (Medicare Hospice Deaths / Medicare Deaths):**
  - 46.14% 2020 National Hospice Utilization (of beneficiaries who died, died on hospice).
  - 45.47% 2020 Washington State Hospice Utilization.
  - 45.91% 2020 King County Hospice Utilization.

Therefore, Washington state and both King County hospice utilization rates are all below the national average. Additionally, both King County hospice utilization rates are below the Washington state average. This alone speaks to *some* numeric need for either existing hospices in King County to increase activity or need for another hospice provider.

- **Hospice Utilization x Race:** Breaking hospice utilization rates down further by race, we find hospice utilization for Whites in King County to be significantly higher than all other races:
  - 46.96% White
  - 34.93% Hispanic
  - 34.81% Asian
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This trend for Whites to have higher hospice utilization rates is consistent and long-standing across both Washington state and nationally. Per the hospice utilization definition, this addresses hospice deaths by race.

- **Hospice Admissions and Length of Stay x Race:** Consistent with hospice utilization trends above, hospice admissions occur at higher percentages for Whites compared to all other races. Additionally, both mean and median hospice lengths of stay are longer for Whites compared to all other races. These trends hold true for beneficiaries residing in King County as well as Washington state and nationally.

- **Hospice Levels of Care x Race:** Because 99%+ of hospice days are billed at the Routine Home Care level of care, there is little differentiation across the four hospice levels of care by race. This is expected and holds true across beneficiaries residing in King County as well as Washington state and nationally.

- **Hospice Locations of Care:** Hospice beneficiaries in King County are slightly more likely to receive care at Home and less likely to receive care in other settings compared to Washington state and national averages.
  - 64% Home location of hospice care in King County
  - 62% Home location of hospice care in Washington state
  - 59% Home location of hospice care Nationally

There were slight differences in all other hospice locations of care, generally falling between Washington state and national averages. Other hospice locations of care include: Assisted Living Residences, Skilled Nursing Facilities, Non-skilled Nursing Facilities, Hospice Inpatient, Hospital Inpatient, Long Term Care Hospital, Psychiatric Inpatient, and Other.

- **Hospice Locations of Care x Race:** Whites received hospice care slightly less frequently at the home location of care and more frequently across all other locations of care. All other races were significantly more likely to receive hospice care at Home, and less likely to receive hospice care across all other locations of care.

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

WAC 246-310-290(10) provides the following direction for review this sub-criterion of applications for hospice agencies. It states: "In addition to demonstrating numeric need under subsection (7) of this section, applicants must meet the following certificate of need requirements: (a) Determination of need under WAC 246-310-210; (b) Determination of financial feasibility under WAC 246-310-220; (c) Criteria for structure and process of care under WAC 246-310-230; and (d) Determination of cost containment under WAC 246-310-240." If there are multiple applications, the department's assessment is to apply any service or facility superiority criteria is in WAC 246-310-290(11) provides the superiority criteria used to compare competing projects and make the determination between two or more approvable projects, which is the best alternative

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

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

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

2. If the answer to the previous question is yes, clarify:

- Are these applications being submitted under separate companies owned by the same applicant(s); or
- Are these applications being submitted under a single company/applicant?
- Will they be operated under some other structure? Describe in detail.

The applicant plans to submit hospice CN application for Pierce County under a separate company owned by the same applicants.

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

PRO FORMA PROFIT & LOSS

	2023	2024	2025	2026
Total Revenue	**$794,102**	**$2,038,107**	**$2,683,158**	**$4,083,282**
Total Direct Labor Cost	$479,973	$1,184,228	$1,552,330	$2,356,787
Gross Margin	$314,129	$853,879	$1,130,828	$1,726,495
Gross Margin/Revenue	40%	42%	42%	42%
Expenses				
Audit / Accounting Fees	$2,250	$2,250	$2,250	$2,250
Bad Debt	$7,941	$20,381	$26,832	$40,833
B&O Taxes	$11,912	$30,572	$40,247	$61,249
MyCancerJourney	$1,800	$1,800	$1,800	$1,800
EMR (MatrixCare)	$66,255	$50,255	$50,255	$50,255
Education (Quarterly Staff Mee	$1,000	$1,000	$1,500	$1,500
Facilities - Insurance (Commer	$600	$600	$600	$600
Facilities - Licensing (Joint Co	$8,000	$1,200	$1,200	$1,200
Depreciation	$655	$655	$655	$655
Aministrative/Office Payroll Ta	$66,650	$76,229	$103,130	$122,184
Total Admininstrative/Office P	$266,600	$304,918	$412,519	$488,736
Total Op. Expenses	**$469,909**	**$526,106**	**$679,112**	**$811,387**
Op. Expenses/Revenue	59%	26%	25%	20%
Profit Before Int. & Tax	($155,780)	$327,772	$451,716	$915,108
EBITDA	($155,125)	$328,428	$452,371	$915,763
Interest Expense	$0	$0	$0	$0
Taxes Incurred	$26,856	$88,227	$136,278	$206,806
Net Profit	**($182,636)**	**$239,546**	**$315,438**	**$708,302**
Net Profit %	**-23.0%**	**11.8%**	**11.8%**	**17.3%**

PIERCE

PRO FORMA PROFIT & LOSS

	2023	2024	2025	2026
Total Revenue	**$1,087,071**	**$2,038,259**	**$2,717,679**	**$3,668,866**
Total Direct Labor Cost	**$506,478**	**$1,098,642**	**$1,443,878**	**$2,134,330**
Gross Margin	$580,593	$939,617	$1,273,801	$1,534,536
Gross Margin/Revenue	53%	46%	47%	42%
Expenses				
Audit / Accounting Fees	$2,250	$2,250	$2,250	$2,250
Bad Debt	$7,941	$20,381	$26,832	$40,833
B&O Taxes	$11,912	$30,572	$40,247	$61,249
MyCancerJourney	$1,800	$1,800	$1,800	$1,800
EMR (MatrixCare)	$66,255	$50,255	$50,255	$50,255
Education (Quarterly Staff Mee	$1,000	$1,000	$1,500	$1,500
Facilities - Insurance (Commer	$600	$600	$600	$600
Facilities - Licensing (Joint Co	$8,000	$1,200	$1,200	$1,200
Depreciation	$655	$655	$655	$655
Aministrative/Office Payroll Ta	$66,650	$76,229	$103,130	$122,184
Total Admininstrative/Office P	$266,600	$304,918	$412,519	$488,736
Total Op. Expenses	**$469,909**	**$526,106**	**$679,112**	**$811,387**
Op. Expenses/Revenue	43%	26%	25%	22%
Profit Before Int. & Tax	($155,780)	$327,772	$451,716	$915,108
EBITDA	($155,125)	$328,428	$452,371	$915,763
Interest Expense	$0	$0	$0	$0
Taxes Incurred	$26,856	$88,227	$136,278	$206,806
Net Profit	**($182,636)**	**$239,546**	**$315,438**	**$708,302**
Net Profit %	**-16.8%**	**11.8%**	**11.6%**	**19.3%**

Combined

PRO FORMA PROFIT & LOSS

	2023	2024	2025	2026
Total Revenue	**$1,881,174**	**$4,076,366**	**$5,400,837**	**$7,752,148**
Total Direct Labor Cost	**$986,451**	**$2,282,870**	**$2,996,208**	**$4,491,117**
Gross Margin	$894,722	$1,793,496	$2,404,629	$3,261,031
Gross Margin/Revenue	48%	44%	45%	42%
Expenses				
Audit / Accounting Fees	$4,500	$4,500	$4,500	$4,500
Bad Debt	$15,882	$40,762	$53,663	$81,666
B&O Taxes	$23,823	$61,143	$80,495	$122,498
MyCancerJourney	$3,600	$3,600	$3,600	$3,600
EMR (MatrixCare)	$132,511	$100,511	$100,511	$100,511
Education (Quarterly Staff Mee	$2,000	$2,000	$3,000	$3,000
Facilities - Insurance (Commer	$1,200	$1,200	$1,200	$1,200
Facilities - Licensing (Joint Co	$16,000	$2,400	$2,400	$2,400
Depreciation	$1,310	$1,310	$1,310	$1,310
Aministrative/Office Payroll Ta	$133,300	$152,459	$206,260	$244,368
Total Admininstrative/Office P	$533,200	$609,836	$825,038	$977,473
Total Op. Expenses	**$939,818**	**$1,052,213**	**$1,358,225**	**$1,622,774**
Op. Expenses/Revenue	50%	26%	25%	21%
Profit Before Int. & Tax	($311,560)	$655,545	$903,432	$1,830,216
EBITDA	($310,250)	$656,855	$904,742	$1,831,526
Interest Expense	$0	$0	$0	$0
Taxes Incurred	$53,713	$176,454	$272,555	$413,612
Net Profit	**($365,273)**	**$479,091**	**$630,877**	**$1,416,603**
Net Profit %	**-19.4%**	**11.8%**	**11.7%**	**18.3%**

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

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

Certificate of Need Program Revised Code of Washington (RCW) and Washington Administrative Code (WAC)

Certificate of Need Program laws RCW 70.38

Certificate of Need Program rules WAC 246-310

Certificate of Need Program 'Frequently Asked Questions'

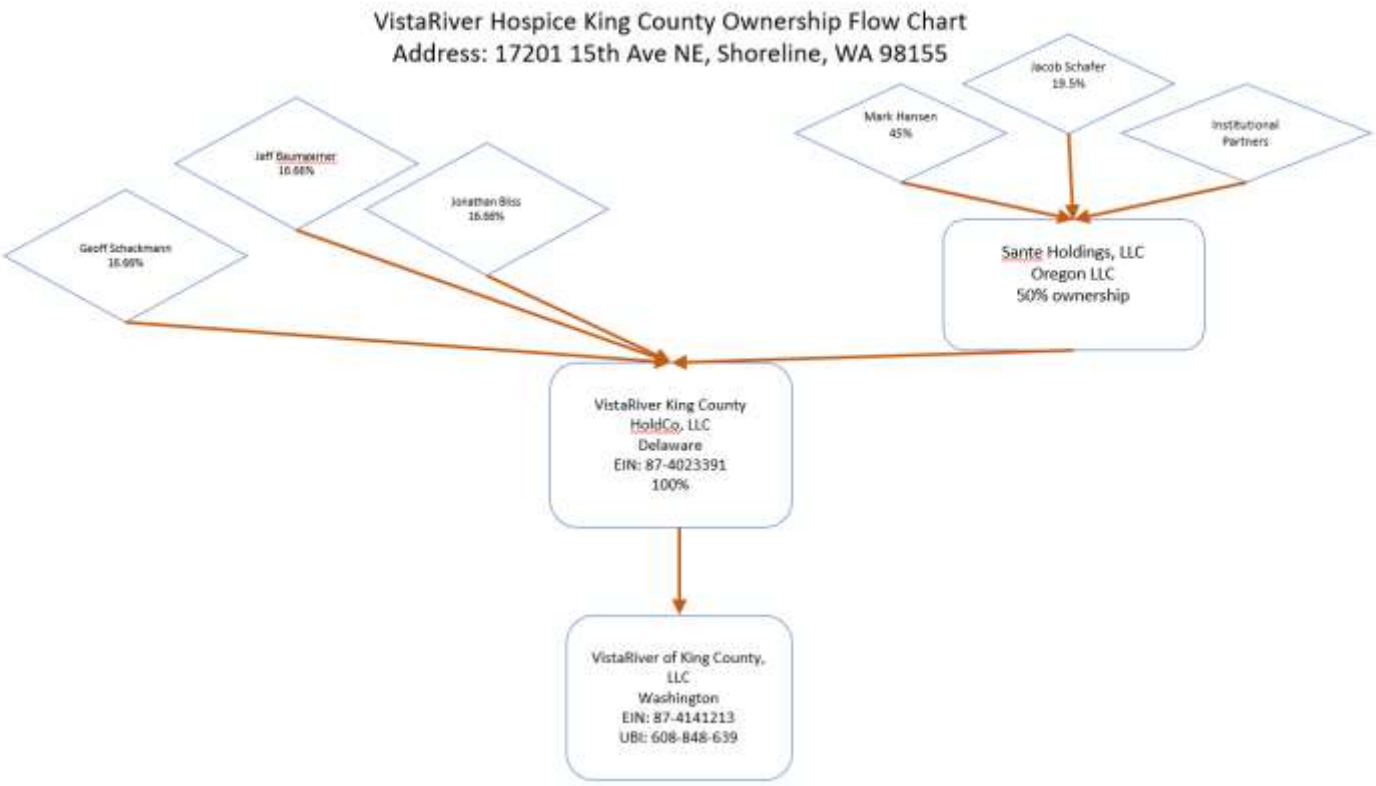
Commonly Referenced Rules for Hospice Projects:

WAC Reference	Title/Topic
246-310-010	Certificate of Need Definitions
246-310-200	Bases for findings and action on applications
246-310-210	Determination of Need
246-310-220	Determination of Financial Feasibility
246-310-230	Criteria for Structure and Process of Care
246-310-240	Determination of Cost Containment
246-310-290	Hospice services—Standards and need forecasting method.

Certificate of Need Contact Information: Certificate of Need Program Web Page Phone: (360) 236-2955
Email: FSLCON@doh.wa.gov

Licensing Resources:
In-Home Services Agencies Laws, RCW 70.127 In-Home Services Agencies Rules, WAC 246-335 Hospice Agencies Program Web Page

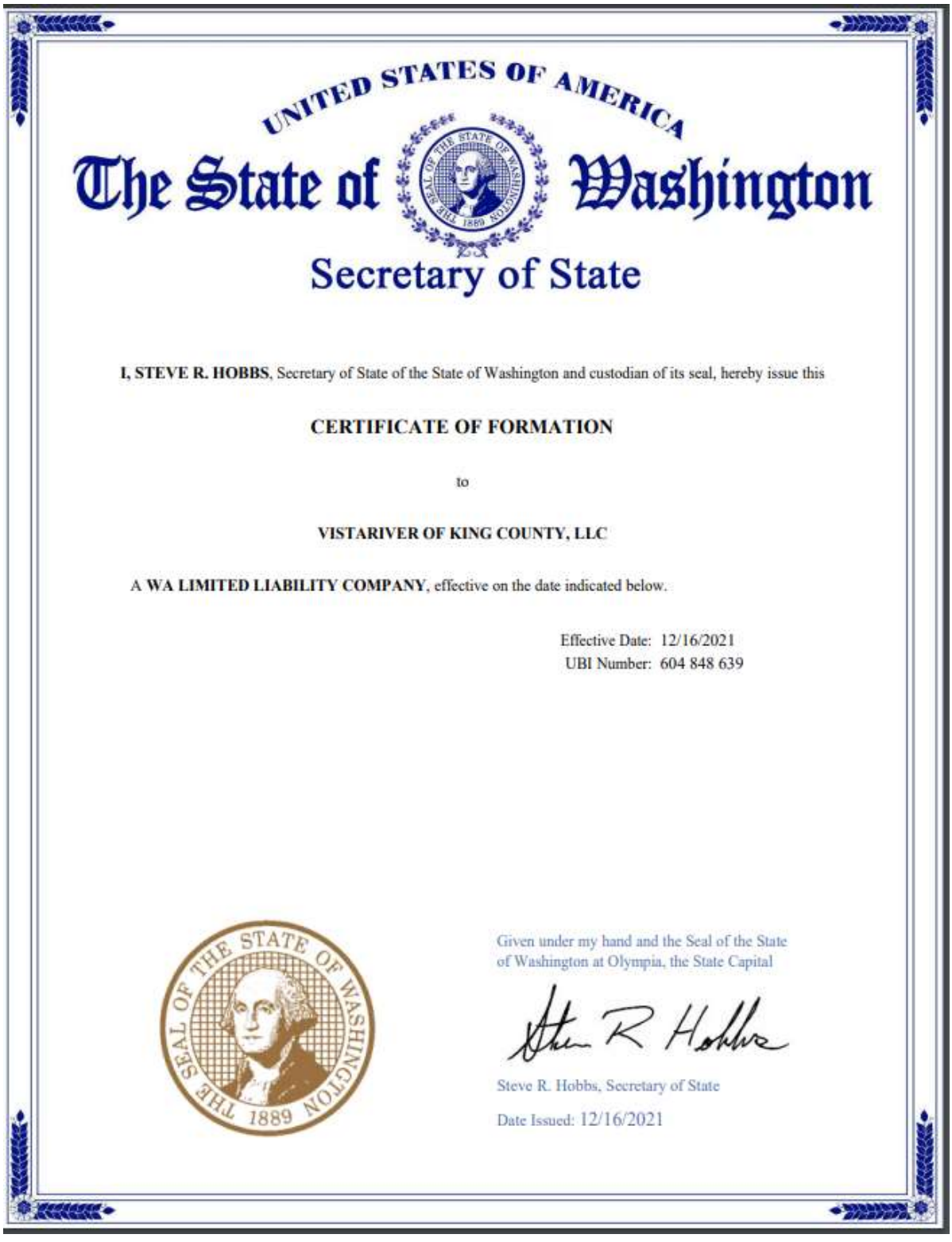
Appendix 1: Organizational Chart



Appendix 2: Existing Organizations

Facility or Agency Name	Location	License #	CMS Certification #	Acquired <3 calendar years, yes, list the corresponding month and year the sale became final, N/A	Type of facility or agency
Clearbrook Inn	2333 Schold Place NW	2147	N/A	N/A	ALF
	Silverdale, WA 98383				
Country Meadows	12169 Country Meadows Lane NW	N/A	N/A	N/A	ILF
	Silverdale, WA 98383				
Laurel Cove Community	17201 15th Avenue NE	2389	N/A	N/A	ALF/MC
	Shoreline, WA 98155				
Northwoods Lodge	2321 NW Schold Place	1589	505484	N/A	SNF
	Silverdale, WA 98383				
The Ridge	1501 NW Tower View Circle	2231	N/A	N/A	MC
	Silverdale, WA 98383				
Aleca Home Health	1220 20th St SE, Suite 310	Pending	Pending	Dec. 2021	HH
	Salem, OR 97302				
Aleca Home Health	2400 NW Schold Place	Active WDOH License, but no #		Feb. 2020	HH
VistaRiver Hospice - Portland	29100 SW Town Center Loop W Suite 130	16-1085	38-1574	NA	Hospice
	Wilsonville, OR 97070				

Appendix 3: VistaRiver of King County, LLC UBI 608 848 639



UNITED STATES OF AMERICA

The State of Washington

Secretary of State

I, STEVE R. HOBBS, Secretary of State of the State of Washington and custodian of its seal, hereby issue this

CERTIFICATE OF FORMATION

to

VISTARIVER OF KING COUNTY, LLC

A WA LIMITED LIABILITY COMPANY, effective on the date indicated below.

Effective Date: 12/16/2021
UBI Number: 604 848 639

Given under my hand and the Seal of the State of Washington at Olympia, the State Capital

Steve R. Hobbs, Secretary of State

Date Issued: 12/16/2021

Appendix 4: Washington Wage-Index Adjusted Medicare Hospice Payment Rates (BKD)

National Medicare Hospice Payment Rates

BKD CPAs & Advisors

	0651 Routine Home Care			0652	0655	0656
	High Rate (1)	Low Rate (2)	Service Intensity Add-on (3)**	Continuous Home Care**	Inpatient Respite Care	General Inpatient Care
	Daily Rate	*Daily Rate*	*Hourly Rate*	*Daily Rate*	*Daily Rate*	*Daily Rate*
National payment rate, before wage-index adjustment, effective October 1, 2021	$ 203.40	$ 160.74	$ 60.94	$ 1,462.52	$ 473.75	$ 1,068.28
Labor share, subject to wage-index adjustment	$ 134.24	$ 106.09	$ 45.83	$ 1,099.82	$ 288.99	$ 678.36
Non-labor share, not subject to wage-index adjustment	$ 69.16	$ 54.65	$ 15.11	$ 362.70	$ 184.76	$ 389.92
% change from prior year	*2.1%*	*2.1%*	*2.1%*	*2.1%*	*2.7%*	*2.2%*
National payment rate, before wage-index adjustment, effective October 1, 2020	*$ 199.25*	*$ 157.49*	*$ 59.68*	*$ 1,432.41*	*$ 461.09*	*$ 1,045.66*
Labor share, subject to wage-index adjustment	*$ 136.90*	*$ 108.21*	*$ 41.01*	*$ 984.21*	*$ 249.59*	*$ 669.33*
Non-labor share, not subject to wage-index adjustment	*$ 62.35*	*$ 49.28*	*$ 18.67*	*$ 448.20*	*$ 211.50*	*$ 376.33*

Hospice aggregate payment cap for cap year ending September 30, 2022	$31,297.61
Hospice aggregate payment cap for cap year ended September 30, 2021	$30,683.93

(1) Routine home care (RHC) high rate applies to hospice patients whose services occur during the first 60 calendar days of a hospice episode of care. A hospice episode of care is considered to be continuous unless there has been more than 60 days between hospice discharge and readmission.

(2) RHC low rate applies to hospice patients whose services occur on calendar day 61 or later during a hospice episode of care. A hospice episode of care is considered to be continuous unless there has been more than 60 days between hospice discharge and readmission.

(3) Service intensity add-on (SIA) is paid on visits performed by registered nurses (RNs) or medical social workers (MSW) for patients during the last seven days of life. SIA is paid in 15-minute increments for up to four hours total per day of combined RN and MSW direct visit time and is in addition to the daily RHC rate. SIA does not apply to days paid at the continuous home care, inpatient respite or general inpatient care rates.

All rate information based on the ***Federal Register*** dated August 4, 2021, and the ***Centers for Medicare and Medicaid Services Manual System Pub. 100-04 Medicare Claims Processing Transmittal 10929, Change Request 12354*** dated August 4, 2021.

BKD National Health Care Group is a division of **BKD, LLP,** a top national accounting and consulting firm, that provides a full range of services for home health and hospice agencies throughout the nation. Questions? Click one of the following.

Contact M. Aaron Little | Visit bkd.com | Download more rates

*Sorted by county or parish
**Hourly rate is paid in 15-minute increments

Washington Wage-Index Adjusted Medicare Hospice Payment Rates
Effective October 1, 2021 Through September 30, 2022

BKD CPAs & Advisors

Billing Code	Core-Based Statistical Area	County or Parish*	State	Wage-Index	0651 Routine Home Care High Rate (1) Daily Rate	0651 Routine Home Care Low Rate (2) Daily Rate	0651 Routine Home Care Service Intensity Add-on (3)** Hourly Rate	0652 Continuous Home Care** Hourly Rate	0655 Inpatient Respite Care Daily Rate	0656 General Inpatient Care Daily Rate
30300	Lewiston	Asotin	WA	0.8635	$ 185.08	$ 146.26	$ 54.68	$ 54.68	$ 434.30	$ 975.68
	After 2% reduction for sequestration				*$ 181.38*	*$ 143.33*	*$ 53.59*	*$ 53.59*	*$ 425.61*	*$ 956.17*
	% change from prior year			*6.0%*	*6.4%*	*6.4%*	*5.0%*	*5.0%*	*4.7%*	*5.8%*
	Prior year comparison, after 2% reduction for sequestration			*0.8150*	*$ 170.44*	*$ 134.72*	*$ 51.05*	*$ 51.06*	*$ 406.62*	*$ 903.39*
28420	Kennewick-Richland	Benton	WA	0.9897	$ 202.02	$ 159.65	$ 60.47	$ 60.47	$ 470.77	$ 1,061.29
	After 2% reduction for sequestration				*$ 197.98*	*$ 156.46*	*$ 59.26*	*$ 59.26*	*$ 461.35*	*$ 1,040.06*
	% change from prior year			*0.8%*	*2.7%*	*2.7%*	*2.6%*	*2.6%*	*3.1%*	*2.7%*
	Prior year comparison, after 2% reduction for sequestration			*0.9819*	*$ 192.83*	*$ 152.42*	*$ 57.76*	*$ 57.76*	*$ 447.44*	*$ 1,012.88*
48300	Wenatchee	Chelan	WA	0.9495	$ 196.62	$ 155.38	$ 58.63	$ 58.62	$ 459.16	$ 1,034.02
	After 2% reduction for sequestration				*$ 192.69*	*$ 152.27*	*$ 57.46*	*$ 57.45*	*$ 449.98*	*$ 1,013.34*
	% change from prior year			*-1.0%*	*1.5%*	*1.5%*	*1.1%*	*1.0%*	*1.8%*	*1.5%*
	Prior year comparison, after 2% reduction for sequestration			*0.9594*	*$ 189.82*	*$ 150.04*	*$ 56.85*	*$ 56.86*	*$ 441.94*	*$ 998.12*
38900	Portland-Vancouver-Hillsboro	Clark	WA	1.2332	$ 234.71	$ 185.48	$ 71.63	$ 71.62	$ 541.14	$ 1,226.47
	After 2% reduction for sequestration				*$ 230.02*	*$ 181.77*	*$ 70.20*	*$ 70.19*	*$ 530.32*	*$ 1,201.94*
	% change from prior year			*1.1%*	*2.3%*	*2.3%*	*4.2%*	*4.2%*	*4.9%*	*2.8%*
	Prior year comparison, after 2% reduction for sequestration			*1.2202*	*$ 224.81*	*$ 177.69*	*$ 67.34*	*$ 67.34*	*$ 505.73*	*$ 1,169.19*
31020	Longview	Cowlitz	WA	1.0954	$ 216.21	$ 170.86	$ 65.31	$ 65.31	$ 501.32	$ 1,133.00
	After 2% reduction for sequestration				*$ 211.89*	*$ 167.44*	*$ 64.00*	*$ 64.00*	*$ 491.29*	*$ 1,110.34*
	% change from prior year			*4.2%*	*4.8%*	*4.8%*	*5.7%*	*5.7%*	*5.8%*	*4.9%*
	Prior year comparison, after 2% reduction for sequestration			*1.0510*	*$ 202.11*	*$ 159.75*	*$ 60.53*	*$ 60.54*	*$ 464.34*	*$ 1,058.20*
48300	Wenatchee	Douglas	WA	0.9495	$ 196.62	$ 155.38	$ 58.63	$ 58.62	$ 459.16	$ 1,034.02
	After 2% reduction for sequestration				*$ 192.69*	*$ 152.27*	*$ 57.46*	*$ 57.45*	*$ 449.98*	*$ 1,013.34*
	% change from prior year			*-1.0%*	*1.5%*	*1.5%*	*1.1%*	*1.0%*	*1.8%*	*1.5%*
	Prior year comparison, after 2% reduction for sequestration			*0.9594*	*$ 189.82*	*$ 150.04*	*$ 56.85*	*$ 56.86*	*$ 441.94*	*$ 998.12*

*Sorted by county or parish
**Hourly rate is paid in 15-minute increments

Washington Wage-Index Adjusted Medicare Hospice Payment Rates
Effective October 1, 2021 Through September 30, 2022

BKD CPAs & Advisors

Billing Code	Core-Based Statistical Area	County or Parish*	State	Wage-Index	0651 Routine Home Care High Rate (1) Daily Rate	0651 Routine Home Care Low Rate (2) Daily Rate	0651 Service Intensity Add-on (3)** Hourly Rate	0652 Continuous Home Care** Hourly Rate	0655 Inpatient Respite Care Daily Rate	0656 General Inpatient Care Daily Rate
28420	Kennewick-Richland	Franklin	WA	0.9897	$ 202.02	$ 159.65	$ 60.47	$ 60.47	$ 470.77	$ 1,061.29
		After 2% reduction for sequestration			*$ 197.98*	*$ 156.46*	*$ 59.26*	*$ 59.26*	*$ 461.35*	*$ 1,040.06*
		% change from prior year		*0.8%*	*2.7%*	*2.7%*	*2.6%*	*2.6%*	*3.1%*	*2.7%*
	Prior year comparison, after 2% reduction for sequestration			*0.9819*	*$ 192.83*	*$ 152.42*	*$ 57.76*	*$ 57.76*	*$ 447.44*	*$ 1,012.88*
42644	Seattle-Bellevue-Everett	King	WA	1.1851	$ 228.25	$ 180.38	$ 69.42	$ 69.42	$ 527.24	$ 1,193.84
		After 2% reduction for sequestration			*$ 223.69*	*$ 176.77*	*$ 68.03*	*$ 68.03*	*$ 516.70*	*$ 1,169.96*
		% change from prior year		*0.7%*	*2.2%*	*2.1%*	*3.7%*	*3.7%*	*4.4%*	*2.6%*
	Prior year comparison, after 2% reduction for sequestration			*1.1767*	*$ 218.97*	*$ 173.08*	*$ 65.59*	*$ 65.59*	*$ 495.09*	*$ 1,140.65*
14740	Bremerton-Silverdale-Port Orchard	Kitsap	WA	1.1455	$ 222.93	$ 176.18	$ 67.61	$ 67.61	$ 515.80	$ 1,166.98
		After 2% reduction for sequestration			*$ 218.47*	*$ 172.66*	*$ 66.26*	*$ 66.26*	*$ 505.48*	*$ 1,143.64*
		% change from prior year		*0.0%*	*1.7%*	*1.7%*	*3.0%*	*3.0%*	*3.7%*	*2.1%*
	Prior year comparison, after 2% reduction for sequestration			*1.1451*	*$ 214.73*	*$ 169.73*	*$ 64.32*	*$ 64.32*	*$ 487.36*	*$ 1,119.92*
45104	Tacoma-Lakewood	Pierce	WA	1.1563	$ 224.38	$ 177.32	$ 68.10	$ 68.10	$ 518.92	$ 1,174.31
		After 2% reduction for sequestration			*$ 219.89*	*$ 173.77*	*$ 66.74*	*$ 66.74*	*$ 508.54*	*$ 1,150.82*
		% change from prior year		*1.4%*	*2.7%*	*2.7%*	*4.1%*	*4.1%*	*4.6%*	*3.0%*
	Prior year comparison, after 2% reduction for sequestration			*1.1403*	*$ 214.09*	*$ 169.22*	*$ 64.12*	*$ 64.13*	*$ 486.19*	*$ 1,116.78*
34580	Mount Vernon-Anacortes	Skagit	WA	0.9918	$ 202.30	$ 159.87	$ 60.56	$ 60.56	$ 471.38	$ 1,062.72
		After 2% reduction for sequestration			*$ 198.25*	*$ 156.67*	*$ 59.35*	*$ 59.35*	*$ 461.95*	*$ 1,041.47*
		% change from prior year		*-0.9%*	*1.5%*	*1.4%*	*1.4%*	*1.4%*	*2.2%*	*1.6%*
	Prior year comparison, after 2% reduction for sequestration			*1.0011*	*$ 195.41*	*$ 154.46*	*$ 58.54*	*$ 58.54*	*$ 452.13*	*$ 1,025.47*
38900	Portland-Vancouver-Hillsboro	Skamania	WA	1.2332	$ 234.71	$ 185.48	$ 71.63	$ 71.62	$ 541.14	$ 1,226.47
		After 2% reduction for sequestration			*$ 230.02*	*$ 181.77*	*$ 70.20*	*$ 70.19*	*$ 530.32*	*$ 1,201.94*
		% change from prior year		*1.1%*	*2.3%*	*2.3%*	*4.2%*	*4.2%*	*4.9%*	*2.8%*
	Prior year comparison, after 2% reduction for sequestration			*1.2202*	*$ 224.81*	*$ 177.69*	*$ 67.34*	*$ 67.34*	*$ 505.73*	*$ 1,169.19*

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Billing Code	Core-Based Statistical Area	County or Parish*	State	Wage-Index	0651 Routine Home Care: High Rate (1) Daily Rate	0651 Routine Home Care: Low Rate (2) Daily Rate	0651 Routine Home Care: Service Intensity Add-on (3)** Hourly Rate	0652 Continuous Home Care** Hourly Rate	0655 Inpatient Respite Care Daily Rate	0656 General Inpatient Care Daily Rate
42644	Seattle-Bellevue-Everett	Snohomish	WA	1.1851	$ 228.25	$ 180.38	$ 69.42	$ 69.42	$ 527.24	$ 1,193.84
	After 2% reduction for sequestration				*$ 223.69*	*$ 176.77*	*$ 68.03*	*$ 68.03*	*$ 516.70*	*$ 1,169.96*
	% change from prior year			*0.7%*	*2.2%*	*2.1%*	*3.7%*	*3.7%*	*4.4%*	*2.6%*
	Prior year comparison, after 2% reduction for sequestration			*1.1767*	*$ 218.97*	*$ 173.08*	*$ 65.59*	*$ 65.59*	*$ 495.09*	*$ 1,140.65*
44060	Spokane-Spokane Valley	Spokane	WA	1.0976	$ 216.50	$ 171.09	$ 65.41	$ 65.41	$ 501.96	$ 1,134.49
	After 2% reduction for sequestration				*$ 212.17*	*$ 167.67*	*$ 64.10*	*$ 64.10*	*$ 491.92*	*$ 1,111.80*
	% change from prior year			*-0.6%*	*1.4%*	*1.4%*	*2.2%*	*2.2%*	*3.0%*	*1.7%*
	Prior year comparison, after 2% reduction for sequestration			*1.1045*	*$ 209.29*	*$ 165.42*	*$ 62.69*	*$ 62.69*	*$ 477.43*	*$ 1,093.29*
44060	Spokane-Spokane Valley	Stevens	WA	1.0976	$ 216.50	$ 171.09	$ 65.41	$ 65.41	$ 501.96	$ 1,134.49
	After 2% reduction for sequestration				*$ 212.17*	*$ 167.67*	*$ 64.10*	*$ 64.10*	*$ 491.92*	*$ 1,111.80*
	% change from prior year			*-0.6%*	*1.4%*	*1.4%*	*2.2%*	*2.2%*	*3.0%*	*1.7%*
	Prior year comparison, after 2% reduction for sequestration			*1.1045*	*$ 209.29*	*$ 165.42*	*$ 62.69*	*$ 62.69*	*$ 477.43*	*$ 1,093.29*
36500	Olympia-Tumwater	Thurston	WA	1.1490	$ 223.40	$ 176.55	$ 67.77	$ 67.77	$ 516.81	$ 1,169.36
	After 2% reduction for sequestration				*$ 218.93*	*$ 173.02*	*$ 66.41*	*$ 66.41*	*$ 506.47*	*$ 1,145.97*
	% change from prior year			*1.1%*	*2.5%*	*2.5%*	*3.8%*	*3.8%*	*4.4%*	*2.9%*
	Prior year comparison, after 2% reduction for sequestration			*1.1363*	*$ 213.55*	*$ 168.80*	*$ 63.96*	*$ 63.96*	*$ 485.21*	*$ 1,114.15*
47460	Walla Walla	Walla Walla	WA	1.0600	$ 211.45	$ 167.11	$ 63.69	$ 63.69	$ 491.09	$ 1,108.98
	After 2% reduction for sequestration				*$ 207.22*	*$ 163.77*	*$ 62.42*	*$ 62.42*	*$ 481.27*	*$ 1,086.80*
	% change from prior year			*-1.8%*	*0.6%*	*0.6%*	*1.2%*	*1.2%*	*2.1%*	*0.9%*
	Prior year comparison, after 2% reduction for sequestration			*1.0795*	*$ 205.93*	*$ 162.77*	*$ 61.68*	*$ 61.68*	*$ 471.31*	*$ 1,076.89*
13380	Bellingham	Whatcom	WA	1.2296	$ 234.22	$ 185.10	$ 71.46	$ 71.46	$ 540.10	$ 1,224.03
	After 2% reduction for sequestration				*$ 229.54*	*$ 181.40*	*$ 70.03*	*$ 70.03*	*$ 529.30*	*$ 1,199.55*
	% change from prior year			*1.2%*	*2.4%*	*2.4%*	*4.3%*	*4.3%*	*4.9%*	*2.9%*
	Prior year comparison, after 2% reduction for sequestration			*1.2149*	*$ 224.10*	*$ 177.13*	*$ 67.12*	*$ 67.13*	*$ 504.44*	*$ 1,165.71*

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Billing Code	Core-Based Statistical Area	County or Parish*	State	Wage-Index	0651 Routine Home Care: High Rate (1) Daily Rate	0651 Routine Home Care: Low Rate (2) Daily Rate	0651 Service Intensity Add-on (3)** Hourly Rate	0652 Continuous Home Care** Hourly Rate	0655 Inpatient Respite Care Daily Rate	0656 General Inpatient Care Daily Rate
49420	Yakima	Yakima	WA	0.9192	$ 192.55	$ 152.17	$ 57.24	$ 57.24	$ 450.40	$ 1,013.47
	After 2% reduction for sequestration				*$ 188.70*	*$ 149.13*	*$ 56.10*	*$ 56.10*	*$ 441.39*	*$ 993.20*
	% change from prior year			*-2.8%*	*0.4%*	*0.4%*	*-0.3%*	*-0.3%*	*0.7%*	*0.4%*
	Prior year comparison, after 2% reduction for sequestration			*0.9453*	*$ 187.92*	*$ 148.54*	*$ 56.29*	*$ 56.29*	*$ 438.49*	*$ 988.87*
99950	Rural Washington	All Other Counties	WA	1.0666	$ 212.34	$ 167.81	$ 63.99	$ 63.99	$ 493.00	$ 1,113.46
	After 2% reduction for sequestration				*$ 208.09*	*$ 164.45*	*$ 62.71*	*$ 62.71*	*$ 483.14*	*$ 1,091.19*
	% change from prior year			*3.6%*	*4.5%*	*4.5%*	*5.1%*	*5.1%*	*5.3%*	*4.5%*
	Prior year comparison, after 2% reduction for sequestration			*1.0292*	*$ 199.19*	*$ 157.44*	*$ 59.66*	*$ 59.66*	*$ 459.01*	*$ 1,043.90*

*Sorted by county or parish
**Hourly rate is paid in 15-minute increments

Appendix 5: Washington State Health Care Authority (HCA) Hospice Medicaid Fee Schedule

Washington State Health Care Authority (HCA)
Hospice Rates
Effective October 1, 2021

Rev Code 0651		CBSA	Days 1-60 Rate	Days 61+ Rate
Routine Home Care (Capitated Daily Rate)	All Other Areas	50	$212.34	$167.81
	Asotin	30300	$185.08	$146.26
	Benton	28420	$202.02	$159.65
	Chelan	48300	$196.62	$155.38
	Clark	38900	$234.70	$185.48
	Cowlitz	31020	$216.21	$170.86
	Douglas	48300	$196.62	$155.38
	Franklin	28420	$202.02	$159.65
	King	42644	$228.25	$180.38
	Kitsap	14740	$222.93	$176.18
	Pierce	45104	$224.38	$177.32
	Skagit	34580	$202.30	$159.87
	Skamania	38900	$234.70	$185.48
	Snohomish	42644	$228.25	$180.38
	Spokane	44060	$216.50	$171.09
	Thurston	36500	$223.40	$176.55
	Whatcom	13380	$234.22	$185.10
	Yakima	49420	$192.55	$152.17

Rev Code 0655		CBSA	Rate
Inpatient Respite Care (Daily Rate)	All Other Areas	50	$ 493.00
	Asotin	30300	$ 434.30
	Benton	28420	$ 470.77
	Chelan	48300	$ 459.16
	Clark	38900	$ 541.14
	Cowlitz	31020	$ 501.32
	Douglas	48300	$ 459.16
	Franklin	28420	$ 470.77
	King	42644	$ 527.24
	Kitsap	14740	$ 515.80
	Pierce	45104	$ 518.92
	Skagit	34580	$ 471.38
	Skamania	38900	$ 541.14
	Snohomish	42644	$ 527.24
	Spokane	44060	$ 501.96
	Thurston	36500	$ 516.81
	Whatcom	13380	$ 540.10
	Yakima	49420	$ 450.40

Rev Code 0652		CBSA	Rate
Continuous Home Care (Hourly Rate)	All Other Areas	50	$ 63.99
	Asotin	30300	$ 54.68
	Benton	28420	$ 60.47
	Chelan	48300	$ 58.62
	Clark	38900	$ 71.63
	Cowlitz	31020	$ 65.31
	Douglas	48300	$ 58.62
	Franklin	28420	$ 60.47
	King	42644	$ 69.42
	Kitsap	14740	$ 67.61
	Pierce	45104	$ 68.10
	Skagit	34580	$ 60.56
	Skamania	38900	$ 71.63
	Snohomish	42644	$ 69.42
	Spokane	44060	$ 65.41
	Thurston	36500	$ 67.77
	Whatcom	13380	$ 71.46
	Yakima	49420	$ 57.24

Rev Code 0656		CBSA	Rate
General Inpatient Care	All Other Areas	50	$1,113.46
	Asotin	30300	$ 975.68
	Benton	28420	$1,061.29
	Chelan	48300	$1,034.02
	Clark	38900	$1,226.47
	Cowlitz	31020	$1,133.00
	Douglas	48300	$1,034.02
	Franklin	28420	$1,061.29
	King	42644	$1,193.84
	Kitsap	14740	$1,166.98
	Pierce	45104	$1,174.31
	Skagit	34580	$1,062.72
	Skamania	38900	$1,226.47
	Snohomish	42644	$1,193.84
	Spokane	44060	$1,134.49
	Thurston	36500	$1,169.36
	Whatcom	13380	$1,224.03
	Yakima	49420	$1,013.47

Washington State Health Care Authority (HCA)
Hospice Rates
Effective October 1, 2021

Rev Code 0652		CBSA	Rate
Continuous Home Care (Hourly Rate)	All Other Areas	50	$ 63.99
	Asotin	30300	$ 54.68
	Benton	28420	$ 60.47
	Chelan	48300	$ 58.62
	Clark	38900	$ 71.63
	Cowlitz	31020	$ 65.31
	Douglas	48300	$ 58.62
	Franklin	28420	$ 60.47
	King	42644	$ 69.42
	Kitsap	14740	$ 67.61
	Pierce	45104	$ 68.10
	Skagit	34580	$ 60.56
	Skamania	38900	$ 71.63
	Snohomish	42644	$ 69.42
	Spokane	44060	$ 65.41
	Thurston	36500	$ 67.77
	Whatcom	13380	$ 71.46
	Yakima	49420	$ 57.24

Rev Code 0656		CBSA	Rate
General Inpatient Care	All Other Areas	50	$1,113.46
	Asotin	30300	$ 975.68
	Benton	28420	$1,061.29
	Chelan	48300	$1,034.02
	Clark	38900	$1,226.47
	Cowlitz	31020	$1,133.00
	Douglas	48300	$1,034.02
	Franklin	28420	$1,061.29
	King	42644	$1,193.84
	Kitsap	14740	$1,166.98
	Pierce	45104	$1,174.31
	Skagit	34580	$1,062.72
	Skamania	38900	$1,226.47
	Snohomish	42644	$1,193.84
	Spokane	44060	$1,134.49
	Thurston	36500	$1,169.36
	Whatcom	13380	$1,224.03
	Yakima	49420	$1,013.47

Pediatric Palliative Care (PPC)			
Rev Code 0659		CBSA	Rate
Pediatric Palliative Care (PPC)	All Other Areas	50	$ 88.95
	Asotin	30300	$ 88.95
	Benton	28420	$ 80.67
	Chelan	48300	$ 88.95
	Clark	38900	$ 83.99
	Cowlitz	31020	$ 88.95
	Douglas	48300	$ 88.95
	Franklin	28420	$ 80.67
	King	42644	$ 88.95
	Kitsap	14740	$ 77.91
	Pierce	45104	$ 77.91
	Skagit	34580	$ 88.95
	Skamania	38900	$ 88.95
	Snohomish	42644	$ 88.95
	Spokane	44060	$ 88.27
	Thurston	36500	$ 83.99
	Whatcom	13380	$ 88.27
	Yakima	49420	$ 80.67

Service Intensity Add-on			
		CBSA	Per unit
Service Intensity Add-on	All Other Areas	50	$ 16.00
	Asotin	30300	$ 13.67
	Benton	28420	$ 15.12
	Chelan	48300	$ 14.66
	Clark	38900	$ 17.91
	Cowlitz	31020	$ 16.33
	Douglas	48300	$ 14.66
	Franklin	28420	$ 15.12
	King	42644	$ 17.36
	Kitsap	14740	$ 16.90
	Pierce	45104	$ 17.03
	Skagit	34580	$ 15.14
	Skamania	38900	$ 17.91
	Snohomish	42644	$ 17.36
	Spokane	44060	$ 16.35
	Thurston	36500	$ 16.94
	Whatcom	13380	$ 17.87
	Yakima	49420	$ 14.31

Hospice Care Center	
Rev Code 0145	Rate
All Hospice Care Centers	$269.00

Appendix 6: MatrixCare EMR Contract

MatrixCare by ResMed
Formerly Brightree Home Health & Hospice

Brightree HomeHealth & Hospice, LLC
c/o Matrixcare, Inc.
10900 Hampshire Avenue South, Ste. 100
Bloomington, MN 55438

ORDER FORM for ("Client"): VistaRiver Hospice
Offer Valid Thru Date: 12/7/2021
Proposed by: Michael Kemp
Contract Number: TM_20211202_M

Billing Address: VistaRiver of King County, LLC

Contact Name: Geoff Schackmann
Title: Managing Member
Phone: (480) 495-5474
Fax:
Email: geoffschackmann@vistariver.com

Terms & Conditions
Effective Date the date signed by Brightree
Billing Term Start Date To be determined (CON)
Billing Frequency: Monthly
Payment Method: Check
Payment Terms: Net 30
Initial Term (months): 36

Product key/SKU	Product Description	Units	Monthly Subscription fee	One time Implementation & Training fee [1]	Line Total
18	Enterprise Package - Agency Management Software (Hospice) *Includes: eClaims, Commercial Eligibility, Scanning and Photo, CommonWell, Direct Secure Messaging, Medications Import, Supply Interface, ePrescribe w/ BetterRx, GL/ Month end, Mileage AutoCalc, Fax on Demand, eReferral, Physician Portal, 2 Way Telehealth Interface, 2 Way PBM, Payroll Time & Attendance, Document Management, Outbound ADT, CRM interface, Celltrak interface, myAnalytics, Total Triage*	65 census	$ 4,187.95	$ 16,000.00	$ 20,187.95

Subscription Fee Total $ 4,187.95
One Time Implementation & Training Fee Total [1] $ 16,000.00

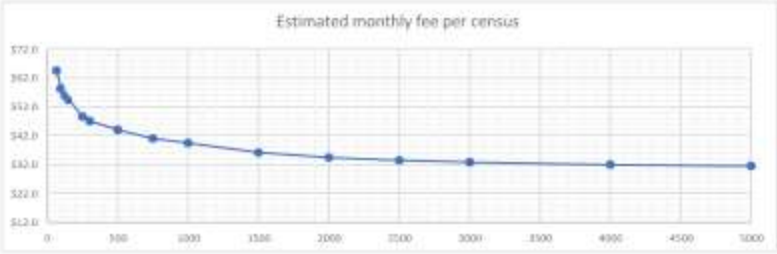
[1] Detailed in Exhibit A. Training and travel expenses billed at cost. 50% of the Implementation & Training Fee is due within 30-days from execution of contract signing. Remaining balance is due no later than thirty (30) days after the date of invoice. Implementation & Training fees are non-refundable. The Palliative Care solution is not fully available at this time. Customer may use the current Brightree HHP solution for their palliative care business, but Customer acknowledges that it is not currently a full-blown certified Palliative Care solution and is currently a work in progress. Brightree reserves the right to modify pricing in the future as the Palliative Care solution gets built out to reflect the value it delivers and what the market will support.

Upon signature by Client and submission to Brightree, this Order Form shall become legally binding and governed by the attached Services Agreement between Brightree and Client as of the date of execution by the Client, unless this Order Form is rejected by Brightree. Brightree may reject this Order Form if: (1) the signatory below doesn't have the authority to bind Client to this Order Form, (2) Changes have been made to this Order Form (other than completion of the purchase order information and the signature block), (3) the requested purchase order information or signature is incomplete or does not match the rest of the Order Form, or (4) Credit is not approved. CLIENT AGREES THE ORDER FORM REPLACES AND SUPERCEDES THE PROVISIONS OF ANY CLIENT DRAFTED PURCHASE ORDER PROPOSAL OR OTHER COMMUNICATION, WHETHER WRITTEN OR ORAL, RELATING TO THE SUBJECT MATTER OF THIS ORDER FORM.

Growth Chart

Enterprise Package - Agency Management Software (Hospice)

Patient census	Estimated monthly fee	Estimated monthly fee per census
63	$4,188	$64.4
100	$5,835	$58.4
125	$7,012	$56.1
150	$8,188	$54.6
250	$12,139	$48.6
300	$14,115	$47.0
500	$22,017	$44.0
750	$30,743	$41.0
1000	$39,469	$39.5
1500	$54,224	$36.1
2000	$68,978	$34.5
2500	$83,733	$33.5
3000	$98,487	$32.8
4000	$127,996	$32.0
5000	$157,505	$31.5



Growth chart based on current rates and subject to change as outlined in the Services Agreement

EXHIBIT A - Standard Implementation Plan

A. Services Provided, Initial System Setup

- SQL database set up, including the following items:
- One Business Unit and one location set up with Medicare, Medicaid, up to 5 Medicare PPS and up to 10 Private Insurers
- Sample user group and permission setup
- Brightree website configuration, planning and go-live

B. Training, System Setup and Project Management

Brightree Learning Center, Learning Lockers
Unlimited access to the Brightree Learning Center Portal

Clinical Point-of-Care Coaching and Training Program
Coaching on functional usage of the Brightree Clinical Point of Care Software via onsite and/or on-line sessions, emails and phone calls; to be consumed within 4 months of Initial Term Start Date. The outcome of the sessions will be a baseline understanding of Clinical functionality and configuration/design plans related to the office functions and clinical point of care software to accommodate best practice design.

Client agrees to complete the required Brightree University Clinical curriculum prior to the commencement of the formal Brightree remote coaching sessions.*

Clinical Office Coaching and Training Program
Remote coaching on functional usage of the Brightree Clinical Office Software on-line sessions (unless an alternative method is agreed to), emails and phone calls; to be consumed within 4 months of effective Date. The outcome of the sessions will be a baseline understanding of Clinical functionality and configuration/design plans related to the office functions and clinical point of care software to accommodate best practice design and optimal implementation of the clinical system to help drive billing.

Client agrees to complete the required Brightree University Clinical Office curriculum prior to the commencement of the formal Brightree remote coaching sessions.*

Billing and A/R Coaching and Training Program
Remote coaching on functional usage of the Brightree Financial module with a Brightree billing specialist including an overview training session via onsite and/or on-line sessions, emails and phone calls. The outcome of the sessions will be a baseline understanding of the month end reporting, validation hold training, A/R cycle and management and senior management reporting.

Client agrees to complete the required Brightree University Billing and A/R curriculum prior to the commencement of the formal Brightree remote coaching sessions.*

Billing System Setup and Configuration*
Data entry for payors, service codes, revenue codes, procedure codes and contractual rules for payors.

Project Management
Remote project management via onsite and/or on-line sessions, emails and phone calls with designated Brightree Project Manager. This includes: management of the activities, deliverables and schedules of Brightree resources, weekly project management meetings with Client project team, interfacing with Client's executive management to communicate project status and proactively identify and work to resolve any risks or issues that might impact overall timeline, communicating and following up on assigned tasks for both Brightree and Client team members.*

Up to 128 hours total

*ALL HOURS MUST BE CONSUMED WITHIN 5 MONTHS OF THE "INITIAL TERM START DATE".

Appendix 7: Brightree BAA

BRIGHTREE HOME HEALTH & HOSPICE LLC SERVICES AGREEMENT

TERMS AND CONDITIONS

The Brightree Home Health & Hospice LLC Services Agreement (the "**Agreement**") consists of these terms and conditions (the "**Terms and Conditions**") and one or more Order Forms. These Terms and Conditions shall apply to each Order Form executed by Brightree and Client.

1. **DEFINITIONS.**

1.1 "**Active Patients**" means accepted and admitted patients of Client.

1.2 "**Active Patient Census**" means the rolling 3-month average number of Active Patients as determined by Brightree's records established by the Application Services.

1.3 "**Agency Management Software**" means Brightree's proprietary clinical point of care, mobile clinical, advanced front office and private duty software licensed to Client for use in conjunction with the Application Services.

1.4 "**Authorized Users**" means persons authorized by Client to read and use the Services and who possess an authorized user ID and password.

1.5 "**Application Services**" means hosting and operating a Brightree Application to provide Client with access to and use of such Brightree Application over the Internet.

1.6 "**Brightree Application**" means all software and databases used by Brightree to provide the Agency Management Software or the Private Duty Software to Client.

1.7 "**Content**" means all Client Confidential Information, software applications, text, pictures, sound, graphics, video and other data transmitted by Authorized Users using the Services.

1.8 "**Hours**" means the verified Private Duty billable hours recorded in the Private Duty Software.

1.9 "**Licensed Software**" means the Agency Management Software or the Private Duty Software licensed by Client under an Order Form.

1.10 "**Order Form**" means the written description of the Services to be provided by Brightree to Client that is executed by Client and Brightree and expressly refers to this Agreement.

1.11 "**Private Duty**" means the provision of a broad range of services by caregivers to allow persons to remain independent in their personal residences.

1.12 "**Private Duty Software**" means Brightree's proprietary private duty software licensed to Client for use in conjunction with the Application Services.

1.13 "**Private Duty Visits**" means, in connection with the use of the Agency Management Software, the rolling 3-month average number visits for the non-Medicare certified service line visits as determined by Brightree's records established by the Application Services.

1.14 "**Professional Services**" shall mean any training, consulting, data migration, additional site and location setup, conversion, integration, implementation and/or other services provided by Brightree to Client, with associated fees for such services as described explicitly in an Order Form.

1.15 "**Services**" means the Application Services, Professional Services and Support Services.

1.16 "**Support Services**" means the provision of technical support to Authorized Users via email and telephone during Brightree's regular business hours, in accordance with Brightree's then-current technical support policies, and any other support services set forth in an Order Form.

2. **SERVICES.**

2.1 **Services.** Brightree shall use commercially reasonable efforts to provide the Services in accordance with the terms and conditions of this Agreement. In the event of any conflict between the body of this Agreement and an Order Form, the terms and conditions set forth in the body of this Agreement shall govern. Brightree shall not be obligated to provide any particular service to Client, including without limitation installation, additional site or location setup, implementation, training and data migration services, unless such service is explicitly described in a fully executed Order Form.

2.2 **Client Operating Environment**. Unless otherwise explicitly set forth in an Order Form, Client shall, at its sole expense, be responsible for procuring, installing and maintaining the telecommunications services, hardware (including point of care devices on which the Licensed Software will be installed by Client) and software needed to access the Application Services that meets Brightree's then-current telecommunications, hardware and software specifications (the "**Client Operating Environment**"). Client shall be solely responsible for the security of the Client Operating Environment.

2.3 **Brightree Application Changes.** Brightree may from time to time develop enhancements, upgrades, updates, improvements, modifications, extensions and other changes to the Application Services ("**Brightree Application Changes**"). Client hereby authorizes Brightree to implement such Brightree Application Changes for use with the Application Services, provided that such Brightree Application Changes do not have a material adverse effect on the functionality or performance of the Application Services. When commercially practicable, Brightree shall notify Client in advance of the implementation of any material Brightree Application Changes.

2.4 **Cooperation; Access.** Client acknowledges that the successful and timely rendering of the Services shall require the good faith cooperation of Client. Brightree shall not be liable for any failure to perform the Services that arises from Client's failure to cooperate with Brightree.

2.5 **Special Terms.** The Application Services provided to Client shall be subject to any specific terms or limitations set forth in the Order Form. In addition, terms and conditions applicable to certain third party services included within the Application Service are located at http://www.Brightree.com/Contracts ("**Third Party Terms**"), which are incorporated herein by reference. Client's use of the Application Services is subject to its compliance with all Third Party Terms.

2.6 **Business Associate Agreement.** By executing an Order Form under which Brightree will provide Services involving the use of Protected Health Information (as defined in HIPAA), Brightree and Client hereby agree to be bound by Brightree's standard Business Associate Agreement set forth as Exhibit C hereto.

3. USE OF THE APPLICATION SERVICES.

3.1 **Application Service.** Brightree hereby grants to Client a nontransferable, non-exclusive, license during the term of the applicable Order Form, to allow Authorized Users to access and use, over public and private networks, the Application Services for its homecare and hospice service business.

3.2 **Licensed Software**. Brightree hereby grants to Client, a nontransferable, nonexclusive, license during the term of an Order Form under which Client purchases access to the Application Services to be used in conjunction with the Licensed Software. Client shall have the right to make additional copies of the Licensed Software for such use. Client shall be responsible for its Authorized Users use of the Licensed Software in compliance with the terms of this Agreement.

3.3 **Restrictions.**

3.3.1 Brightree owns all right, title and interest in and to the Application Services, Brightree Application and Licensed Software. The Application Services, Brightree Application and Licensed Software are provided to Client for use only as expressly set forth in this Agreement, and Client will not use the Application Services, Brightree Application or Licensed Software in whole or in part for any other use or purpose. Client will not, and will not allow any third party to (i) decompile, disassemble, reverse engineer or attempt to reconstruct, identify or discover any source code, underlying ideas, underlying user interface techniques or algorithms of the Brightree Application or Licensed Software by any means, or disclose any of the foregoing; (ii) except as expressly set forth in this Agreement, provide, rent, lease, lend, or use the Brightree Application or Licensed Software for timesharing, subscription, or service bureau purposes; or (iii) sublicense, transfer or assign the Brightree Application or Licensed Software or any of the rights or licenses granted under this Agreement.

3.3.2 Client shall not use the Application Services for storage, possession, or transmission of any information, the possession, creation or transmission of which violates any state, local or federal law, including without limitation, those laws regarding stolen materials, obscene materials or child pornography. Client shall not transmit Content over the Application Services that infringes upon or misappropriates the intellectual property or privacy rights of any third party.

3.3.3 Brightree shall provide a password allowing Client to give each Authorized Users a user name and password to access the Application Services. Client shall establish and maintain lists of Authorized Users and comply with Brightree's procedures for verification of Authorized Users, revision of access rights to Application Services, security, and assignment and use of passwords. Client shall notify Brightree immediately in writing if the security or integrity of a password or authority level has been compromised. Client shall be fully responsible, and indemnify and hold Brightree harmless, for any charges, costs, expenses, and third party claims that may result from unauthorized use of or access to the Application Services using Client's user names.

3.3.4 Client is responsible for its use of the Application Services. Brightree may, from time to time, require a person to agree to Brightree's then-current Terms of Services for the Application Service (or any part thereof) prior to permitting such person to use the Application Services. Client hereby authorizes Brightree to prominently display within the Application Services, Brightree's then-current Privacy Policy and Terms of Service. Brightree shall be free to terminate an individual's access to the Application Services if it determines, in its sole discretion, that such individual's use of the Application Services is in breach of Brightree's then-current Terms of Service, or could harm Brightree's reputation.

3.3.5 Regardless of whether Brightree requires its Authorized Users to agree to Brightree's then-current Terms of Service, Client agrees that it is responsible for developing and implementing appropriate policies for use of the Application Services by such persons including policies regarding such persons compliance with the terms hereof.

3.3.6 Brightree is not responsible for Client's access to or use of patients' protected health information (as defined under the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**")) stored within the Application Services. Any such access or use shall be in accordance with all applicable laws, rules and regulations, including, without limitation HIPAA.

3.4 **Client Content.** Client hereby grants to Brightree a worldwide, non-exclusive, fully paid-up license to use, copy, modify, enhance, display, publish, distribute, create derivative works of and otherwise use the Content in any manner reasonably necessary to perform the Services. Client represents and warrants that it has all rights necessary to grant Brightree the foregoing license. Client further represents and warrants that Client owns or all right, title and interest in and to the Content or has a license granting it the rights necessary to permit it to grant the foregoing license. If Client licenses any Content, it shall not provide such Content to Brightree until it provides Brightree with a copy of the license.

4. PAYMENTS.

4.1 **Fees.** Client agrees to pay Brightree for the performance of the Services in accordance with the rates and fees specified in the Order Form. Following the first year of the term, on each one year anniversary of an Order Form, Brightree may adjust the rates and fees set forth in such Order Form. Brightree shall give Client not less than thirty (30) days written notice of such increase prior to its effective date. Unless otherwise set forth in the Order Form, all payments shall be made in United States dollars no later than thirty (30) days after the date of invoice. All payments not received when due shall accrue interest at a rate per month of one and one-half percent (1.5%) or seventy-five dollars ($75) per month, whichever is greater.

4.2 **Growth Clause**. Client acknowledges that the initial fees for its use of the Application Services are based upon the Active Patient Census figures identified in the Services Order. At any time during the term, if the number of Active Patients under such Active Patient Census exceeds the Active Patient Census range upon which the fees were previously based, the fees shall be increased at Brightree's then-current rates, or if pre-determined at the rate set forth in the Order Form. Installation and implementation of the Application Services at additional sites or locations (regardless of the reason for such expansion) shall be subject to the negotiation and execution of an Order Form for the appropriate Professional Services, which Services will be performed at Brightree's then-current rates.

4.3 **Expenses.** Client shall reimburse Brightree for its out-of-pocket travel expenses to include food, lodging and incidentals. Transportation will be reimbursed to Brightree by Client at the current IRS mileage rates or at current coach airfare rate for providing services to Client at facilities of Client. Client will bear the travel and other out-of-pocket expenses incurred by its employees and other designees who receive training at Brightree's facilities.

4.4 **Taxes.** The fees payable under this Agreement shall not include taxes or duties now in force or enacted in the future imposed on the transaction and/or the delivery of the Services, all of which Client shall be responsible for and pay in full.

5. TERM AND TERMINATION.

5.1 **Term.** Unless earlier terminated in accordance with its terms, each Order Form commences on the Effective Date and remains in effect for the Initial Term (Months) from the Billing Term Start Date (the "**Initial Term**"). Unless otherwise set forth in an Order Form, upon the expiration of each Initial Term, the term of an Order Form will renew automatically for additional terms of one (1) year each ("**Renewal Term**"), and together with the Initial Term, the "**Term**"), unless either a party notifies the other party, at least ninety (90) days prior to the end of the then-current Term that it has elected to terminate such Order Form, in which event such Order Form will terminate at the end of such Term. Unless earlier terminated in accordance with its terms, this Agreement will expire on the date the last Order Form then in effect expires or is terminated pursuant to the terms and conditions set forth in this Agreement. Notwithstanding the foregoing, either party shall have the right, for any reason or no reason, to terminate the Order Form and Services Agreement on the first anniversary of the Billing Term Start Date by providing the other party with written notice of termination at least ninety (90) days prior thereto.

5.2 **Termination for Cause.** Except as otherwise provided herein, upon the material breach of the other party, either party may terminate this Agreement or the applicable Order Form, if such breach remains uncured for thirty (30) days following written notice to the breaching party. Notwithstanding the foregoing, if the breaching party certifies to the other party in writing within the thirty (30) day period that a curable breach (other than a breach relating to the payment of fees owing under the Agreement) cannot reasonably be cured in thirty (30) days but that it will be remedied by a specified date (which date may be no later than is commercially reasonable under the circumstances), the termination will be effective on the date specified in the certification if the breach has not been remedied by that date.

5.3 **Suspension of Services.** In the event any payment hereunder is not received by Brightree within thirty (30) days of the due date, Brightree may, in addition to any other remedies available to it hereunder or at law, suspend access to Support Services and/or the Application Services in whole or in part under any Order Form to which Client is a party.

5.4 **Effect of Termination.** Upon the expiration or termination of an Order Form or this Agreement, (i) Brightree will terminate Client's access to the Application Services under affected Order Forms and will cease the provision of all Services under such Order Forms and (ii) to the extent Brightree has stored patient and clinical data as part of the Application Services provided under the affected Order Forms, it will provide such patient and clinical data to Client pursuant to its then-current data retrieval options, which are currently (i) the right to remotely access and view patient and clinical data on an annual basis. The provision of such Professional Services shall be subject to Client's execution of an Order Form and payment of applicable then-current fees.

6. WARRANTIES; DISCLAIMER

6.1 Brightree hereby warrants that during the term of an Order Form, the Application Service provided thereunder will perform, in all material respects, in accordance with its then-current published documentation. In the event of any reproducible failure of the Application Services to perform in a material respect to such documentation, Brightree will, as Client's sole and exclusive remedy for breach of the warranty set forth in this Section 6.1, use commercially reasonable efforts repair the applicable Application Service.

6.2 **DISCLAIMER OF WARRANTIES.** EXCEPT AS SET FORTH IN SECTION 6.1, BRIGHTREE MAKES NO WARRANTIES REGARDING THE SERVICES, AND BRIGHTREE HEREBY DISCLAIMS ALL WARRANTIES, EXPRESS AND IMPLIED, WITH RESPECT TO THE SERVICES, INCLUDING WITHOUT LIMITATION ANY IMPLIED WARRANTIES OF MERCHANTABILITY, FITNESS FOR A PARTICULAR PURPOSE, NONINFRINGEMENT, COMPATIBILITY OR SECURITY. BRIGHTREE DOES NOT WARRANT THAT ACCESS TO OR USE OF THE APPLICATION SERVICES WILL BE UNINTERRUPTED OR ERROR-FREE, THAT ALL DEFECTS AND ERRORS IN THE APPLICATION SERVICE WILL BE CORRECTED, OR THAT THE SERVICES WILL MEET ANY PARTICULAR CRITERIA OF PERFORMANCE OR QUALITY. BRIGHTREE DOES NOT PROVIDE ANY WARRANTIES REGARDING THE ACCURACY OF DATA OR INFORMATION PROVIDED BY THIRD PARTIES. The provisions of this Section allocate the risks under this Agreement between Brightree and Client. Brightree's pricing reflects this allocation of risk and the limitation of liability specified herein.

7. INDEMNITY.

7.1 **Infringement.** Brightree shall defend, indemnify and hold harmless Client, its subsidiaries, affiliates, officers, directors, agents, employees and assigns, from and against any and all claims, suits, proceedings, losses, damages, liabilities, costs and expenses (including, without limitation, reasonable attorneys' fees) (collectively, "**Losses**") suffered or incurred by them in connection with a third party claim arising out of any actual or threatened claim that the Application Services infringes upon or misappropriates any copyright, patent, trademark, trade secret, or other proprietary or other rights of any third party. Brightree shall have no obligation to indemnify Client to the extent the alleged infringement arises out of (i) the use of the Application Services in combination by Client with other data products, processes or materials not provided by Brightree and such infringement would not have occurred but for Client's combination; or (ii) the Content. Should the Application Services as used by Client become, or in Brightree's opinion be likely to become, the subject of an infringement claim, Brightree shall at its option and sole expense either: (i) procure for Client the right to continue to use the Application Services as contemplated hereunder, or (ii) modify the Application Services to eliminate any such claim that might result from its use hereunder or (iii) replace the Application Services with an equally suitable, compatible and functionally equivalent non-infringing Application Services at no additional charge to Client. If none of these options is reasonably available to Brightree, then this Agreement may be terminated at the option of either party hereto without further obligation or liability on the part of either party hereto except that Brightree agrees to promptly refund to Client the pro-rata portion of any fees prepaid by Client amortized on a straight-line basis based over the term of this Agreement.

7.2 **Client Indemnity.** Client shall defend, indemnify and hold harmless Brightree, its subsidiaries, affiliates, officers, directors, agents, employees and assigns, from and against any and all Losses suffered or incurred by them in connection with a third party claim arising out of (i) a breach by Client of this Agreement, (ii) Client's use of the Licensed Software or Application Services or (iii) Client's failure to comply with laws, rules, regulations or professional standards.

7.3 **Mechanics of Indemnity.** The indemnifying party's obligations are conditioned upon the indemnified party: (i) giving the indemnifying party prompt written notice of any claim, action, suit or proceeding for which the indemnified party is seeking indemnity; (ii) granting control of the defense and settlement to the indemnifying party; and (iii) reasonably cooperating with the indemnifying party at the indemnifying party's expense.

8. CONFIDENTIAL INFORMATION.

8.1 Except as expressly permitted in this Section 8, no party will, without the prior written consent of the other party, disclose any Confidential Information of the other party to any third party. Information will be considered Confidential Information of a party if either (i) it is disclosed by the party to the other party in tangible form and is conspicuously marked "Confidential", "Proprietary" or the like; or (ii) (a) it is disclosed by a party to the other party in non-tangible form and is identified as

confidential at the time of disclosure; and (b) it contains the disclosing party's customer lists, customer information, technical information, pricing information, pricing methodologies, or information regarding the disclosing party's business planning or business operations. In addition, notwithstanding anything in this Agreement to the contrary, the terms of this Agreement will be deemed Confidential Information of Brightree. Brightree may, in any manner, publicly announce the relationship with Client. Brightree may also develop, with customer review and approval, a business use case that may be used for Brightree marketing purposes.

8.2 Other than the terms and conditions of this Agreement, information will not be deemed Confidential Information hereunder if such information: (i) is known to the receiving party prior to receipt from the disclosing party directly or indirectly from a source other than one having an obligation of confidentiality to the disclosing party; (ii) becomes known (independently of disclosure by the disclosing party) to the receiving party directly or indirectly from a source other than one having an obligation of confidentiality to the disclosing party; (iii) becomes publicly known or otherwise ceases to be secret or confidential, except through a breach of this Agreement by the receiving party; or (iv) is independently developed by the receiving party.

8.3 Each party will secure and protect the Confidential Information of the other party (including, without limitation, the terms of this Agreement) in a manner consistent with the steps taken to protect its own trade secrets and confidential information, but not less than a reasonable degree of care. Each party may disclose the other party's Confidential Information where (i) the disclosure is required by applicable law or regulation or by an order of a court or other governmental body having jurisdiction after giving reasonable notice to the other party with adequate time for such other party to seek a protective order; (ii) if in the opinion of counsel for such party, disclosure is advisable under any applicable securities laws regarding public disclosure of business information; or (iii) the disclosure is reasonably necessary and is to that party's, or its Affiliates', employees, officers, directors, attorneys, accountants and other advisors, or the disclosure is otherwise necessary for a party to exercise its rights and perform its obligations under this Agreement, so long as in all cases the disclosure is no broader than necessary and the person or entity who receives the disclosure agrees prior to receiving the disclosure to keep the information confidential. Each party is responsible for ensuring that any Confidential Information of the other party that the first party discloses pursuant to this Section 8 (other than disclosures pursuant to clauses (i) and (ii) above that cannot be kept confidential by the first party) is kept confidential by the person receiving the disclosure.

9. LIMITATIONS OF LIABILITY. NOTWITHSTANDING ANYTHING TO THE CONTRARY CONTAINED IN THIS AGREEMENT, BRIGHTREE AND ITS SHAREHOLDERS, AFFILIATES, DIRECTORS, MANAGERS, EMPLOYEES OR OTHER REPRESENTATIVES SHALL NOT BE LIABLE TO CLIENT, AUTHORIZED USERS OR ANY THIRD PARTY FOR ANY INDIRECT, INCIDENTAL, SPECIAL, OR CONSEQUENTIAL DAMAGES (INCLUDING REASONABLE ATTORNEYS' FEES AND LOST PROFITS) THAT RESULT FROM OR ARE RELATED TO THIS AGREEMENT, EVEN IF BRIGHTREE HAS BEEN INFORMED OF THE POSSIBILITY OF SUCH DAMAGES. IN ANY EVENT, BRIGHTREE'S AGGREGATE LIABILITY TO CLIENT FOR DAMAGES, COSTS, AND EXPENSES SHALL NOT EXCEED THE AMOUNTS RECEIVED BY BRIGHTREE FROM CLIENT IN THE TWELVE (12) MONTHS PRECEDING THE EVENT GIVING RISE TO SUCH DAMAGES.

10. GENERAL PROVISIONS.

10.1 **Governing Law.** This Agreement shall be governed by and construed in accordance with the laws of the State of Georgia, without regard to the choice of law provisions thereof. The United Nations Convention on Contracts for the International Sale of Goods shall not apply to this Agreement. Any contract dispute or claim arising out of, or in connection with, this Agreement shall be finally settled by binding arbitration in Atlanta, Georgia, and the then current rules and procedures of the Judicial Arbitration and Mediation Services (JAMS) by one (1) arbitrator appointed by JAMS. The arbitrator shall apply the law of the State of Georgia, without reference to rules of conflict of law or statutory rules of arbitration, to the merits of any dispute or claim. Judgment on the award rendered by the arbitrator may be entered in any court of competent jurisdiction. The parties agree that, any provision of applicable law notwithstanding, they will not request, and the arbitrator shall have no authority to award punitive or exemplary damages against any party. In the event that any arbitration, action or proceeding is brought in connection with this Agreement, the prevailing party shall be entitled to recover its costs and reasonable attorneys' fees. Notwithstanding the foregoing, nothing herein shall preclude either party from seeking injunctive relief in any state or federal court of competent jurisdiction without first complying with the arbitration provisions of this Section.

10.2 **Severability.** If any provision of this Agreement is held to be invalid or unenforceable for any reason, it shall be deemed omitted and the remaining provisions will continue in full force without being impaired or invalidated in any way. The parties agree to replace any invalid provision with a valid provision that most closely approximates the intent and economic effect of the invalid provision.

10.3 **Waiver.** The waiver by either party of a breach of any provision of this Agreement will not operate or be interpreted as a waiver of any other or subsequent breach.

10.4 **Assignment.** This Agreement shall be binding upon the parties' respective successors and permitted assigns. Client shall not assign this Agreement, and/or any of its rights and obligations hereunder, without the prior written consent of Brightree,

which consent shall not be unreasonably withheld. This Agreement, and the rights and obligations herein, may be assigned by Brightree to any person or entity without the written consent of the Client.

10.5 **Permission for Data Aggregation**. Client agrees that Brightree may utilize data that comes into the possession of Brightree by virtue of its performance under this Agreement for the purpose of aggregating statistics that may be helpful for Client's benefit, for research and trend analysis, and for other lawful purposes, as determined by Brightree. Brightree shall only aggregate data in a manner that is fully compliant with HIPAA and applicable legislation regarding private personal information. The data utilized or shared pursuant to this provision that is not directly connected to the provision of Services under this Agreement shall not contain any Protected Health Information, as such term is defined by HIPAA

10.6 **Excluded Entity.** Each party represents that it and its employees, that perform services in connection with the business relationship between the parties is not presently debarred, suspended, ineligible, or excluded from participation in any state or federal health care programs. Each party will periodically check itself and its employees for listing within applicable federal and state databases and will notify the other party if it discovers that it or any of its employees has become so debarred, suspended, ineligible, or excluded (such a person, an "**Excluded Person**" or such an entity, an "**Excluded Entity**"). Neither party shall allow an Excluded Person to provide services to the other party. If a party becomes an Excluded Entity, the other party may terminate its relationship with the Excluded Entity.

10.7 **Independent Contractors.** Brightree is acting in performance of this Agreement as an independent contractor.

10.8 **Notices.** All notices required to be given under the terms of this Agreement or which any of the parties hereto may desire to give hereunder, shall be in writing, shall be delivered via one of the following methods, and shall be deemed to have been received: (i) on the day given delivered by hand (securing a receipt evidencing such delivery); or (ii) on the second day after such notice is sent by a nationally recognized overnight or two (2) day air courier service, full delivery cost paid; or (iii) on the fifth day after such notice was mailed, registered mail, prepaid, return receipt requested, and addressed to the party to be notified at the addresses set forth in the Order Form.

10.9 **Survival.** All provisions of Sections 3.3.1, 4, 6.2, 7, 8, 9 and 10 of this Agreement shall survive the expiration or termination of any Order Form or any termination of this Agreement.

10.10 **Legal Fees.** In the event of any proceeding or lawsuit brought by Brightree or Client in connection with this Agreement, the prevailing party shall be entitled to recover its costs and legal fees (including, but not limited to, allocated costs of in-house staff counsel) and court costs.

10.11 **Force Majeure.** Neither party will be liable to the other for failure to meet its obligations under this Agreement where such failure is caused by events beyond its reasonable control such as fire, failure of communications networks, riots, civil disturbances, embargos, storms, acts of terrorism, pestilence, war, floods, tsunamis, earthquakes or other acts of God.

10.12 **Subsequent Modifications.** No amendment, alteration or modification of this Agreement shall be effective or binding unless it is set forth in a writing signed by duly authorized representatives of both parties.

10.13 **Entire Agreement.** This Agreement and any exhibits and schedules attached hereto, constitutes the entire agreement between the parties in connection with the subject matter hereof and supersedes all prior and contemporaneous agreements, understandings, negotiations and discussions, whether oral or written, of the parties, and there are no warranties, representations and/or agreements among the parties in conjunction with the subject matter hereof except as set forth in this Agreement.

Exhibit C

HIPAA Business Associate Addendum

This HIPAA Business Associate Addendum ("**Addendum**") supplements and is made a part of the Services Agreement ("**Agreement**") by and between Client and Brightree Home Health & Hospice LLC ("**Brightree**"), and is effective as of the Effective Date of the Agreement.

RECITALS

Client wishes to disclose certain information, some of which may constitute Protected Health Information (as defined below), to Brightree pursuant to the terms of the Agreement.

Client and Brightree intend to protect the privacy and provide for the security of PHI disclosed to Brightree pursuant to the Agreement in compliance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("**HIPAA**"), as amended by the Health Information Technology for Economic and Clinical Health ("**HITECH**") Act, Public Law 111-005, and their respective implementing regulations, including the Privacy Rule, the Security Rule, the Breach Notification Standards adopted by the U.S. Department of Health and Human Services, as they may be amended from time to time, at 45 C.F.R. part 164, subpart D, as well as related state laws and/or regulations (the preceding collectively referred to as the "**HIPAA Regulations**"), all as may be amended from time to time.

The HIPAA Regulations require Client to enter into an agreement with Brightree containing specific requirements with respect to the disclosure of PHI and Electronic PHI, as set forth in, but not limited to, Title 45, Sections 164.308(b)(1), 164.310, 164.312, 164.314(a), 164.502(e) and 164.504(e) of the Code of Federal Regulations ("**CFR**"), and as contained in this Addendum.

In consideration of the mutual promises below and the exchange of information pursuant to the Agreement, the parties agree as follows:

1) DEFINITIONS

a) Terms used, but not otherwise defined, in this Business Associate Agreement (the "Agreement") shall have the same meaning as those terms in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended by the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH") and their implementing regulations (the "Electronic Transaction Rule," the "Privacy Rule," the "Security Rule," and the "Breach Notification Rule" as set forth at 45 CFR Parts 160, 162 and 164, and collectively, the "HIPAA Rules").

b) "**Business Associate**" shall mean **Brightree**.

c) "**Covered Entity**" shall mean Client.

2) OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE

a) Business Associate agrees not to use or disclose Protected Health Information including electronic Protected Health Information other than as permitted or required to perform the services under the Services Agreement (the "Services"), as permitted or required by this Agreement, as permitted by HIPAA, or as Required by Law.

b) Business Associate agrees to use appropriate safeguards to prevent use or disclosure of electronic Protected Health Information other than as provided for by this Agreement. Business Associate agrees to implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of any electronic Protected Health Information that it creates, receives, maintains or transmits from or on behalf of Covered Entity. Business Associate further agrees to ensure that any agent, including a subcontractor, to whom it provides such information, agrees to implement reasonable and appropriate safeguards to protect such information. Business Associate shall comply with 45 CFR §§ 164.308, 164.310, 164.312, and 164.316 of the Security Rule as such regulations are amended from time to time.

c) Business Associate agrees to report to Covered Entity (i) any use or disclosure of Protected Health Information in violation of this Agreement of which it becomes aware and (ii) any security incident of which it becomes aware. Business Associate agrees to report to Covered Entity any Breach of Unsecured Protected Health Information, as such terms are defined at 45 CFR § 164.402, in accord with Section 2(d) of this Agreement.

d) Business Associate agrees that, with the exception of law enforcement delays that satisfy the requirements under 45 CFR § 164.412 or as otherwise required by applicable state law, Business Associate shall notify Covered Entity in writing without unreasonable delay and in no case later than sixty (60) calendar days upon discovery of a Breach of Unsecured Protected Health Information, as such terms are defined at 45 CFR § 164.402. Such notice must include, to the extent possible, the name of each individual whose Unsecured Protected Health Information has been, or is reasonably believed by Business Associate to have been, accessed, acquired, or disclosed during such breach. Business Associate shall also provide, to the extent possible, Covered Entity with any other available information that Covered Entity is required to include in its notification to individuals under 45 CFR § 164.404(c) at the time of Business Associate's notification to Covered Entity or as promptly thereafter as such information becomes available. For purposes of this Agreement, a Breach of Unsecured Protected Health Information shall be treated as discovered by Business Associate as of the first day on which such breach is known to Business Associate (including any person, other than the individual committing the breach, who is an employee, officer, or other agent of Business Associate, as determined in accordance with the federal common law of agency) or should reasonably have been known to Business Associate following the exercise of reasonable diligence.

e) Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information created, received, maintained or transmitted by Business Associate from or on behalf of Covered Entity agrees to substantially the

same restrictions and conditions that apply through this Agreement to Business Associate with respect to such Protected Health Information.

f) Business Associate agrees to make internal practices, books, and records, including policies and procedures relating to the use and disclosure of Protected Health Information received from, or created, received, maintained or transmitted by Business Associate from or on behalf of Covered Entity available to the Secretary, for purposes of the Secretary's determining Covered Entity's compliance with the Privacy Rule, if and to the extent Required by Law.

g) Business Associate agrees to document such disclosures of Protected Health Information as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528.

h) Business Associate agrees to provide to Covered Entity information collected to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528. In the event the request for an accounting of disclosures is delivered directly to Business Associate, Business Associates shall, as soon as practicable, forward such request to Covered Entity.

i) Business Associate agrees to meet the requirements of 45 CFR § 164.504 if it knows of a pattern of activity or practice of one of its subcontractors that constitutes a material breach or violation of the subcontractor's obligation under a contract or other arrangement with the Business Associate.

3) GENERAL USE AND DISCLOSURE PROVISIONS

a) Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information to perform the Services for, or on behalf of, Covered Entity provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity except as otherwise permitted by the Privacy Rule. Business Associate agrees to limit, to the extent practicable and except as permitted by 45 CFR § 164.502(b)(2), its uses, disclosures and requests of Protected Health Information under this Agreement to the minimum necessary to accomplish the intended purpose of such use, disclosure or request in accord with HIPAA, HITECH and the HIPAA Rules.

4) SPECIFIC USE AND DISCLOSURE PROVISIONS

a) Business Associate and its affiliates may use Protected Health Information (i) for the proper management and administration of Business Associate or its affiliates, (ii) to carry out the legal responsibilities of Business Associate, (iii) to provide data aggregation services relating to the healthcare operation of the Covered Entity or other covered entities to permit the creation of data for analyses that related to the health care operations of the respective covered entities; and/ or (iv) to review and/or improve Business Associate Services.

b) Business Associate may disclose Protected Health Information (i) for the proper management and administration of Business Associate and its affiliates, (ii) to other covered entity(ies) or health care provider(s) for the payment activities or healthcare operation activities of the entity that received the Protected Health Information if that entity has or had a relationship with the individual, or (iii) to carry out Business Associate's legal responsibilities if (a) the disclosures are either permitted or Required By Law or (b) Business Associate obtains reasonable assurances from the person to whom such information is disclosed that such information will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies Business Associate of any instances of which it becomes aware in which the confidentiality of such information has been breached.

c) Business Associate may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 45 CFR § 164.512(j)(1).

d) Business Associate and its affiliates may de-identify Protected Health Information in accord with 45 CFR § 164.514 and use it in any manner determined by Business Associate.

5) OBLIGATIONS OF COVERED ENTITY

a) Covered Entity shall notify Business Associate of any limitation(s) in the notice of privacy practices of Covered Entity in accordance with 45 CFR § 164.520 within five (5) business days of the imposition of said limitation, to the extent that such limitation may affect Business Associate's use or disclosure of Protected Health Information.

b) Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose Protected Health Information, within five (5) business days of such changes, to the extent that such changes may affect Business Associate's use or disclosure of Protected Health Information.

c) Covered Entity shall notify Business Associate of any restriction on the use or disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 CFR § 164.522 within five (5) business days of such restriction, to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information.

d) Covered Entity shall limit its uses, disclosures and requests of Protected Health Information under this Agreement to the minimum necessary to accomplish the intended purpose of such use, disclosure or request in accord with HIPAA, HITECH, and the HIPAA Rules.

e) Electronic Protected Health Information transmitted or otherwise transferred from Covered Entity to Business Associate must be encrypted by a process that renders the electronic Protected Health Information unusable, unreadable, or indecipherable to unauthorized individuals within the meaning of HITECH § 13402 and any implementing guidance.

6) **PERMISSIBLE REQUESTS BY COVERED ENTITY**

a) Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule or the Security Rule if done by Covered Entity.

7) **TERM AND TERMINATION**

a) **Term.** The Term of this Agreement shall be effective as of the date on which the Services Agreement is signed, or, if earlier, as of the date on which any Protected Health Information is provided by Covered Entity to Business Associate or created, received, maintained or transmitted by Business Associate from or on behalf of Covered Entity, and shall terminate when all of the Protected Health Information provided by Covered Entity to Business Associate, or created, received, maintained, or transmitted by Business Associate from or on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such Protected Health Information, in accordance with the termination provisions in this Section 7.

b) **Termination for Cause.** Upon one Party's knowledge of a material breach by the other Party, the non-breaching Party shall:

i) Provide a reasonable opportunity for Business Associate to cure the material breach or end the violation;

ii) Immediately terminate this Agreement (and any underlying agreement) if Business Associate has breached a material term of this Agreement and cure is not possible; or

iii) If neither termination nor cure is feasible, the non-breaching Party may report the violation to the Secretary of the U.S. Department of Health and Human Services.

c) **Effect of Termination.**

i) Except as provided Section 7(c)(2), upon termination of this Agreement, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created, received, maintained or transmitted by Business Associate from or on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information except as retained pursuant to Section 4, as set forth in this Section 7, or as permitted by applicable law.

ii) In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. If the return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

8) **MISCELLANEOUS**

a) **Regulatory References.** A reference in this Agreement to a section in the HIPAA Rules means the section as in effect or as amended.

b) **Amendment.** The Parties mutually agree to enter into good faith negotiations to amend this Agreement from time to time in order for each of the Parties to comply with the requirements of the HIPAA Rules and any other applicable law as may be in effect.

c) **Survival.** The respective rights and obligations of Business Associate under Section 7(c) of this Agreement shall survive the termination of this Agreement.

d) **Interpretation.** Any ambiguity in this Agreement shall be resolved to permit the Parties to comply with the HIPAA Rules.

e) **Scope.** This Agreement shall apply only if and to the extent MC is a "business associate" to a "covered entity" as such terms are defined at 45 CFR § 160.103, and MC does not, merely by signing this agreement, concede that it holds such legal status.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by their duly authorized representatives as of the Effective Date, and each represents and warrants to the other that it is legally free to enter into this Agreement.

BRIGHTREE HOME HEALTH & HOSPICE LLC	**CLIENT NAME:**
Name Signed	Name Signed
By:	By:
Name Printed	Name
Title	Title
Date	Date

Appendix 8: Washington State DOH 2021 Hospice Need Methodology

Department of Health
2021-2022 Hospice Numeric Need Methodology
Posted November 10, 2021

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

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

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

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

Hospice admissions ages 0-64	
Year	Admissions
2018	4,114
2019	3,699
2020	3,679
	average: 3,831

Deaths ages 0-64	
Year	Deaths
2018	14,055
2019	14,047
2020	16,663
	average: 14,922

Use Rates	
0-64	25.67%
65+	60.15%

Hospice admissions ages 65+	
Year	Admissions
2018	26,207
2019	26,017
2020	27,956
	average: 26,727

Deaths ages 65+	
Year	Deaths
2018	42,773
2019	44,159
2020	46,367
	average: 44,433

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

Department of Health
2021-2022 Hospice Numeric Need Methodology
Posted November 10, 2021

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

0-64				
County	2018	2019	2020	2018-2020 Average Deaths
Adams	28	35	20	**28**
Asotin	52	54	56	**54**
Benton	331	346	555	**411**
Chelan	130	137	224	**164**
Clallam	191	186	195	**191**
Clark	874	887	1,043	**935**
Columbia	6	7	7	**7**
Cowlitz	300	294	314	**303**
Douglas	51	63	42	**52**
Ferry	28	20	19	**22**
Franklin	145	123	100	**123**
Garfield	5	5	5	**5**
Grant	195	197	186	**193**
Grays Harbor	227	251	209	**229**
Island	135	167	110	**137**
Jefferson	64	72	68	**68**
King	3,264	3,275	4,456	**3,665**
Kitsap	515	557	454	**509**
Kittitas	68	90	78	**79**
Klickitat	58	46	42	**49**
Lewis	227	210	205	**214**
Lincoln	25	25	15	**22**
Mason	158	167	143	**156**
Okanogan	103	119	88	**103**
Pacific	64	66	55	**62**
Pend Oreille	43	31	41	**38**
Pierce	1,964	1,911	2,364	**2,080**
San Juan	19	20	18	**19**
Skagit	231	229	269	**243**
Skamania	27	19	26	**24**
Snohomish	1,533	1,533	1,587	**1,551**
Spokane	1,177	1,143	1,634	**1,318**
Stevens	113	112	86	**104**
Thurston	554	525	628	**569**
Wahkiakum	13	11	10	**11**
Walla Walla	110	118	150	**126**
Whatcom	390	394	457	**404**
Whitman	66	47	51	**55**
Yakima	601	555	653	**603**

65+				
County	2018	2019	2020	2018-2020 Average Deaths
Adams	72	93	59	**75**
Asotin	214	222	186	**207**
Benton	1,125	1,154	1,522	**1,267**
Chelan	573	626	785	**661**
Clallam	871	955	777	**868**
Clark	2,767	2,987	3,205	**2,986**
Columbia	43	52	43	**46**
Cowlitz	840	951	968	**920**
Douglas	255	270	160	**228**
Ferry	55	64	58	**59**
Franklin	278	313	263	**285**
Garfield	30	21	11	**21**
Grant	524	508	455	**496**
Grays Harbor	647	659	558	**621**
Island	675	642	505	**607**
Jefferson	336	338	273	**316**
King	9,917	10,213	11,186	**10,439**
Kitsap	1,713	1,811	1,714	**1,746**
Kittitas	239	266	241	**249**
Klickitat	158	160	113	**144**
Lewis	730	722	653	**702**
Lincoln	94	89	75	**86**
Mason	526	548	408	**494**
Okanogan	332	358	277	**322**
Pacific	279	265	177	**240**
Pend Oreille	130	125	101	**119**
Pierce	4,926	5,002	5,608	**5,179**
San Juan	114	127	94	**112**
Skagit	1,001	1,018	1,068	**1,029**
Skamania	56	87	47	**63**
Snohomish	4,055	4,081	4,278	**4,138**
Spokane	3,556	3,545	4,322	**3,808**
Stevens	373	345	248	**322**
Thurston	1,823	1,908	2,007	**1,913**
Wahkiakum	33	53	18	**35**
Walla Walla	445	450	522	**472**
Whatcom	1,252	1,461	1,481	**1,398**
Whitman	199	219	226	**215**
Yakima	1,517	1,451	1,675	**1,548**

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

Department of Health
2021-2022 Hospice Numeric Need Methodology
Posted November 10, 2021

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

0-64		
County	2018-2020 Average Deaths	Projected Patients: 25.67% of Deaths
Adams	28	7
Asotin	54	14
Benton	411	105
Chelan	164	42
Clallam	191	49
Clark	935	240
Columbia	7	2
Cowlitz	303	78
Douglas	52	13
Ferry	22	6
Franklin	123	31
Garfield	5	1
Grant	193	49
Grays Harbor	229	59
Island	137	35
Jefferson	68	17
King	3,665	941
Kitsap	509	131
Kittitas	79	20
Klickitat	49	12
Lewis	214	55
Lincoln	22	6
Mason	156	40
Okanogan	103	27
Pacific	62	16
Pend Oreille	38	10
Pierce	2,080	534
San Juan	19	5
Skagit	243	62
Skamania	24	6
Snohomish	1,551	398
Spokane	1,318	338
Stevens	104	27
Thurston	569	146
Wahkiakum	11	3
Walla Walla	126	32
Whatcom	404	104
Whitman	55	14
Yakima	603	155

65+		
County	2018-2020 Average Deaths	Projected Patients: 60.15% of Deaths
Adams	75	45
Asotin	207	125
Benton	1,267	762
Chelan	661	398
Clallam	868	522
Clark	2,986	1,796
Columbia	46	28
Cowlitz	920	553
Douglas	228	137
Ferry	59	35
Franklin	285	171
Garfield	21	12
Grant	496	298
Grays Harbor	621	374
Island	607	365
Jefferson	316	190
King	10,439	6,279
Kitsap	1,746	1,050
Kittitas	249	150
Klickitat	144	86
Lewis	702	422
Lincoln	86	52
Mason	494	297
Okanogan	322	194
Pacific	240	145
Pend Oreille	119	71
Pierce	5,179	3,115
San Juan	112	67
Skagit	1,029	619
Skamania	63	38
Snohomish	4,138	2,489
Spokane	3,808	2,290
Stevens	322	194
Thurston	1,913	1,150
Wahkiakum	35	21
Walla Walla	472	284
Whatcom	1,398	841
Whitman	215	129
Yakima	1,548	931

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

Department of Health
2021-2022 Hospice Numeric Need Methodology
Posted November 10, 2021

Health

WAC246-310-290(8)(d) Step 4:
Using the projected patients calculated in Step 3, calculate a use rate by dividing projected patients by the three-year historical average population by county. Use this rate

0-64								
County	Projected Patients	2018-2020 Average Population	2021 projected population	2022 projected population	2023 projected population	2021 potential volume	2022 potential volume	2023 potential volume
Adams	7	18,160	18,456	18,622	18,787	7	7	7
Asotin	14	16,715	16,596	16,540	16,485	14	14	14
Benton	105	167,984	171,026	172,638	174,249	107	108	109
Chelan	42	62,227	62,512	62,562	62,611	42	42	42
Clallam	49	52,494	52,233	52,027	51,821	49	49	48
Clark	240	411,278	421,901	426,529	431,158	246	249	252
Columbia	2	2,822	2,745	2,710	2,675	2	2	2
Cowlitz	78	85,817	85,843	85,769	85,695	78	78	78
Douglas	13	35,130	35,803	36,080	36,356	14	14	14
Ferry	6	5,628	5,541	5,506	5,470	6	6	6
Franklin	31	88,012	92,443	94,784	97,124	33	34	35
Garfield	1	1,581	1,541	1,522	1,502	1	1	1
Grant	49	86,033	88,240	89,322	90,403	51	51	52
Grays Harbor	59	57,387	56,679	56,401	56,122	58	58	57
Island	35	63,114	63,280	63,296	63,312	35	35	35
Jefferson	17	20,705	20,636	20,550	20,463	17	17	17
King	941	1,885,115	1,918,470	1,930,192	1,941,913	958	963	969
Kitsap	131	218,538	220,614	221,192	221,771	132	132	133
Kittitas	20	38,453	39,286	39,556	39,827	21	21	21
Klickitat	12	15,702	15,439	15,304	15,168	12	12	12
Lewis	55	62,700	63,164	63,327	63,491	55	55	56
Lincoln	6	7,864	7,751	7,698	7,644	5	5	5
Mason	40	50,632	51,397	51,672	51,946	41	41	41
Okanogan	27	32,364	32,087	31,991	31,896	26	26	26
Pacific	16	14,545	14,322	14,242	14,161	16	16	15
Pend Oreille	10	9,859	9,769	9,727	9,684	10	10	10
Pierce	534	756,339	769,918	774,696	779,475	543	547	550
San Juan	5	10,863	10,730	10,707	10,684	5	5	5
Skagit	62	100,807	101,887	102,236	102,586	63	63	63
Skamania	6	9,248	9,223	9,205	9,186	6	6	6
Snohomish	398	705,787	721,527	726,273	731,019	407	410	412
Spokane	338	423,256	426,740	428,033	429,326	341	342	343
Stevens	27	34,109	33,917	33,841	33,766	26	26	26
Thurston	146	238,190	243,867	246,235	248,602	150	151	152
Wahkiakum	3	2,498	2,405	2,368	2,332	3	3	3
Walla Walla	32	50,763	51,028	51,075	51,121	33	33	33
Whatcom	104	185,418	189,267	190,722	192,178	106	107	107
Whitman	14	43,222	43,315	43,322	43,330	14	14	14
Yakima	155	222,774	225,822	227,147	228,473	157	158	159

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

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2021-2022 Hospice Numeric Need Methodology
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WAC246-310-290(8)(d) Step 4:
Using the projected patients calculated in Step 3, calculate a use rate by dividing projected patients by the three-year historical average population by county. Use this rate to determine the potential volume of hospice use by the projected population by age cohort using Office of Financial Management (OFM) data.

			65+					
County	Projected Patients	2018-2020 Average Population	2021 projected population	2022 projected population	2023 projected population	2021 potential volume	2022 potential volume	2023 potential volume
Adams	45	2,227	2,383	2,424	2,466	48	49	50
Asotin	125	5,812	6,175	6,344	6,514	132	136	140
Benton	762	30,986	33,373	34,597	35,820	821	851	881
Chelan	398	15,876	17,052	17,695	18,339	427	443	460
Clallam	522	21,800	22,901	23,535	24,168	548	563	579
Clark	1,796	78,605	85,686	89,247	92,807	1,958	2,039	2,121
Columbia	28	1,236	1,287	1,304	1,322	29	29	30
Cowlitz	553	22,148	23,719	24,470	25,220	592	611	630
Douglas	137	7,976	8,666	8,974	9,283	149	155	160
Ferry	35	2,168	2,289	2,337	2,386	37	38	39
Franklin	171	9,188	10,083	10,557	11,030	188	197	206
Garfield	12	645	669	680	692	13	13	13
Grant	298	14,861	16,071	16,665	17,258	322	334	346
Grays Harbor	374	16,123	17,133	17,612	18,092	397	408	419
Island	365	20,239	21,412	22,047	22,682	386	398	409
Jefferson	190	11,588	12,323	12,722	13,121	202	208	215
King	6,279	310,572	337,771	350,881	363,992	6,829	7,094	7,359
Kitsap	1,050	53,833	58,185	60,492	62,800	1,135	1,180	1,225
Kittitas	150	7,647	8,266	8,589	8,911	162	168	174
Klickitat	86	5,829	6,268	6,448	6,627	93	96	98
Lewis	422	16,808	17,697	18,175	18,652	444	456	468
Lincoln	52	2,891	3,039	3,119	3,200	54	56	57
Mason	297	15,905	17,167	17,836	18,504	321	333	346
Okanogan	194	10,475	11,210	11,519	11,827	207	213	219
Pacific	145	6,747	7,035	7,159	7,284	151	153	156
Pend Oreille	71	3,925	4,239	4,371	4,504	77	80	82
Pierce	3,115	130,688	142,422	148,729	155,037	3,395	3,545	3,695
San Juan	67	5,768	6,174	6,357	6,541	72	74	76
Skagit	619	27,881	30,314	31,460	32,607	673	698	724
Skamania	38	2,670	2,923	3,048	3,172	42	43	45
Snohomish	2,489	119,333	131,978	138,737	145,495	2,753	2,894	3,035
Spokane	2,290	87,852	94,670	97,979	101,288	2,468	2,554	2,641
Stevens	194	11,360	12,214	12,591	12,969	208	216	221
Thurston	1,150	50,757	54,900	56,967	59,035	1,244	1,291	1,338
Wahkiakum	21	1,503	1,580	1,595	1,611	22	22	22
Walla Walla	284	11,006	11,350	11,632	11,915	293	300	308
Whatcom	841	40,902	44,217	45,794	47,372	909	941	974
Whitman	129	5,526	6,008	6,201	6,395	140	145	149
Yakima	931	37,530	39,475	40,559	41,643	979	1,006	1,033

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

Department of Health
2021-2022 Hospice Numeric Need Methodology
Posted November 10, 2021

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

County	2021 potential volume	2022 potential volume	2023 potential volume	Current Supply of Hospice Providers	2021 Unmet Need Admissions*	2022 Unmet Need Admissions*	2023 Unmet Need Admissions*
Adams	55	56	57	**51.33**	4	5	6
Asotin	146	150	153	**105.00**	41	45	48
Benton	928	959	990	**1,016.67**	(88)	(57)	(26)
Chelan	469	486	502	**428.67**	41	57	73
Clallam	597	612	627	**392.80**	204	219	234
Clark	2,204	2,288	2,372	**2,584.47**	(380)	(296)	(212)
Columbia	30	31	31	**35.00**	(5)	(4)	(4)
Cowlitz	670	689	708	**788.00**	(118)	(99)	(80)
Douglas	163	168	174	**160.67**	2	8	13
Ferry	43	44	45	**32.00**	11	12	13
Franklin	221	231	240	**201.67**	19	29	39
Garfield	14	14	15	**6.00**	8	8	9
Grant	373	386	398	**292.33**	81	93	106
Grays Harbor	455	466	477	**295.57**	160	170	181
Island	422	433	445	**399.67**	22	34	45
Jefferson	219	226	232	**198.00**	21	28	34
King	7,786	8,057	8,328	**7,830.73**	(44)	226	497
Kitsap	1,267	1,312	1,358	**1,223.57**	43	89	134
Kittitas	182	189	196	**168.00**	14	21	27
Klickitat	105	108	110	**217.80**	(113)	(110)	(107)
Lewis	500	512	524	**445.33**	54	67	79
Lincoln	60	61	63	**29.00**	31	32	34
Mason	361	374	387	**304.57**	57	70	82
Okanogan	234	239	245	**188.33**	45	51	57
Pacific	166	169	171	**93.00**	73	76	78
Pend Oreille	87	89	92	**65.33**	22	24	26
Pierce	3,938	4,092	4,246	**3,596.23**	342	496	649
San Juan	77	79	81	**87.00**	(10)	(8)	(5)
Skagit	736	762	787	**729.00**	7	33	58
Skamania	48	50	51	**32.00**	16	18	19
Snohomish	3,160	3,303	3,447	**3,508.33**	(349)	(205)	(61)
Spokane	2,809	2,897	2,984	**2,720.50**	89	176	263
Stevens	235	241	247	**148.67**	86	92	99
Thurston	1,394	1,442	1,491	**1,565.30**	(171)	(123)	(75)
Wahkiakum	25	25	25	**9.33**	15	16	16
Walla Walla	326	333	340	**272.33**	53	60	68
Whatcom	1,015	1,048	1,081	**1,094.57**	(80)	(46)	(13)
Whitman	154	159	163	**158.17**	(4)	1	5
Yakima	1,136	1,164	1,192	**1,261.00**	(125)	(97)	(69)

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

Sources:
Self-Report Provider Utilization Surveys for Years 2016-2020
Vital Statistics Death Data for Years 2016-2020
Prepared by DOH Program Staff

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2021-2022 Hospice Numeric Need Methodology
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WAC246-310-290(8)(f) Step 6:
Multiply the unmet need from Step 5 by the statewide average length of stay as determined by CMS to determine unmet need patient days in the projection years.

				Step 6 (Admits * ALOS) = Unmet Patient Days			
County	2021 Unmet Need Admissions*	2022 Unmet Need Admissions*	2023 Unmet Need Admissions*	Statewide ALOS	2021 Unmet Need Patient Days*	2022 Unmet Need Patient Days*	2023 Unmet Need Patient Days*
Adams	4	5	6	62.12	244	300	356
Asotin	41	45	48	62.12	2,563	2,786	3,009
Benton	(88)	(57)	(26)	62.12	(5,497)	(3,565)	(1,633)
Chelan	41	57	73	62.12	2,535	3,539	4,542
Clallam	204	219	234	62.12	12,682	13,613	14,543
Clark	(380)	(296)	(212)	62.12	(23,619)	(18,396)	(13,174)
Columbia	(5)	(4)	(4)	62.12	(281)	(258)	(235)
Cowlitz	(118)	(99)	(80)	62.12	(7,320)	(6,160)	(5,000)
Douglas	2	8	13	62.12	134	470	807
Ferry	11	12	13	62.12	691	737	784
Franklin	19	29	39	62.12	1,201	1,801	2,401
Garfield	8	8	9	62.12	506	518	531
Grant	81	93	106	62.12	5,021	5,799	6,578
Grays Harbor	160	170	181	62.12	9,916	10,589	11,261
Island	22	34	45	62.12	1,377	2,090	2,802
Jefferson	21	28	34	62.12	1,324	1,726	2,127
King	(44)	226	497	62.12	(2,759)	14,070	30,899
Kitsap	43	89	134	62.12	2,696	5,513	8,331
Kittitas	14	21	27	62.12	889	1,290	1,691
Klickitat	(113)	(110)	(107)	62.12	(6,994)	(6,835)	(6,676)
Lewis	54	67	79	62.12	3,378	4,132	4,886
Lincoln	31	32	34	62.12	1,917	2,004	2,091
Mason	57	70	82	62.12	3,529	4,319	5,108
Okanogan	45	51	57	62.12	2,823	3,173	3,523
Pacific	73	76	78	62.12	4,554	4,714	4,875
Pend Oreille	22	24	26	62.12	1,337	1,483	1,630
Pierce	342	496	649	62.12	21,240	30,788	40,337
San Juan	(10)	(8)	(5)	62.12	(639)	(507)	(375)
Skagit	7	33	58	62.12	435	2,029	3,623
Skamania	16	18	19	62.12	984	1,094	1,204
Snohomish	(349)	(205)	(61)	62.12	(21,649)	(12,726)	(3,802)
Spokane	89	176	263	62.12	5,511	10,934	16,357
Stevens	86	92	99	62.12	5,345	5,741	6,136
Thurston	(171)	(123)	(75)	62.12	(10,646)	(7,645)	(4,643)
Wahkiakum	15	16	16	62.12	956	967	977
Walla Walla	53	60	68	62.12	3,304	3,758	4,213
Whatcom	(80)	(46)	(13)	62.12	(4,953)	(2,888)	(823)
Whitman	(4)	1	5	62.12	(231)	50	330
Yakima	(125)	(97)	(69)	62.12	(7,760)	(6,032)	(4,305)

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

Sources: CPS MDOR Hospice 3 Report
Self-Report Provider Utilization Surveys for Years 2018-2020
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

Department of Health
2021-2022 Hospice Numeric Need Methodology
Posted November 10, 2021

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

				Step 7 (Patient Days / 365) = Unmet ADC		
County	2021 Unmet Need Patient Days*	2022 Unmet Need Patient Days*	2023 Unmet Need Patient Days*	2021 Unmet Need ADC*	2022 Unmet Need ADC*	2023 Unmet Need ADC*
Adams	244	300	356	1	1	1
Asotin	2,563	2,786	3,009	7	8	8
Benton	(5,497)	(3,565)	(1,633)	(15)	(10)	(4)
Chelan	2,535	3,539	4,542	7	10	12
Clallam	12,682	13,613	14,543	35	37	40
Clark	(23,619)	(18,396)	(13,174)	(65)	(50)	(36)
Columbia	(281)	(258)	(235)	(1)	(1)	(1)
Cowlitz	(7,320)	(6,160)	(5,000)	(20)	(17)	(14)
Douglas	134	470	807	0	1	2
Ferry	691	737	784	2	2	2
Franklin	1,201	1,801	2,401	3	5	7
Garfield	506	518	531	1	1	1
Grant	5,021	5,799	6,578	14	16	18
Grays Harbor	9,916	10,589	11,261	27	29	31
Island	1,377	2,090	2,802	4	6	8
Jefferson	1,324	1,726	2,127	4	5	6
King	(2,759)	14,070	30,899	(8)	39	85
Kitsap	2,696	5,513	8,331	7	15	23
Kittitas	889	1,290	1,691	2	4	5
Klickitat	(6,994)	(6,835)	(6,676)	(19)	(19)	(18)
Lewis	3,378	4,132	4,886	9	11	13
Lincoln	1,917	2,004	2,091	5	5	6
Mason	3,529	4,319	5,108	10	12	14
Okanogan	2,823	3,173	3,523	8	9	10
Pacific	4,554	4,714	4,875	12	13	13
Pend Oreille	1,337	1,483	1,630	4	4	4
Pierce	21,240	30,788	40,337	58	84	111
San Juan	(639)	(507)	(375)	(2)	(1)	(1)
Skagit	435	2,029	3,623	1	6	10
Skamania	984	1,094	1,204	3	3	3
Snohomish	(21,649)	(12,726)	(3,802)	(59)	(35)	(10)
Spokane	5,511	10,934	16,357	15	30	45
Stevens	5,345	5,741	6,136	15	16	17
Thurston	(10,646)	(7,645)	(4,643)	(29)	(21)	(13)
Wahkiakum	956	967	977	3	3	3
Walla Walla	3,304	3,758	4,213	9	10	12
Whatcom	(4,953)	(2,888)	(823)	(14)	(8)	(2)
Whitman	(231)	50	330	(1)	0	1
Yakima	(7,760)	(6,032)	(4,305)	(21)	(17)	(12)

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

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
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Prepared by DOH Program Staff

Department of Health
2021-2022 Hospice Numeric Need Methodology
Posted November 10, 2021

Health

WAC246-310-290(5)(h) Step 8:
Determine the number of hospice agencies in the planning area that could support the unmet need with an ADC of thirty-five.

Application Year

	Step 7 (Patient Days / 365) = Unmet ADC			Step 8 - Numeric Need	
County	**2021 Unmet Need ADC***	**2022 Unmet Need ADC***	**2023 Unmet Need ADC***	**Numeric Need?**	**Number of New Agencies Needed?****
Adams	1	1	1	FALSE	FALSE
Asotin	7	8	8	FALSE	FALSE
Benton	(15)	(10)	(4)	FALSE	FALSE
Chelan	7	10	12	FALSE	FALSE
Clallam	35	37	40	*TRUE*	*1*
Clark	(65)	(50)	(36)	FALSE	FALSE
Columbia	(1)	(1)	(1)	FALSE	FALSE
Cowlitz	(20)	(17)	(14)	FALSE	FALSE
Douglas	0	1	2	FALSE	FALSE
Ferry	2	2	2	FALSE	FALSE
Franklin	3	5	7	FALSE	FALSE
Garfield	1	1	1	FALSE	FALSE
Grant	14	16	18	FALSE	FALSE
Grays Harbor	27	29	31	FALSE	FALSE
Island	4	6	8	FALSE	FALSE
Jefferson	4	5	6	FALSE	FALSE
King	(5)	39	86	*TRUE*	*2*
Kitsap	7	15	23	FALSE	FALSE
Kittitas	2	4	5	FALSE	FALSE
Klickitat	(19)	(19)	(18)	FALSE	FALSE
Lewis	9	11	13	FALSE	FALSE
Lincoln	5	5	6	FALSE	FALSE
Mason	10	12	14	FALSE	FALSE
Okanogan	8	9	10	FALSE	FALSE
Pacific	12	13	13	FALSE	FALSE
Pend Oreille	4	4	4	FALSE	FALSE
Pierce	58	84	111	*TRUE*	*3*
San Juan	(2)	(1)	(1)	FALSE	FALSE
Skagit	1	6	10	FALSE	FALSE
Skamania	3	3	3	FALSE	FALSE
Snohomish	(59)	(35)	(10)	FALSE	FALSE
Spokane	15	30	46	*TRUE*	*1*
Stevens	15	16	17	FALSE	FALSE
Thurston	(29)	(21)	(13)	FALSE	FALSE
Wahkiakum	3	3	3	FALSE	FALSE
Walla Walla	9	10	12	FALSE	FALSE
Whatcom	(14)	(8)	(2)	FALSE	FALSE
Whitman	(1)	0	1	FALSE	FALSE
Yakima	(21)	(17)	(12)	FALSE	FALSE

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

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

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2020
Vital Statistics Death Data for Years 2019-2020
Prepared by DOH Program Staff

Department of Health
2021-2022 Hospice Numeric Need Methodology
Admissions - Summarized

0-64 Total Admissions by County

Sum of 0-64	Column Labels		
Row Labels	2018	2019	2020
Adams	6	8	4
Asotin	6	9	24
Benton	118	103	132
Chelan	34	28	32
Clallam	16	23	24
Clark	336	387	297
Columbia	1	3	3
Cowlitz	107	121	94
Douglas	10	19	17
Ferry	6	5	3
Franklin	30	26	34
Garfield	1	1	3
Grant	41	45	40
Grays Harbor	35	41	27
Island	38	43	54
Jefferson	21	26	17
King	1009	765	889
Kitsap	180	173	96
Kittitas	15	16	12
Klickitat	10	12	12
Lewis	56	50	47
Lincoln	7	3	5
Mason	14	34	43
Okanogan	21	27	31
Pacific	13	15	12
Pend Oreille	8	4	17
Pierce	543	556	425
San Juan	6	6	8
Skagit	48	77	70
Skamania	2	1	3
Snohomish	422	342	361
Spokane	400	329	362
Stevens	30	20	21
Thurston	114	115	129
Wahkiakum	2	0	3
Walla Walla	24	41	41
Whatcom	117	138	80
Whitman	19	12	12
Yakima	248	175	195

65+ Total Admissions by County

Sum of 65+	Column Labels		
Row Labels	2018	2019	2020
Adams	34	54	48
Asotin	121	71	84
Benton	887	837	973
Chelan	386	385	421
Clallam	187	234	283
Clark	2124	2060	2238
Columbia	23	25	50
Cowlitz	600	735	707
Douglas	136	130	170
Ferry	29	25	28
Franklin	155	166	194
Garfield	2	4	7
Grant	261	236	254
Grays Harbor	180	212	186
Island	348	341	375
Jefferson	155	181	194
King	6359	6315	7131
Kitsap	1021	1074	921
Kittitas	135	169	157
Klickitat	81	90	87
Lewis	420	362	401
Lincoln	29	22	21
Mason	161	193	263
Okanogan	148	171	167
Pacific	72	98	69
Pend Oreille	53	65	49
Pierce	3175	3170	2714
San Juan	79	73	89
Skagit	680	705	607
Skamania	20	33	37
Snohomish	2636	2214	2636
Spokane	2247.5	2175	2648
Stevens	121	126	128
Thurston	936	947	1070
Wahkiakum	5	7	11
Walla Walla	227	242	242
Whatcom	770	995	978
Whitman	226.5	77	128
Yakima	977	998	1190

Total Admissions by County - Not Adjusted for New

County	2018	2019	2020	Average
Adams	40	62	52	**51.33**
Asotin	127	80	108	**105.00**
Benton	1005	940	1105	**1016.67**
Chelan	420	413	453	**428.67**
Clallam	203	257	307	**255.67**
Clark	2460	2347	2535	**2447.33**
Columbia	24	28	53	**35.00**
Cowlitz	707	856	801	**788.00**
Douglas	146	149	187	**160.67**
Ferry	35	30	31	**32.00**
Franklin	185	192	228	**201.67**
Garfield	3	5	10	**6.00**
Grant	302	281	294	**292.33**
Grays Harb	215	253	213	**227.00**
Island	386	384	429	**399.67**
Jefferson	176	207	211	**198.00**
King	7368	7080	8020	**7489.33**
Kitsap	1201	1247	1017	**1155.00**
Kittitas	150	185	169	**168.00**
Klickitat	91	102	99	**97.33**
Lewis	476	412	448	**445.33**
Lincoln	36	25	26	**29.00**
Mason	175	227	306	**236.00**
Okanogan	169	198	198	**188.33**
Pacific	85	113	81	**93.00**
Pend Oreil	61	69	66	**65.33**
Pierce	3718	3726	3139	**3527.67**
San Juan	85	79	97	**87.00**
Skagit	728	782	677	**729.00**
Skamania	22	34	40	**32.00**
Snohomish	3058	2556	2997	**2870.33**
Spokane	2647.5	2504	3010	**2720.50**
Stevens	151	146	149	**148.67**
Thurston	1050	1062	1199	**1103.67**
Wahkiakur	7	7	14	**9.33**
Walla Wall	251	283	283	**272.33**
Whatcom	887	1133	1058	**1026.00**
Whitman	245.5	89	140	**158.17**
Yakima	1225	1173	1385	**1261.00**

Total Admissions by County - Adjusted for New
Adjusted Cells Highlighted in YELLOW

County	2018	2019	2020	Average
Adams	40	62	52	**51.33**
Asotin	127	80	108	**105.00**
Benton	1005	940	1105	**1016.67**
Chelan	420	413	453	**428.67**
Clallam	203	462.7	512.7	**392.80**
Clark	2460	2552.7	2740.7	**2584.47**
Columbia	24	28	53	**35.00**
Cowlitz	707	856	801	**788.00**
Douglas	146	149	187	**160.67**
Ferry	35	30	31	**32.00**
Franklin	185	192	228	**201.67**
Garfield	3	5	10	**6.00**
Grant	302	281	294	**292.33**
Grays Harb	215	253	418.7	**295.57**
Island	386	384	429	**399.67**
Jefferson	176	207	211	**198.00**
King	7368	7400.4	8723.8	**7830.73**
Kitsap	1201	1247	1222.7	**1223.57**
Kittitas	150	185	169	**168.00**
Klickitat	272.7	281.7	99	**217.80**
Lewis	476	412	448	**445.33**
Lincoln	36	25	26	**29.00**
Mason	175	227	511.7	**304.57**
Okanogan	169	198	198	**188.33**
Pacific	85	113	81	**93.00**
Pend Oreil	61	69	66	**65.33**
Pierce	3718	3726	3344.7	**3596.23**
San Juan	85	79	97	**87.00**
Skagit	728	782	677	**729.00**
Skamania	22	34	40	**32.00**
Snohomish	3058	3178.8	4088.2	**3508.33**
Spokane	2647.5	2504	3010	**2720.50**
Stevens	151	146	149	**148.67**
Thurston	1255.7	1449.4	1990.8	**1565.30**
Wahkiakur	7	7	14	**9.33**
Walla Wall	251	283	283	**272.33**
Whatcom	887	1133	1263.7	**1094.57**
Whitman	245.5	89	140	**158.17**
Yakima	1225	1173	1385	**1261.00**

35 ADC * 365 days per year = 12,775 default patient days
12,775 patient days/62.12 ALOS = 205.7 default admissions
205.7 Default
For affected counties, the actual volumes from these recently approved agencies will be subtracted, and default values will be added.

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Prepared by DOH Program Staff

Department of Health
2021-2022 Hospice Numeric Need Methodology
Admissions - Summarized

Recent approvals showing default volumes:
Olympic Medical Center - Clallam County. Approved in September 2019. Default volumes for 2019-2020
Providence Hospice - Clark County. Approved in 2019. Default volumes in 2019-2020
The Pennant Group - Grays Harbor County. Approved August 2021. No adjustment possible for 2021, adjustment in 2020 as proxy.
Wesley Homes Hospice - King County. Approved in 2015, operational since 2017. 2018 volumes exceed "default" - no adjustment for 2018. Adjustments in 2019.
Envision Hospice - King County. Approved in 2019. Default volumes for 2019-2020
Continuum Care of King - King County. CN issued March 2020. Default volumes for 2020
Empires Healthcare Group - King County. Approved in 2021. No adjustment possible for 2021, adjustment in 2020 as proxy.
Seasons Hospice - King County. Approved in 2021. No adjustment possible for 2021, adjustment in 2020 as proxy.
Envision Hospice - Kitsap County. Approved in 2020. Default volumes for 2020
Heart of Hospice - Klickitat County. Approved in August 2017. Operational since August 2017. Default volumes in 2018-2019.
The Pennant Group - Mason County. Approved September 2021. No adjustment possible for 2021, adjustment in 2020 as proxy.
Providence Health & Services - Pierce County. Approved in 2021. No adjustment possible for 2021, adjustment in 2020 as proxy.
Continuum Care of Snohomish - Snohomish County. Approved in July 2019. Default volumes in 2019-2020
Heart of Hospice - Snohomish County. Approved in November 2019. Default volumes for 2019-2020
Envision Hospice - Snohomish County. Approved in November 2019. Default volumes for 2019-2020
Glacier Peak Healthcare - Snohomish County. Approved in November 2019. Default volumes for 2019-2020
Empires Healthcare Group - Snohomish County. Approved in 2021. No adjustment possible for 2021, adjustment in 2020 as proxy.
Seasons Hospice - Snohomish County. Approved in 2021. No adjustment possible for 2021, adjustment in 2020 as proxy.
Envision Hospice - Thurston County. Approved in September 2018. Default volumes in 2018-2020.
Symbol Healthcare - Thurston County. Approved in November 2019. Default volumes for 2019-2020
Bristol Hospice - Thurston County. Approved March 2021. No adjustment possible for 2021, adjustment in 2020 as proxy.
MultiCare Health - Thurston County. Approved in 2021. No adjustment possible for 2021, adjustment in 2020 as proxy.
Empires Healthcare Group - Whatcom County. Approved in 2020. Default volumes for 2020

Sources:
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Note: Kindred Hospice in Whitman and Spokane Counties did not respond to the department's survey for 2018 data. As a result, the average of 2016 and 2017 data was used as a proxy for 2018.

Agency Name	License Number	County	Year	0-64	65+
Assured Home Health and Hospice (Central Basin/Assured Hospice)	IHS.FS.60092413	Grant	2018	40	254
Assured Home Health and Hospice (Central Basin/Assured Hospice)	IHS.FS.60092413	Lincoln	2018	6	28
Assured Home Health and Hospice (Central Basin/Assured Hospice)	IHS.FS.60092413	Adams	2018	6	34
Assured Home Health, Hospice & Home Care	IHS.FS.00000229	Jefferson	2018	1	11
Assured Home Health, Hospice & Home Care	IHS.FS.00000229	Mason	2018	4	44
Assured Home Health, Hospice & Home Care	IHS.FS.00000229	Clallam	2018	16	186
Assured Home Health, Hospice & Home Care	IHS.FS.00000229	Thurston	2018	24	273
Assured Home Health, Hospice & Home Care	IHS.FS.00000229	Lewis	2018	35	280
Astria Home Health and Hospice (Yakima Regional Home Health and Hospice)	IHS.FS.60097245	Yakima	2018	41	8
Central Washington Hospital Home Care Services	IHS.FS.00000250	Douglas	2018	10	133
Central Washington Hospital Home Care Services	IHS.FS.00000250	Chelan	2018	34	386
Community Home Health and Hospice CHHH Community Home Care Hospice	IHS.FS.00000262	Wahkiakum	2018	2	5
Community Home Health and Hospice CHHH Community Home Care Hospice	IHS.FS.00000262	Clark	2018	54	383
Community Home Health and Hospice CHHH Community Home Care Hospice	IHS.FS.00000262	Cowlitz	2018	87	524
Elite Home Health and Hospice	IHS.FS.60384078	Garfield	2018	1	2
Elite Home Health and Hospice	IHS.FS.60384078	Asotin	2018	6	121
Evergreen Health Home Care Services	IHS.FS.00000278	Island	2018	1	9
Evergreen Health Home Care Services	IHS.FS.00000278	Snohomish	2018	79	690
Evergreen Health Home Care Services	IHS.FS.00000278	King	2018	348	1989
Franciscan Hospice	IHS.FS.00000287	Kitsap	2018	141	693
Franciscan Hospice	IHS.FS.00000287	King	2018	102	921
Franciscan Hospice	IHS.FS.00000287	Pierce	2018	331	2110
Frontier Home Health and Hospice (Okanogan Regional)	IHS.FS.60379608	Douglas	2018	0	3
Frontier Home Health and Hospice (Okanogan Regional)	IHS.FS.60379608	Grant	2018	1	7
Frontier Home Health and Hospice (Okanogan Regional)	IHS.FS.60379608	Okanogan	2018	21	148
Gentiva Hospice (Odyssey Hospice)	IHS.FS.60330209	King	2018	37	180
Harbors Home Health and Hospice	IHS.FS.00000306	Pacific	2018	13	71
Harbors Home Health and Hospice	IHS.FS.00000306	Grays Harbor	2018	35	180
Heart of Hospice	IHS.FS.00000185	Skamania	2018	none repo	10
Heart of Hospice	IHS.FS.00000185	Klickitat	2018	1	23
Heartlinks Hospice and Palliative Care (Lower Valley Hospice)	IHS.FS.00000369	Benton	2018	6	137
Heartlinks Hospice and Palliative Care (Lower Valley Hospice)	IHS.FS.00000369	Yakima	2018	24	219
Home Health Care of Whidbey General Hospital (Whidbey General)	IHS.FS.00000323	Island	2018	20	235
Homecare and Hospice Southwest (Hospice SW)	IHS.FS.60331226	Skamania	2018	1	1
Homecare and Hospice Southwest (Hospice SW)	IHS.FS.60331226	Cowlitz	2018	20	76
Homecare and Hospice Southwest (Hospice SW)	IHS.FS.60331226	Clark	2018	243	1305
Horizon Hospice	IHS.FS.00000332	Spokane	2018	31	389
Hospice of Kitsap County	IHS.FS.00000335	Kitsap	2018	0	0
Hospice of Spokane	IHS.FS.00000337	Lincoln	2018	1	1
Hospice of Spokane	IHS.FS.00000337	Ferry	2018	6	29
Hospice of Spokane	IHS.FS.00000337	Pend Oreille	2018	8	53
Hospice of Spokane	IHS.FS.00000337	Stevens	2018	30	121
Hospice of Spokane	IHS.FS.00000337	Spokane	2018	346	1593
Hospice of Spokane	IHS.FS.00000337	Whitman	2018	none repo	none repor
Hospice of the Northwest (Skagit Hospice Service)	IHS.FS.00000437	Island	2018	6	60
Hospice of the Northwest (Skagit Hospice Service)	IHS.FS.00000437	Snohomish	2018	2	67
Hospice of the Northwest (Skagit Hospice Service)	IHS.FS.00000437	San Juan	2018	6	79
Hospice of the Northwest (Skagit Hospice Service)	IHS.FS.00000437	Skagit	2018	48	680
IRREGULAR-COMMUNITY HOME HEALTH & HOSPICE	IHS.FS.00000262	Pacific	2018	0	1
IRREGULAR-MULTICARE	IHS.FS.60639376	Clallam	2018	0	1
Jefferson Healthcare Home Health and Hospice (Hospice of Jefferson County)	IHS.FS.00000349	Jefferson	2018	20	144
Kaiser Permanente Continuing Care Services	IHS.FS.00000353	Clark	2018	39	436
Kaiser Permanente Continuing Care Services	IHS.FS.00000353	Cowlitz	2018	none repo	none repor
Kaiser Permanente Continuing Care Services	IHS.FS.00000353	Skamania	2018	none repo	none repor
Kaiser Permanente Home Health and Hospice (Group Health)	IHS.FS.00000305	Snohomish	2018	14	94
Kaiser Permanente Home Health and Hospice (Group Health)	IHS.FS.00000305	Kitsap	2018	14	96
Kaiser Permanente Home Health and Hospice (Group Health)	IHS.FS.00000305	Pierce	2018	35	198
Kaiser Permanente Home Health and Hospice (Group Health)	IHS.FS.00000305	King	2018	25	416
Kindred Hospice (Gentiva Hospice	IHS.FS.60308060	Whitman	2018	19	226.5
Kindred Hospice (Gentiva Hospice	IHS.FS.60308060	Spokane	2018	23	265.5
Kittitas Valley Home Health and Hospice	IHS.FS.00000320	Kittitas	2018	15	135
Klickitat Valley Home Health & Hospice (Klickitat Valley Health)	IHS.FS.00000361	Klickitat	2018	5	40
Kline Galland Community Based Services	IHS.FS.60103742	King	2018	29	368
Memorial Home Care Services	IHS.FS.00000376	Yakima	2018	183	750
MultiCare Home Health, Hospice and Palliative Care	IHS.FS.60639376	King	2018	32	158

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MultiCare Home Health, Hospice and Palliative Care	IHS.FS.60639377	Kitsap	2018	25	232
MultiCare Home Health, Hospice and Palliative Care	IHS.FS.60639378	Pierce	2018	177	867
Providence Hospice (Hospice of the Gorge)	IHS.FS.60201476	Skamania	2018	1	9
Providence Hospice (Hospice of the Gorge)	IHS.FS.60201476	Klickitat	2018	4	18
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Island	2018	11	44
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Snohomish	2018	316	1772
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	King	2018	none repo	none repor
Providence Hospice of Seattle	IHS.FS.00000336	Snohomish	2018	11	13
Providence Hospice of Seattle	IHS.FS.00000336	King	2018	407	1959
Providence SoundHomeCare and Hospice	IHS.FS.00000420	Mason	2018	10	117
Providence SoundHomeCare and Hospice	IHS.FS.00000420	Lewis	2018	21	140
Providence SoundHomeCare and Hospice	IHS.FS.00000420	Thurston	2018	90	663
Tri-Cities Chaplaincy	IHS.FS.00000456	Franklin	2018	30	155
Tri-Cities Chaplaincy	IHS.FS.00000456	Benton	2018	112	750
Walla Walla Community Hospice	IHS.FS.60480441	Columbia	2018	1	23
Walla Walla Community Hospice	IHS.FS.60480441	Walla Walla	2018	24	227
Wesley Homes	IHS.FS.60276500	King	2018	29	368
Whatcom Hospice (Peacehealth)	IHS.FS.00000471	Whatcom	2018	117	770
Alpha Home Health	IHS.FS.61032013	Snohomish	2019	0	0
Alpowa Healthcare Inc. d/b/a Elite Home Health and Hospice	IHS.FS.60384078	Asotin	2019	9	71
Alpowa Healthcare Inc. d/b/a Elite Home Health and Hospice	IHS.FS.60384078	Garfield	2019	1	4
Central Washington Homecare Services	IHS.FS.00000250	Chelan	2019	28	385
Central Washington Homecare Services	IHS.FS.00000250	Douglas	2019	19	125
Chaplaincy Health Care 2018	IHS.FS.00000456	Benton	2019	96	700
Chaplaincy Health Care 2018	IHS.FS.00000456	Franklin	2019	26	164
Community Home Health/Hospice	IHS.FS.00000262	Cowlitz	2019	98	636
Community Home Health/Hospice	IHS.FS.00000262	Wahkiakum	2019	0	7
Community Home Health/Hospice	IHS.FS.00000262	Clark	2019	60	453
Continuum Care of King LLC	IHS.FS.61058934	King	2019	0	0
Continuum Care of Snohomish LLC	IHS.FS.61010090	Snohomish	2019	0	0
Envision Hospice of Washington	IHS.FS.60952486	Thurston	2019	2	22
EvergreenHealth	IHS.FS.00000278	King	2019	225	2025
EvergreenHealth	IHS.FS.00000278	Snohomish	2019	53	471
EvergreenHealth	IHS.FS.00000278	Island	2019	1	11
Franciscan Hospice	IHS.FS.00000287	King	2019	92	921
Franciscan Hospice	IHS.FS.00000287	Kitsap	2019	118	757
Franciscan Hospice	IHS.FS.00000287	Pierce	2019	364	2236
Frontier Home Health & Hospice	IHS.FS.60379608	Okanogan	2019	27	171
Frontier Home Health & Hospice	IHS.FS.60379608	Douglas	2019	0	5
Frontier Home Health & Hospice	IHS.FS.60379608	Grant	2019	4	8
Harbors Home Health and Hospice	IHS.FS.00000306	Grays Harbor	2019	41	212
Harbors Home Health and Hospice	IHS.FS.00000306	Pacific	2019	15	98
Heartlinks	IHS.FS.00000369	Benton	2019	7	137
Heartlinks	IHS.FS.00000369	Yakima	2019	21	180
Heartlinks	IHS.FS.00000369	Franklin	2019	0	2
Horizon Hospice	IHS.FS.00000332	Spokane	2019	30	393
Hospice of Jefferson County, Jefferson Healthcare	IHI.FS.00000349	Jefferson	2019	26	172
Hospice of Spokane	IHS.FS.00000337	Spokane	2019	289	1692
Hospice of Spokane	IHS.FS.00000337	Stevens	2019	20	126
Hospice of Spokane	IHS.FS.00000337	Ferry	2019	5	25
Hospice of Spokane	IHS.FS.00000337	Pend Oreille	2019	4	65
Hospice of the Northwest	IHS.FS.00000437	Island	2019	14	56
Hospice of the Northwest	IHS.FS.00000437	San Juan	2019	6	73
Hospice of the Northwest	IHS.FS.00000437	Skagit	2019	77	705
Hospice of the Northwest	IHS.FS.00000437	Snohomish	2019	5	58
Inspiring Hospice Partners of Oregon dba Heart of Hospice	IHS.FS.60741443	Skamania	2019	0	17
Inspiring Hospice Partners of Oregon dba Heart of Hospice	IHS.FS.60741443	Klickitat	2019	2	24
Inspiring Hospice Partners of Oregon dba Heart of Hospice	IHS.FS.60741443	Clark	2019	0	3
Inspiring Hospice Partners of Oregon dba Heart of Hospice	IHS.FS.60741443	Snohomish	2019	0	0
Kaiser Continuing Care Services Hospice	IHS.FS.00000353	Clark	2019	43	387
Kaiser Permanente Home Health and Hospice	IHS.FS.00000305	King	2019	37	489
Kaiser Permanente Home Health and Hospice	IHS.FS.00000305	Kitsap	2019	18	123
Kaiser Permanente Home Health and Hospice	IHS.FS.00000305	Pierce	2019	25	176
Kaiser Permanente Home Health and Hospice	IHS.FS.00000305	Snohomish	2019	7	62
Kindred Hospice	IHS.FS.60308060	Spokane	2019	10	90
Kindred Hospice	IHS.FS.60308060	Whitman	2019	12	77
Kindred Hospice	IHS.FS.60330209	King	2019	6	217
Kittitas Valley Healthcare Home Health and Hospice	IHS.FS.00000320	Kittitas	2019	16	169

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Klickitat Valley Hospice	IHS.FS.00000361	Klickitat	2019	1	44
Kline Galland Community Based Services	IHS.FS.60103742	King	2019	35	345
Memorial Home Care Services	IHS.FS.00000376	Yakima	2019	148	730
MultiCare Hospice	IHS.FS.60639376	King	2019	27	149
MultiCare Hospice	IHS.FS.60639376	Pierce	2019	167	758
MultiCare Hospice	IHS.FS.60639376	Kitsap	2019	37	194
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Clallam	2019	23	234
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Jefferson	2019	0	9
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Lewis	2019	17	244
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Mason	2019	6	45
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Thurston	2019	22	240
Olympic Medical Hospice	IHS.FS.00000393	Clallam	2019	0	0
PeaceHealth Hospice	IHS.FS.60331226	Clark	2019	184	1217
PeaceHealth Hospice	IHS.FS.60331226	Cowlitz	2019	23	99
PeaceHealth Hospice	IHS.FS.60331226	Skamania	2019	0	1
PeaceHealth Whatcom	IHS.FS.00000471	Whatcom	2019	138	995
Providence Hospice	IHS.FS.60201476	Klickitat	2019	9	22
Providence Hospice	IHS.FS.60201476	Skamania	2019	1	15
Providence Hospice	IHS.FS.60201476	Clark	2019	0	0
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Snohomish	2019	272	1613
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Island	2019	1	29
Providence Hospice of Seattle	IHS.FS.00000336	King	2019	338	2083
Providence Hospice of Seattle	IHS.FS.00000336	Snohomish	2019	5	10
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Thurston	2019	91	685
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Mason	2019	28	148
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Lewis	2019	33	118
Puget Sound Hopsice	IHS.FS.61032138	Thurston	2019	0	0
Walla Walla Community Hospice	IHS.FS.60480441	Walla Walla	2019	41	242
Walla Walla Community Hospice	IHS.FS.60480441	Columbia	2019	3	25
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Adams	2019	8	54
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Grant	2019	41	228
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Lincoln	2019	3	22
Wesley Homes	IHS.FS.60276500	King	2019	5	86
WhidbeyHealth Home Health, Hospice	IHS.FS.00000323	Island	2019	27	245
Yakima HMA Home Health, LLC	IHS.FS.60097245	Yakima	2019	6	88
Alpha Hospice	IHS.FS.61032013	Snohomish	2020	1	30
Alpowa Healthcare, Inc. d/b/a Elite Home Health & Hospice	IHS.FS.60384078	Asotin	2020	24	84
Alpowa Healthcare, Inc. d/b/a Elite Home Health & Hospice	IHS.FS.60384078	Garfield	2020	3	7
Astria Hospice	IHS.FS.60097245	Yakima	2020	0	56
Central Washington Home Care Service	IHS.FS.00000250	Chelan	2020	32	421
Central Washington Home Care Service	IHS.FS.00000250	Douglas	2020	13	159
Chaplaincy Health Care	IHS.FS.00000456	Benton	2020	118	821
Chaplaincy Health Care	IHS.FS.00000456	Franklin	2020	30	192
Community Home Health/Hospice	IHS.FS.00000262	Cowlitz	2020	78	616
Community Home Health/Hospice	IHS.FS.00000262	Pacific	2020	1	3
Community Home Health/Hospice	IHS.FS.00000262	Wahkiakum	2020	3	11
Community Home Health/Hospice	IHS.FS.60547198	Clark	2020	61	430
Continuum Care of King LLC	IHS.FS.61058934	King	2020	0	0
Continuum Care of Snohomish	IHS.FS.61010090	King	2020	2	40
Continuum Care of Snohomish	IHS.FS.61010090	Snohomish	2020	12	131
Eden Hospice at Whatcom County, LLC	IHS.FS.61117985	Whatcom	2020	0	0
Envision Hospice of Washington LLC	IHS.FS.60952486	King	2020	1	76
Envision Hospice of Washington LLC	IHS.FS.60952486	Kitsap	2020	0	0
Envision Hospice of Washington LLC	IHS.FS.60952486	Pierce	2020	1	20
Envision Hospice of Washington LLC	IHS.FS.60952486	Thurston	2020	1	24
Envision Hospice of Washington LLC	IHS.FS.60952486	Snohomish	2020	0	0
EvergreenHealth	IHS.FS.00000278	King	2020	316	2451
EvergreenHealth	IHS.FS.00000278	Snohomish	2020	70	672
EvergreenHealth	IHS.FS.00000278	Island	2020	0	6
Frontier Home Health & Hospice	IHS.FS.60379608	Douglas	2020	4	11
Frontier Home Health & Hospice	IHS.FS.60379608	Grant	2020	0	3
Frontier Home Health & Hospice	IHS.FS.60379608	Okanogan	2020	30	167
Harbors Home Health and Hospice	IHS.FS.00000306	Grays Harbor	2020	27	186
Harbors Home Health and Hospice	IHS.FS.00000306	Pacific	2020	11	66
HEART OF HOSPICE	IHS.FS.60741443	Clark	2020	0	3
HEART OF HOSPICE	IHS.FS.60741443	Klickitat	2020	2	21
HEART OF HOSPICE	IHS.FS.60741443	Skamania	2020	2	18
HEART OF HOSPICE	IHS.FS.60741443	Snohomish	2020	0	0

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Heartlinks	IHS.FS.00000369	Benton	2020	14	152
Heartlinks	IHS.FS.00000369	Yakima	2020	20	181
Heartlinks	IHS.FS.00000369	Franklin	2020	4	2
Horizon Hospice & Palliative Care	IHS.FS.00000332	Spokane	2020	28	456
Hospice of Jefferson County	IHS.FS.00000349	Jefferson	2020	17	178
Hospice of Spokane	IHS.FS.00000337	Spokane	2020	302	1895
Hospice of Spokane	IHS.FS.00000337	Stevens	2020	21	128
Hospice of Spokane	IHS.FS.00000337	Ferry	2020	3	28
Hospice of Spokane	IHS.FS.00000337	Pend Oreille	2020	17	49
Hospice of Spokane	IHS.FS.00000337	Lincoln	2020	0	0
Hospice of Spokane	IHS.FS.00000337	Whitman	2020	0	1
Hospice of Spokane	IHS.FS.00000337	Okanogan	2020	1	0
Kaiser Permanente Continuing Care Services	IHS.FS.00000353	Clark	2020	42	433
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	King	2020	49	446
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	Kitsap	2020	13	114
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	Pierce	2020	30	181
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	Snohomish	2020	3	84
Kindred Hospice	IHS.FS.60308060	Spokane	2020	32	297
Kindred Hospice	IHS.FS.60308060	Whitman	2020	12	127
Kindred Hospice	IHS.FS.60330209	King	2020	9	200
Kittitas Valley Home Health and Hospice	IHS.FS.00000320	Kittitas	2020	12	157
Klickitat Valley Health Home Health & Hospice	IHS.FS.00000361	Klickitat	2020	4	38
Kline Galland Hospice	IHS.FS.60103742	King	2020	83	896
Memorial Home Care Services	IHS.FS.00000376	Yakima	2020	175	953
Multicare Home Health, Hospice	IHS.FS.60639376	Pierce	2020	161	866
Multicare Home Health, Hospice	IHS.FS.60639376	King	2020	36	137
Multicare Home Health, Hospice	IHS.FS.60639376	Kitsap	2020	12	126
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Clallam	2020	24	283
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Jefferson	2020	0	16
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Lewis	2020	15	226
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Mason	2020	8	70
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Pierce	2020	0	1
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Thurston	2020	22	268
Olympic Medical Hospice	IHS.FS.00000393	Clallam	2020	0	0
PeaceHealth Hospice Southwest	IHS.FS.60331226	Clark	2020	194	1372
PeaceHealth Hospice Southwest	IHS.FS.60331226	Cowlitz	2020	16	91
PeaceHealth Hospice Southwest	IHS.FS.60331226	Skamania	2020	0	3
Providence Hospice	IHS.FS.60201476	Klickitat	2020	6	28
Providence Hospice	IHS.FS.60201476	Skamania	2020	1	16
Providence Hospice	IHS.FS.60201476	Clark	2020	0	0
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Snohomish	2020	267	1645
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Island	2020	5	36
Providence Hospice of Seattle	IHS.FS.00000336	King	2020	338	2059
Providence Hospice of Seattle	IHS.FS.00000336	Snohomish	2020	0	0
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Thurston	2020	106	772
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Mason	2020	35	193
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Lewis	2020	32	175
Puget Sound Hospice	IHS.FS.61032138	Thurston	2020	0	6
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	Island	2020	20	81
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	San Juan	2020	8	89
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	Skagit	2020	70	607
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	Snohomish	2020	8	74
Virginia Mason Franciscan Hospice & Palliative Care	IHS.FS.00000287	King	2020	52	716
Virginia Mason Franciscan Hospice & Palliative Care	IHS.FS.00000287	Pierce	2020	232	1630
Virginia Mason Franciscan Hospice & Palliative Care	IHS.FS.00000287	Kitsap	2020	71	681
Walla Walla Community Hospice	IHS.FS.60480441	Walla Walla	2020	41	242
Walla Walla Community Hospice	IHS.FS.60480441	Columbia	2020	3	50
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Adams	2020	4	48
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Grant	2020	40	251
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Lincoln	2020	5	21
Wesley Homes Hospice, LLC	IHS.FS.60276500	King	2020	3	110
Wesley Homes Hospice, LLC	IHS.FS.60276500	Pierce	2020	1	16

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Prepared by DOH Program Staff

Department of Health
2021-2022 Hospice Numeric Need Methodology
Preliminary Death Data Updated October 12, 2021

County	0-64			65+		
	2018	2019	2020	2018	2019	2020
ADAMS	28	35	20	72	93	59
ASOTIN	52	54	56	214	222	186
BENTON	331	346	555	1,125	1154	1522
CHELAN	130	137	224	573	626	785
CLALLAM	191	186	195	871	955	777
CLARK	874	887	1043	2,767	2987	3205
COLUMBIA	6	7	7	43	52	43
COWLITZ	300	294	314	840	951	968
DOUGLAS	51	63	42	255	270	160
FERRY	28	20	19	55	64	58
FRANKLIN	145	123	100	278	313	263
GARFIELD	5	5	5	30	21	11
GRANT	195	197	186	524	508	455
GRAYS HARBOR	227	251	209	647	659	558
ISLAND	135	167	110	675	642	505
JEFFERSON	64	72	68	336	338	273
KING	3,264	3,275	4456	9,917	10213	11186
KITSAP	515	557	454	1,713	1811	1714
KITTITAS	68	90	78	239	266	241
KLICKITAT	58	46	42	158	160	113
LEWIS	227	210	205	730	722	653
LINCOLN	25	25	15	94	89	75
MASON	158	167	143	526	548	408
OKANOGAN	103	119	88	332	358	277
PACIFIC	64	66	55	279	265	177
PEND OREILLE	43	31	41	130	125	101
PIERCE	1,964	1,911	2364	4,926	5002	5608
SAN JUAN	19	20	18	114	127	94
SKAGIT	231	229	269	1,001	1018	1068
SKAMANIA	27	19	26	56	87	47
SNOHOMISH	1,533	1,533	1587	4,055	4081	4278
SPOKANE	1,177	1,143	1634	3,556	3545	4322
STEVENS	113	112	86	373	345	248
THURSTON	554	525	628	1,823	1908	2007
WAHKIAKUM	13	11	10	33	53	18
WALLA WALLA	110	118	150	445	450	522
WHATCOM	360	394	457	1,252	1461	1481
WHITMAN	66	47	51	199	219	226
YAKIMA	601	555	653	1,517	1451	1675

Sources:
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

Department of Health
2021-2022 Hospice Numeric Need Methodology
0-64 Population Projection

County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2018-2020 Average Population
Adams	17,637	17,768	17,899	18,029	18,160	18,291	18,456	18,622	18,787	18,953	19,118	18,160
Asotin	16,969	16,906	16,842	16,779	16,715	16,652	16,596	16,540	16,485	16,429	16,373	16,715
Benton	162,262	163,693	165,123	166,554	167,984	169,415	171,026	172,638	174,249	175,861	177,472	167,984
Chelan	61,284	61,520	61,755	61,991	62,227	62,463	62,512	62,562	62,611	62,661	62,710	62,227
Clallam	52,716	52,661	52,605	52,550	52,494	52,439	52,233	52,027	51,821	51,615	51,409	52,494
Clark	387,296	393,291	399,287	405,282	411,278	417,273	421,901	426,529	431,158	435,786	440,414	411,278
Columbia	2,988	2,947	2,905	2,863	2,822	2,780	2,745	2,710	2,675	2,640	2,605	2,822
Cowlitz	85,417	85,517	85,617	85,717	85,817	85,917	85,843	85,769	85,695	85,621	85,547	85,817
Douglas	33,540	33,938	34,335	34,732	35,130	35,527	35,803	36,080	36,356	36,633	36,909	35,130
Ferry	5,834	5,782	5,731	5,680	5,628	5,577	5,541	5,506	5,470	5,435	5,399	5,628
Franklin	79,651	81,742	83,832	85,922	88,012	90,102	92,443	94,784	97,124	99,465	101,806	88,012
Garfield	1,665	1,644	1,623	1,602	1,581	1,560	1,541	1,522	1,502	1,483	1,464	1,581
Grant	81,535	82,660	83,784	84,909	86,033	87,158	88,240	89,322	90,403	91,485	92,567	86,033
Grays Harb	59,105	58,675	58,246	57,817	57,387	56,958	56,679	56,401	56,122	55,844	55,565	57,387
Island	62,514	62,664	62,814	62,964	63,114	63,264	63,280	63,296	63,312	63,328	63,344	63,114
Jefferson	20,636	20,653	20,670	20,688	20,705	20,722	20,636	20,550	20,463	20,377	20,291	20,705
King	1,798,581	1,820,215	1,841,848	1,863,482	1,885,115	1,906,749	1,918,470	1,930,192	1,941,913	1,953,635	1,965,356	1,885,115
Kitsap	212,548	214,045	215,543	217,040	218,538	220,035	220,614	221,192	221,771	222,349	222,928	218,538
Kittitas	36,206	36,768	37,330	37,892	38,453	39,015	39,286	39,556	39,827	40,097	40,368	38,453
Klickitat	16,208	16,082	15,955	15,828	15,702	15,575	15,439	15,304	15,168	15,033	14,897	15,702
Lewis	61,494	61,796	62,097	62,398	62,700	63,001	63,164	63,327	63,491	63,654	63,817	62,700
Lincoln	8,101	8,042	7,982	7,923	7,864	7,805	7,751	7,698	7,644	7,591	7,537	7,864
Mason	48,672	49,162	49,652	50,142	50,632	51,122	51,397	51,672	51,946	52,221	52,496	50,632
Okanogan	33,087	32,906	32,726	32,545	32,364	32,183	32,087	31,991	31,896	31,800	31,704	32,364
Pacific	15,115	14,972	14,830	14,688	14,545	14,403	14,322	14,242	14,161	14,081	14,000	14,545
Pend Oreill	10,045	9,998	9,952	9,905	9,859	9,812	9,769	9,727	9,684	9,642	9,599	9,859
Pierce	721,137	729,937	738,738	747,538	756,339	765,139	769,918	774,696	779,475	784,253	789,032	756,339
San Juan	11,305	11,194	11,084	10,974	10,863	10,753	10,730	10,707	10,684	10,661	10,638	10,863
Skagit	97,885	98,616	99,346	100,076	100,807	101,537	101,887	102,236	102,586	102,935	103,285	100,807
Skamania	9,272	9,266	9,260	9,254	9,248	9,242	9,223	9,205	9,186	9,168	9,149	9,248
Snohomish	661,812	672,806	683,800	694,793	705,787	716,781	721,527	726,273	731,019	735,765	740,511	705,787
Spokane	414,493	416,684	418,875	421,066	423,256	425,447	426,740	428,033	429,326	430,619	431,912	423,256
Stevens	34,576	34,459	34,343	34,226	34,109	33,992	33,917	33,841	33,766	33,690	33,615	34,109
Thurston	224,951	228,261	231,571	234,880	238,190	241,500	243,867	246,235	248,602	250,970	253,337	238,190
Wahkiakun	2,726	2,669	2,612	2,555	2,498	2,441	2,405	2,368	2,332	2,295	2,259	2,498
Walla Wall	49,893	50,111	50,328	50,546	50,763	50,981	51,028	51,075	51,121	51,168	51,215	50,763
Whatcom	175,840	178,234	180,629	183,023	185,418	187,812	189,267	190,722	192,178	193,633	195,088	185,418
Whitman	42,880	42,965	43,051	43,137	43,222	43,308	43,315	43,322	43,330	43,337	43,344	43,222
Yakima	215,882	217,605	219,328	221,051	222,774	224,497	225,822	227,147	228,473	229,798	231,123	222,774

Sources:
2017 OFM Population Projections, Medium-Series
Prepared by DOH Program Staff

Department of Health
2020-2021 Hospice Numeric Need Methodology
65+ Population Projection

County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2018-2020 Average Population
Adams	1,773	1,887	2,000	2,114	2,227	2,341	2,383	2,424	2,466	2,507	2,549	2,227
Asotin	5,041	5,233	5,426	5,619	5,812	6,005	6,175	6,344	6,514	6,683	6,853	5,812
Benton	26,328	27,492	28,657	29,821	30,986	32,150	33,373	34,597	35,820	37,044	38,267	30,986
Chelan	13,746	14,279	14,811	15,343	15,876	16,408	17,052	17,695	18,339	18,982	19,626	15,876
Clallam	19,934	20,401	20,867	21,334	21,800	22,267	22,901	23,535	24,168	24,802	25,436	21,800
Clark	64,524	68,044	71,564	75,085	78,605	82,125	85,686	89,247	92,807	96,368	99,929	78,605
Columbia	1,102	1,135	1,169	1,202	1,236	1,269	1,287	1,304	1,322	1,339	1,357	1,236
Cowlitz	18,863	19,684	20,505	21,326	22,148	22,969	23,719	24,470	25,220	25,971	26,721	22,148
Douglas	6,450	6,831	7,213	7,595	7,976	8,358	8,666	8,974	9,283	9,591	9,899	7,976
Ferry	1,876	1,949	2,022	2,095	2,168	2,241	2,289	2,337	2,386	2,434	2,482	2,168
Franklin	7,499	7,921	8,343	8,765	9,188	9,610	10,083	10,557	11,030	11,504	11,977	9,188
Garfield	595	607	620	633	645	658	669	680	692	703	714	645
Grant	12,395	13,011	13,628	14,244	14,861	15,477	16,071	16,665	17,258	17,852	18,446	14,861
Grays Harb	14,005	14,535	15,064	15,594	16,123	16,653	17,133	17,612	18,092	18,571	19,051	16,123
Island	18,086	18,625	19,163	19,701	20,239	20,777	21,412	22,047	22,682	23,317	23,952	20,239
Jefferson	10,244	10,580	10,916	11,252	11,588	11,924	12,323	12,722	13,121	13,520	13,919	11,588
King	254,219	268,307	282,395	296,484	310,572	324,660	337,771	350,881	363,992	377,102	390,213	310,572
Kitsap	45,652	47,697	49,743	51,788	53,833	55,878	58,185	60,492	62,800	65,107	67,414	53,833
Kittitas	6,464	6,760	7,055	7,351	7,647	7,943	8,266	8,589	8,911	9,234	9,557	7,647
Klickitat	4,792	5,051	5,310	5,570	5,829	6,088	6,268	6,448	6,627	6,807	6,987	5,829
Lewis	15,166	15,576	15,987	16,398	16,808	17,219	17,697	18,175	18,652	19,130	19,608	16,808
Lincoln	2,619	2,687	2,755	2,823	2,891	2,959	3,039	3,119	3,200	3,280	3,360	2,891
Mason	13,528	14,123	14,717	15,311	15,905	16,499	17,167	17,836	18,504	19,173	19,841	15,905
Okanogan	8,773	9,198	9,624	10,050	10,475	10,901	11,210	11,519	11,827	12,136	12,445	10,475
Pacific	6,095	6,258	6,421	6,584	6,747	6,910	7,035	7,159	7,284	7,408	7,533	6,747
Pend Oreil	3,195	3,378	3,560	3,742	3,925	4,107	4,239	4,371	4,504	4,636	4,768	3,925
Pierce	108,983	114,409	119,836	125,262	130,688	136,114	142,422	148,729	155,037	161,344	167,652	130,688
San Juan	4,876	5,099	5,322	5,545	5,768	5,991	6,174	6,357	6,541	6,724	6,907	5,768
Skagit	22,735	24,021	25,308	26,595	27,881	29,168	30,314	31,460	32,607	33,753	34,899	27,881
Skamania	2,158	2,286	2,414	2,542	2,670	2,798	2,923	3,048	3,172	3,297	3,422	2,670
Snohomish	95,788	101,674	107,560	113,447	119,333	125,219	131,978	138,737	145,495	152,254	159,013	119,333
Spokane	73,817	77,325	80,834	84,343	87,852	91,361	94,670	97,979	101,288	104,597	107,906	87,852
Stevens	9,454	9,930	10,407	10,884	11,360	11,837	12,214	12,591	12,969	13,346	13,723	11,360
Thurston	42,459	44,534	46,608	48,683	50,757	52,832	54,900	56,967	59,035	61,102	63,170	50,757
Wahkiakur	1,254	1,316	1,379	1,441	1,503	1,565	1,580	1,595	1,611	1,626	1,641	1,503
Walla Wal	10,757	10,819	10,881	10,944	11,006	11,068	11,350	11,632	11,915	12,197	12,479	11,006
Whatcom	33,950	35,688	37,426	39,164	40,902	42,640	44,217	45,794	47,372	48,949	50,526	40,902
Whitman	4,370	4,659	4,948	5,237	5,526	5,815	6,008	6,201	6,395	6,588	6,781	5,526
Yakima	34,088	34,949	35,809	36,670	37,530	38,391	39,475	40,559	41,643	42,727	43,811	37,530

Sources:
2017 OFM Population Projections, Medium-Series
Prepared by DOH Program Staff

Appendix 9: VistaRiver of King County, LLC Letter of Intent

VISTARIVER
HOSPICE

November 29th, 2021

RECEIVED
By CERTIFICATE OF NEED PROGRAM at 9:16 pm, Nov 29, 2021

LOI21-11VRHK

Eric Hernandez, Program Manager
Certificate of Need Program
Department of Health
P.O. Box 47852
Olympia, WA 98504-7852
Via Email

Dear Mr. Hernandez:

VistaRiver of King County, LLC ("VistaRiver") submits this letter of intent to apply for a certificate of need to establish a hospice agency. In accordance with WAC 246-310-080, please find the following information:

1. **Description of Services Provided**: VistaRiver proposes to establish a Joint Commission accredited, Medicare and Medicaid certified hospice agency.
2. **Estimated Cost of the Proposed Project**: The estimated cost of the proposed hospice agency is $30,000.00
3. **Identification of Services Area:** The service area of the hospice agency will be King County, Washington.

VistaRiver is looking forward to caring for the residents of King County. Please do not hesitate to reach out with any questions or concerns.

Sincerely,

Geoff Schackmann
Program Manager
VistaRiver

Appendix 10: Financial Statements

Santé Consolidated Income Statement 1/1/2020 to 12/31/2020

	Modified 1/1/2020 to 12/31/2020
Santé Network Revenue	
Skilled Nursing Revenue	$ 17,076,407
Assisted Living Revenue	7,356,697
Independent Living Revenue	807,861
Home Health Revenue	5,360,661
Hospice Revenue	1,619,477
Adult Family Revenue	82,157
Other Revenue	225,198
Other Related Party Revenue	-
Management Fee Revenue	3,612,609
Total Santé Network Revenue	36,141,068
Santé Network Expenses	
Santé Operating Expenses	
Pharmacy	$ 743,790
Ancillary	1,535,467
Therapy	4,222,397
Nursing	9,164,311
Respiratory	197,919
Medical Records	106,614
Central Supply	21,901
Dietary	1,959,938
Housekeeping & Laundry	674,705
Plant/Maintenance	1,494,189
Activities	258,453
Marketing	1,590,501
Social Services	66,720
Admissions	171,896
General & Administration	10,250,831
Property Taxes	214,410
Total Santé Operating Expenses	32,674,044
EBITDAR	3,467,024

Santé Non-Operating Expenses		
Debt Service / Third Party Lease	$	2,647,122
Other Real Estate Expenses		41,334
Related Party Interest		61,766
Note Payable Interest		-
Provider Relief Funds		(1,878,457)
Line of Credit Interest		-
Total Santé Non-Operating Expenses		871,765
Total Santé Network Expenses		**33,545,809**
Provider Relief Funds		
Total Santé Non-Operating Expenses		
Santé Net Income (Loss)		**2,595,259**
Net Income Margin		7.2%

Santé Consolidated Income Statement 1/1/2019 to 12/31/2019

	Modified 1/1/2019 to 12/31/2019
Santé Network Revenue	
Skilled Nursing Revenue	$ 18,952,002
Assisted Living Revenue	6,828,993
Independent Living Revenue	807,258
Home Health Revenue	6,110,560
Hospice Revenue	1,324,223
Adult Family Revenue	264,542
Other Revenue	3,403,601
Other Related Party Revenue	-
Management Fee Revenue	3,830,887
Total Santé Network Revenue	41,522,066
Santé Network Expenses	
Santé Operating Expenses	
Pharmacy	$ 975,441
Ancillary	1,130,429
Therapy	5,055,318
Nursing	9,108,642
Respiratory	119,052
Medical Records	123,325
Central Supply	29,900
Dietary	2,047,488
Housekeeping & Laundry	626,131
Plant/Maintenance	1,533,447
Activities	260,291
Marketing	1,781,297
Social Services	111,321
Admissions	264,680
General & Administration	11,769,958
Property Taxes	213,969
Total Santé Operating Expenses	35,150,688
EBITDAR	6,371,378

Santé Non-Operating Expenses		
Debt Service / Third Party Lease	$	2,848,003
Other Real Estate Expenses		746,349
Related Party Interest		56,882
Note Payable Interest		1,048
Line of Credit Interest		2,128
Total Santé Non-Operating Activities		3,654,410
Total Santé Network Expenses		**38,805,098**
Santé Net Income (Loss)		**2,716,969**
Net Income Margin		6.5%

Appendix 11: Medical Director Contract

PROFESSIONAL SERVICES AGREEMENT MEDICAL DIRECTOR

This Agreement is made effective as of **Dec-01-2021** by and between **VistaRiver of King County, LLC**(ORGANIZATION") and **Dr. Bhupinder Walia**, ("MEDICAL DIRECTOR") and **Daiya Health** multi-specialty provider group with their agent(s)**Dr. Nita Vellody and Dr. Bhupinder Walia**, a physician ("MEDICAL DIRECTOR") who will assume patient care in the absence of **Dr. Nita Vellody,** a physician ("MEDICAL DIRECTOR")

1. PURPOSE

ORGANIZATION desires to engage a qualified physician to act as Medical Director for their hospice care program. MEDICAL DIRECTOR is a physician qualified by virtue of training and experience in the practice of medicine or osteopathy, is licensed as a doctor of medicine or osteopathy in the State of Oregon, and meets the requirements for membership on the medical staff of ORGANIZATION.

2. OBLIGATIONS OF MEDICAL DIRECTOR

2.1 Status and Membership. MEDICAL DIRECTOR will remain in full compliance with all of the following conditions continuously during the entire term of this Agreement. Failure of MEDICAL DIRECTOR to satisfy any or all of the following conditions will constitute grounds for automatic termination of this Agreement as set forth in Section 5.

2.2 MEDICAL DIRECTOR will be licensed as a doctor of medicine or osteopathy in the State of Oregon without restriction or subject to any disciplinary or corrective action;

(a) MEDICAL DIRECTOR will be a member in good standing of the active category of the Medical Staff without restriction or subject to any disciplinary or corrective action; and

(b) MEDICAL DIRECTOR will abide by the Bylaws and Rules and Regulations of the medical staff; by the policies and procedures of ORGANIZATION; and in direct compliance with all state, federal, local and Joint Commission rules, regulations, and standards.

2.3 Duties and Responsibilities of MEDICAL DIRECTOR.

MEDICAL DIRECTOR is responsible for the submission to ORGANIZATION of documentation of services provided as appropriate.

(a) MEDICAL DIRECTOR will be a participating member of the hospice interdisciplinary group of the ORGANIZATION and participate in the annual evaluation.

(b) MEDICAL DIRECTOR will advise and/or assist in the resolution of concerns/conflicts involving physicians utilizing the services of ORGANIZATION.

(c) MEDICAL DIRECTOR will review and sign initial hospice certifications of terminal illness, and recertification as indicated.

(d) MEDICAL DIRECTOR (hospice physician) will perform face-to-face encounters as necessary

(e) MEDICAL DIRECTOR will act as a "hospice champion" in the community, raising awareness about hospice services

2.4 Responsibilities of ORGANIZATION To provide skilled services to patients admitted by ORGANIZATION according to its policies on acceptance of patients for service, state rules and regulations, local laws, Federal Conditions of Participation and Joint Commission standards.

The Administrator/Executive Director of hospice will provide MEDICAL DIRECTOR with an orientation to the hospice program. Additional informational materials will be provided, as needed, throughout the term of the agreement. Verbal reports on the status of the ORGANIZATION will be provided at least quarterly at the Professional Advisory Committee meetings. The Administrator/Executive Director of hospice will be accessible to the MEDICAL DIRECTOR and will facilitate coordination and continuity of services to patients.

ORGANIZATION retains all responsibility and authority for the patient admission process; patient assessment; the development, review and revision of the plan of care; the coordination, supervision and evaluation of the patient care provided; the scheduling of visits or hours; and discharge planning.

ORGANIZATION will ensure the quality and utilization of services in accordance with its quality management program. The Administrator/Executive Director of hospice is responsible for the monitoring and control of services provided.

ORGANIZATION will provide MEDICAL DIRECTOR with any changes to these rules, regulations and standards and allow MEDICAL DIRECTOR at least 30 days to meet these changes.

2.5 Compliance with Standards. MEDICAL DIRECTOR will perform all services and duties under this Agreement in strict accordance with all laws, rules, regulations, ordinances, and judicial and administrative interpretations thereof, of the United States, the State of Oregon, the City of Portland, and all political subdivisions, agencies, and instrumentality's of any of them, as well as with the bylaws, rules, regulations, guidelines, policies, and procedures of ORGANIZATION, as all of the foregoing may from time to time be in effect. Particularly, and not by way of limitation, MEDICAL DIRECTOR will comply with the State's Name Medical Practice Act or Osteopathic Practice Act and all rules and regulations of the Oregon State Board of Medical Examiners or State Board of Osteopathic Physicians and will do everything necessary to maintain in effect his license as a doctor of medicine or osteopathy within the State.

2.6 Insurance. The MEDICAL DIRECTOR and all physicians who may provide services hereunder for MEDICAL DIRECTOR will at all times throughout the term of this Agreement maintain professional liability insurance in an amount no less than the greater of (i) the amount required by the Medical Staff Bylaws or (ii) $1,000,000 per occurrence and $3,000,000 in the aggregate.

Moreover, in the event that MEDICAL DIRECTOR (or any physician providing services hereunder for MEDICAL DIRECTOR) ceases to provide services hereunder, and upon the termination or expiration of this Agreement, the MEDICAL DIRECTOR (and each physician) whose insurance is "claims made" insurance rather than "occurrence" insurance will either purchase "tail" coverage to continue the liability insurance coverage for the period during which the Physician rendered services hereunder or (ii) continue in full force and effect the same level of liability insurance coverage on a claims made basis until the longest statute of limitations for minors is tolled until they reach the age of majority). The MEDICAL DIRECTOR and each physician will deliver to ORGANIZATION at least annually in advance

a certificate of insurance evidencing the required coverage, both during the term of this Agreement and thereafter.

Said insurance will cover all of the MEDICAL DIRECTOR 's professional services provided to patients of ORGANIZATION and his private medical practice, as well as his activities and responsibilities as a member of the Medical Staff, including but not be limited to peer review and credentialing activities. On or before the effective date of this Agreement, MEDICAL DIRECTOR will have delivered to the Administrator/Executive Director of ORGANIZATION. a certificate or certificates of insurance evidencing such coverage.

2.7 Time. MEDICAL DIRECTOR will devote such time and attention as is necessary to fulfill all duties and responsibilities. MEDICAL DIRECTOR, and/or backup, will be available 24 hours/day for on-call consultation, assistance and decisions regarding patient care. MEDICAL DIRECTOR will be responsible for arranging for coverage when unavailable; however, prior approval of any physician providing coverage for MEDICAL DIRECTOR must be obtained from the Administrator/Executive Director of ORGANIZATION.

2.8 Disclosure of Information. MEDICAL DIRECTOR recognizes and acknowledges that he will have access to certain confidential information of the ORGANIZATION and that such information constitutes valuable, special and unique property of the ORGANIZATION. MEDICAL DIRECTOR will not, during or after the term of this Agreement, without the consent of the ORGANIZATION disclose any such confidential information to any other person, firm, corporation, association, or other entity for any reason or purpose whatsoever except as may be ordered by a court or governmental agency or as may otherwise be required by law. In the event of a breach or a threatened breach by MEDICAL DIRECTOR of the provisions of this paragraph, the ORGANIZATION will be entitled to an injunction restraining MEDICAL DIRECTOR from disclosing in whole or in part any confidential information. Nothing herein will be construed as prohibiting the ORGANIZATION from pursuing any other remedies available to it for such breach or threatened breach, including the recovery of damages from MEDICAL DIRECTOR.

2.9 Financial Obligation. MEDICAL DIRECTOR will incur no financial obligation on behalf of the ORGANIZATION or for which the ORGANIZATION will be responsible without prior approval of the Administrator/Executive Director.

2.10 Billing. The MEDICAL DIRECTOR will not charge patients for services rendered as MEDICAL DIRECTOR of the ORGANIZATION. The professional fees charged to patients will be for professional services rendered to individual patients only. Such fees will be separate from ORGANIZATION fees to the patient for ORGANIZATION services, including services performed by any physician as MEDICAL DIRECTOR.

2.11 Services. MEDICAL DIRECTOR will perform all obligations of MEDICAL DIRECTOR under this Agreement at the ORGANIZATION's principle place of business, ORGANIZATION's street address. All communications to ORGANIZATION will be directed to the Administrator/Executive Director at such address and the ORGANIZATION's Administrator/Executive Director will have full authority to communicate to MEDICAL DIRECTOR on behalf of ORGANIZATION. If the MEDICAL DIRECTOR is unavailable the following physician will cover all patient services: **Dr. Bhupinder Walia**, a physician.

3. OBLIGATIONS OF ORGANIZATION

3.1 Compensation. See Attached Compensation Addendum

4. INDEPENDENT CONTRACTOR

In the performance of all services pursuant to this Agreement, MEDICAL DIRECTOR is at all times acting as an independent contractor engaged in the profession and practice of medicine or osteopathy. MEDICAL DIRECTOR will employ own means and methods and exercise own professional judgment in the performance of such services, and ORGANIZATION will have no right of control or direction with respect to such means, methods or judgments, or with respect to the details of such services. The only concern of ORGANIZATION under this Agreement or otherwise is that, irrespective of the means selected, such services will be provided in a competent, efficient and satisfactory manner. It is expressly agreed that MEDICAL DIRECTOR will not for any purpose be deemed to be an employee, agent, partner, joint venture, ostensible or apparent agent, servant, or borrowed servant of ORGANIZATION. MEDICAL DIRECTOR, and all physicians and other individuals providing services pursuant to this Agreement, will not have any claim against ORGANIZATION for vacation pay, sick leave, retirement benefits, social security, workers' compensation, disability or unemployment insurance benefits, or employee benefits of any kind.

5. DURATION AND TERMINATION

5.1 Term. This Agreement will continue in effect for a term of one (1) calendar year from the effective date and thereafter from year to year thereafter unless terminated sooner as hereinafter set forth.

5.2 Termination. Either party at any time may terminate the Agreement, with or without cause, by giving written notice of such termination to the other party at least fifteen (15) days prior to the date on which the termination is to be effective, such date to be specified in the notice. Notwithstanding the above, if MEDICAL DIRECTOR fails to comply with any or all of the requirements set forth in Section 2, of this Agreement at any time during this Agreement, ORGANIZATION will be entitled to terminate this Agreement effective immediately.

5.3 Modification or Renewal. The payment provisions of this Agreement may not be altered or modified during any 12-month term. Moreover, following termination without cause, the parties will not enter into the same or a similar contract with each other unless the new contract does not have the effect of altering or modifying the previous Agreement's payment provisions within a 12-month period. The intent of this provision is to prohibit the parties from terminating this Agreement without cause and then entering into a new contract in order to alter or modify the payment provisions within a period of less than one year. Contract renewal will also be contingent upon an annual competency review and evaluation.

6. MISCELLANEOUS

6.1 Governing Law. This Agreement will be subject to and governed by the laws of the State of Oregon.

6.2 Remedies. All rights, powers and remedies granted to either party by any particular term of this Agreement are in addition to, and not in limitation of, any rights, powers or remedies which it has under any other term of this Agreement, at common law, in equity, by statute, or otherwise. All such rights, powers and remedies may be exercised separately or concurrently, in such order and as often as may be deemed expedient by either party. No delay or omission by either party to exercise any right, power or remedy will impair such right, power or remedy or be construed to be a waiver of or an acquiescence to any breach or default. A waiver by either party of any breach or default hereunder will not constitute a waiver of any subsequent breach or default.

6.3 Amendment. No amendment or variation of the terms of this Agreement will be valid unless in writing and signed by both parties in the manner provided in Section 6.11 of this Agreement.

6.4 Assignment. Neither this Agreement nor any rights, powers or duties hereunder may be assigned by either party without the express written consent of the other party, and any such unauthorized assignment will be void. If any such unauthorized assignment is attempted by either party, the other party will have the power, at its election, to terminate this Agreement effective immediately. Further, MEDICAL DIRECTOR may not subcontract or otherwise arrange for another individual or entity to perform his duties under this Agreement, with the exception of the limited coverage provisions set out in Section 2.5, of this Agreement.

6.5 Captions. The captions for each Paragraph of this Agreement are included for convenience of reference only and are not to be considered a part hereof, and will not be deemed to modify, restrict or enlarge any of the terms of provisions of this Agreement.

6.6 Notice. Any notice required or permitted to be given under this Agreement will be sufficient if in writing and hand delivered or sent by certified or registered mail, return receipt requested, addressed as follows:

For Hospice Agency:
VistaRiver of King County, LLC
17201 15th Ave NE
Shoreline, WA 98155

For Medical Director:
Dr Bhupinder Walia
11120 NE 33rd Place, Suite 202
Bellevue, Washington 98004

For Backup Medical Director:
Dr. Nita Vellody
11120 NE 33rd Place, Suite 202
Bellevue, Washington 98004

or to any other address as may be given by either party to the other by notice in writing pursuant to the provisions of this Section.

6.7 Severability. In the event that any provision of the Agreement is held to be unenforceable for any reason, the unenforceability of that provision will not affect the remainder of this Agreement, which will remain in full force and effect in accordance with its terms.

6.8 Fraud and Abuse. The parties enter into this Agreement with the intent of conducting their relationship in full compliance with applicable state, local, and federal law including the Medicare/Medicaid Anti-fraud and Abuse Amendments. Notwithstanding any unanticipated effect of any of the provisions herein, neither party will intentionally conduct itself under the terms of this Agreement in a manner to constitute a violation of the Medicare and Medicaid fraud and abuse provisions. Further, if legislation is passed, the effect of which would be to hinder ORGANIZATION's ability to obtain reimbursement from Medicare/Medicaid due to

the existence of this Agreement, or if this Agreement becomes illegal under any subsequent law or regulation, then this Agreement will terminate immediately.

6.9 Access to Books and Records of Subcontractor. Upon the written request of the Secretary of Health and Human Services or the Comptroller General or any of their duly authorized representatives, the MEDICAL DIRECTOR will make available those contracts, books, documents, and records necessary to verify the nature and extent of the costs of providing services under this Agreement. Such inspection will be available up to four (4) years after the rendering of such services. If the MEDICAL DIRECTOR carries out any of the duties of this Agreement through a subcontract with a value of $10,000 or more over a 12-month period with a related individual or ORGANIZATION, the MEDICAL DIRECTOR agrees to include this requirement in any such subcontract. This section is included pursuant to and is governed by the requirements of Public Law 96-+99, Sec. 952 (Sec. 1861(v)(1) of the Social Security Act) and the regulations promulgated thereunder. No attorney-client, accountant-client or other legal privilege will be deemed to have been waived by the ORGANIZATION or the MEDICAL DIRECTOR by virtue of this Agreement.

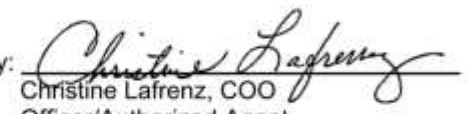
6.10 Policy. Nothing contained in this Agreement will require MEDICAL DIRECTOR or any physician to admit or refer any patients to ORGANIZATION as a precondition to receiving the benefits set forth herein except insofar as the ORGANIZATION's bylaws may now or in the future establish minimum requirements for eligibility for active staff privileges.

6.11 Entire Agreement. This Agreement constitutes the entire Agreement between the parties with respect to the subject matter hereof, and supersedes any and all other agreements, understandings, negotiations, or representations, oral or written, between them.

6.12 Execution in Counterparts. This Agreement and any amendments hereto will be executed in multiple counterparts by MEDICAL DIRECTOR and by the Administrator/Executive Director of ORGANIZATION for and on behalf of ORGANIZATION. Each counterpart will be deemed an original but all counterparts together will constitute one and the same instrument.

6.13 Authorization for Agreement. The execution and performance of this Agreement by ORGANIZATION and MEDICAL DIRECTOR have been duly authorized by all necessary laws, resolutions, and corporate action, and this Agreement constitutes the valid and enforceable obligations of MEDICAL DIRECTOR and ORGANIZATION in accordance with its terms.

In WITNESS WHEREOF, the parties hereto have executed this Agreement on the day and year first above written.

By:  Date: 12/1/2021

Christine Lafrenz, COO
Officer/Authorized Agent
Daiya Healthcare, PLLC.

By: _____ Date: _____

Agency Administrator/Executive Director

EXHIBIT A

CONSULTANT DUTIES AND RESPONSIBILITIES

Consultant's duties shall include:

(a) **Reviewing training programs for Agency Staff and personnel;**

(b) **Preparing such reports and records as may be required by this Agreement or the Agency;**

(c) **Participating in continuing medical education, research and teaching activities upon request by the Agency;**

(d) **Advising and assisting in the development of protocols and policies for the Agency;**

(e) **Upon request by the Agency, be available at all times to respond/consult in the event of urgent or emergency situations;**

(f) **Working with the Agency to monitor and review the clinical performance of professionals who provide services to the Agency's patients. Consultant shall assist in monitoring the performance of those professionals who are not meeting Agency quality and/or performance standards, and in disciplining any professionals who continue poor performance, recognizing that the Agency Board of Consultants is ultimately responsible for maintaining the standards of care provided to patients; and**

(g) **Assisting Agency management with preparation for, and conduct of, any inspections and on-site surveys of the Agency conducted by governmental agencies, accrediting organizations, or payers contracting with Agency.**

(h) **Interacting with the administration and Board of Consultants in all matters of mutual concern within the Agency.**

(i) **Attending meetings of the Board of Consultants as provided by Agency by-laws.**

(j) **Consulting with Agency Utilization Review Consultant, Quality Assurance Consultant, and Therapy Services Consultant as deemed necessary.**

(k) **Assisting in reviewing documentation for completeness as per Medicare guidelines.**

(l) **Assisting in developing reference materials to resolve inadequacies.**

(m) **Communicating with management of notable situations requiring more extensive actions.**

(n) **Helping to develop, approve, and implement specific clinical practices for the Agency to incorporate plan of care related policies and procedures, including areas required by laws and regulations.**

(o) **Assisting in developing procedures and guidance for facility staff regarding communication with practitioners, including information gathering and presentation, change in patient conditions, and when to contact contracted Consultants.**

(p) Reviewing other Consultants' recommendations that affect the Agency's patient care policies and procedures or the care of an individual patient.

(q) Attending team conference meetings and IDG weekly and/or as deemed necessary.

(r) Providing medical input or interpretation of social, political, regulatory or economic factors that impact patient care.

(s) Acting as a physician spokesperson and resource in representing the Agency's position in dealing with regulatory or accrediting organizations.

(t) Serving as a spokesman for Agency professional and public matters as deemed necessary.

(u) Participating in internal Agency surveys and inspections.

(v) Assisting with federal, state, local and other external surveys and inspections.

(w) Serving as liaison between professional services staff and patient's private physician on concerns related to medical management and patient progress.

(x) Participating in the development of ethical policies and decisions and provide medical input on patient care issues of an ethical nature.

EXHIBIT B

MEDICAL CONSULTANT SERVICE LOG

Name _____ **Month/Year** _____

Record Hours Per Week

Description of Consultant Services	Week 1	Week2	Week 3	Week 4	Week 5
• **Training**: Staff In-Service, 1:1 Education					
• **Meetings**: Case Conferences, Professional Advisory Committee, Survey Readiness, Peer Review					
• **Patient Care:** Care Coordination, Care Plan Oversight, Input on Change of Condition					
• **Document Preparation/Signing**					
• **Chart Review:** Including Providing Medical Input & Interpretation					
• **Marketing:** Including Spokesperson For Agency In Public & Professional Matters, Professional Interactions on Behalf of Agency to Improve Community Awareness					
• **Consultation:** Liaison With Other Professionals, Interacting With Administration and Directors on matters of The Agency, Advise and Assist with Medical Procedures & Practices of the Agency					
• **Emergency Management:** Including Addressing Urgent or Emergency Situations					
• **Programs:** Development/Review of Policies & Procedures					
• **Communications:** Medical Input on Factors that Impact Patient Care, Agency Operations, &/or Regulatory Requirements					
• **Other: (require pre-approval)**					
Weekly Total					
Monthly Total					

APPROVED BY:

_____ _____

AGENCY MANAGING MEMBER **MEDICAL CONSULTANT SIGNATURE**

EXHIBIT C

BUSINESS ASSOCIATE ADDENDUM / MEDICAL DIRECTOR

This Business Associate Addendum ("**Addendum**" or "**BAA**") supplements and is made a part of the Medical Director Agreement ("**Agreement**") by and between **VistaRiver of King County, LLC**, a Washington limited liability corporation ("**Covered Entity**" or "**CE**") **Bhupinder Walia, MD** and **Nita Vellody**, D.O. ("**Business Associate**" or "**BA**"), dated **Dec-01-2021**. This BAA is effective as of the Commencement Date of the Agreement ("**BAA Effective Date**"). This BAA is attached to and made a part of the Agreement.

RECITALS

CE is a "covered entity" under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("**HIPAA**") and, as such, must enter into so-called "business associate" contracts with certain contractors that may have access to certain patient medical information.

CE wishes to disclose certain information to BA pursuant to the terms of the Agreement, some of which may constitute Protected Health Information ("**PHI**") (defined below).

CE and BA intend to protect the privacy and provide for the security of PHI disclosed to BA pursuant to the Agreement in compliance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("**HIPAA**"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("**HITECH Act**"), and regulations promulgated thereunder by the U.S. Department of Health and Human Services ("**HIPAA Regulations**") and other applicable laws, including without limitation Oregon patient privacy laws.

As part of the HIPAA Regulations, the Privacy Rule and the Security Rule (defined below) require CE to enter into a contract containing specific requirements with BA prior to the disclosure of PHI (defined below), as set forth in, but not limited to, Title 45, Sections 164.314(a), 164.502(e) and 164.504(e) of the Code of Federal Regulations ("**C.F.R.**") and contained in this BAA.

NOW, THEREFORE, in consideration of the mutual promises below and the exchange of information pursuant to this BAA, CE and BA agree as follows:

AGREEMENT

1. Definitions

1.1 **Breach** shall have the meaning given under 42 U.S.C. § 17921(1) and 45 C.F.R. § 164.402.

1.2 **Business Associate** shall have the meaning given to such term under 42 U.S.C. § 17938 and 45 C.F.R. § 160.103.

1.3 **Covered Entity** shall have the meaning given to such term under 45 C.F.R. § 160.103.

1.4 **Data Aggregation** shall have the meaning given to such term under 45 C.F.R. § 164.501.

1.5 **Designated Record Set** shall have the meaning given to such term 45 C.F.R. § 164.501.

1.6 Electronic Protected Health Information means Protected Health Information that is maintained in or transmitted by electronic media.

1.7 Electronic Health Record shall have the meaning given to such term under 42 U.S.C. § 17921(5).

1.8 Health Care Operations shall have the meaning given to such term under 45 C.F.R. § 164.501.

1.9 Privacy Rule shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and E.

1.10 Protected Health Information or PHI means any information, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and (ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual, and shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. § 164.501. Protected Health Information includes Electronic Protected Health Information.

1.11 Security Rule shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and C.

1.12 Unsecured PHI shall have the meaning given to such term under 42 U.S.C. § 17932(h), 45 C.F.R. § 164.402 and guidance issued pursuant to the HITECH Act including, but not limited to the guidance issued on April 17, 2009 and published in 74 Federal Register 19006 (April 27, 2009), by the Secretary of the U.S. Department of Health and Human Services ("**Secretary**").

2. Obligations of Business Associate

2.1 Permitted Uses and Disclosures. BA shall not use or disclose PHI other than as permitted or required by the Agreement, this BAA or as permitted or required by law. Further, BA shall not use PHI in any manner that would constitute a violation of the Privacy Rule or the HITECH Act if so used by CE. However, BA may use or disclose PHI (i) for the proper management and administration of BA's business, (ii) to carry out BA's legal responsibilities, or (iii) for Data Aggregation purposes for the Health Care Operations of BA. If BA discloses PHI to a third party, BA must obtain, prior to making any such disclosure, (i) reasonable written assurances from such third party that such PHI will be held confidential as provided pursuant to this BAA and only disclosed as required by law or for the purposes for which it was disclosed to such third party, and (ii) a written agreement from such third party to immediately notify BA of any breaches of confidentiality of the PHI, to the extent it has obtained knowledge of such breach.

2.2 Prohibited Uses and Disclosures under HITECH. Notwithstanding any other provision in this BAA, BA shall comply with the following requirements: (i) BA shall not use or disclose PHI for fundraising or marketing purposes, except as provided under the Agreement and consistent with the requirements of 42 U.S.C. § 17936; (ii) BA shall not disclose PHI to a health plan for payment or health care operations purposes if CE has informed BA that the patient has requested this special restriction, and has paid out of pocket in full for the health care item or service to which the PHI solely relates, 42 U.S.C. § 17935(a); (iii) BA shall not directly or indirectly receive remuneration in exchange for PHI, except with the prior written consent of CE and as permitted by the HITECH Act, 42 U.S.C. § 17935(d)(2); however, this prohibition shall not affect payment by CE to BA for services provided pursuant to the Agreement.

2.3 Appropriate Safeguards. BA shall implement appropriate safeguards as are necessary to prevent the use or disclosure of PHI other than as permitted by the Agreement, this BAA, or other applicable laws. To the extent BA creates, maintains, receives or transmits Electronic PHI on behalf of CE, BA shall use administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of such Electronic PHI. BA shall comply with each of the requirements of 45 C.F.R. §§ 164.308, 164.310, and 164.312 and the policies and procedures and documentation requirements of the HIPAA Security Rule set forth in 45 C.F.R. § 164.316.

2.4 Mitigation. BA shall mitigate, to the extent practicable, any harmful effect that is known to BA of a use or disclosure of PHI in violation of this BAA.

2.5 Reporting of Improper Access, Use or Disclosure. BA shall promptly report to CE in writing of any access, use or disclosure of PHI not permitted by the Agreement, this BAA, or applicable laws; and any security incident, as defined in the Security Rule, of which it becomes aware. BA shall, following the discovery of any Breach of Unsecured PHI, notify CE in writing of such breach without unreasonable delay and in no case later than three (3) business days after discovery. The notice shall include the following information if known (or can be reasonably obtained) by BA: (i) contact information for the individuals who were or who may have been impacted by the Breach (*e.g.*, first and last name, mailing address, street address, phone number, email address); (ii) a brief description of the circumstances of the Breach, including the date of the Breach and date of discovery (as defined in 42 U.S.C. § 17932(c)); (iii) a description of the types of Unsecured PHI involved in the Breach (*e.g.*, names, social security numbers, date of birth, addresses, account numbers of any type, disability codes, diagnostic and/or billing codes and similar information); (iv) a brief description of what BA has done or is doing to investigate the Breach, mitigate harm to the individuals impacted by the Breach. BA shall pay the actual, reasonable costs of CE to provide required notifications.

2.6 BA's Subcontractors and Agents. BA shall ensure that any agents or subcontractors to whom it provides PHI agree in writing to the same restrictions and conditions that apply to BA with respect to such PHI, including without limitation, the duty to notify BA of the discovery of any Breach of Unsecured PHI without unreasonable delay and in no event later than sixty (60) days after discovery.

2.7 Access to PHI. To the extent BA maintains a Designated Record Set on behalf of CE, BA shall make PHI it maintains or maintained by its agents or subcontractors in Designated Record Sets available to CE for inspection and copying within ten (10) days of a request by CE to enable CE to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 C.F.R. § 164.524. If BA maintains an Electronic Health Record, BA shall provide such information in electronic format to enable CE to fulfill its obligations under the HITECH Act, including, but not limited to, 42 U.S.C. § 17935(e). BA may charge a reasonable fee based on its labor costs in responding to a request to access PHI and a cost-based fee for the production of non-electronic media copies. BA shall notify CE within five (5) business days of receipt of any request for access to PHI.

2.8 Amendment of PHI. To the extent BA maintains a Designated Record Set on behalf of CE, within ten (10) days of receipt of a request from CE or an individual for an amendment of PHI or a record about an individual contained in a Designated Record Set, BA or its agents or subcontractors shall make any amendments that CE directs or agrees to in accordance with the Privacy Rule. BA may charge a reasonable fee based on its labor costs in responding to a request to amend PHI and a cost-based fee for the production of non-electronic media copies. BA shall notify CE within five (5) business days of receipt of any request for amendment to PHI.

2.9 Accounting Rights. Within ten (10) days of notice by CE of a request for an accounting of disclosures of PHI, BA and its agents or subcontractors shall make available to CE the information

required to provide an accounting of disclosures to enable CE to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 C.F.R. § 164.528, and its obligations under the HITECH Act, including but not limited to 42 U.S.C. § 17935(c), as determined by CE. BA agrees to implement a process that allows for an accounting to be collected and maintained by BA and its agents or subcontractors for at least six (6) years prior to the request. However, accounting of disclosures from an Electronic Health Record for treatment, payment, or health care operations purposes are required to be collected and maintained for only three (3) years prior to the request, and only to the extent BA maintains an electronic health record and is subject to this requirement. At a minimum, the information collected and maintained shall include: (i) the date of the disclosure; (ii) the name of the entity or person who received PHI and, if known, the address of the entity or person; (iii) a brief description of the PHI disclosed; and (iv) a brief statement of the purpose of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individual's authorization, or a copy of the written request for disclosure. The accounting must be provided without cost to the individual or the requesting party if it is the first accounting requested by such individual within any twelve (12) month period. For subsequent accountings within a twelve (12) month period, BA may charge the individual or party requesting the accounting a reasonable fee based upon BA's labor costs in responding to the request and a cost-based fee for the production of non-electronic media copies, so long as BA informs the individual or requesting party in advance of the fee and the individual or requesting party is afforded an opportunity to withdraw or modify the request. BA shall notify CE within five (5) business days of receipt of any request by an individual or other requesting party for an accounting of disclosures. The provisions of this subparagraph 2.9 shall survive the termination of this BAA.

2.10 Governmental Access to Records. BA shall make its internal practices, books and records relating to the use and disclosure of PHI available to CE and to the Secretary for purposes of determining BA's compliance with HIPAA. BA shall make such internal practices, books and records available within five (5) business days of a request by CE for inspection for the purposes of determining compliance with this BAA.

2.11 Minimum Necessary. BA (and its agents or subcontractors) shall request, use and disclose only the minimum amount of PHI necessary to accomplish the purpose of the request, use or disclosure. Because the definition of "minimum necessary" is in flux, BA shall keep itself informed of guidance issued by the Secretary with respect to what constitutes "minimum necessary."

3. Term and Termination

3.1 Term. The term of this BAA shall be effective as of the BAA Effective Date and shall terminate when all of the PHI provided by CE to BA, or created or received by BA on behalf of CE, is destroyed or returned to CE.

3.2 Termination.

3.2.1 Material Breach by BA. Upon any material breach of this BAA by BA, CE shall provide BA with written notice of such breach and such breach shall be cured by BA within thirty (30) business days of such notice. If such breach is not cured within such time period, CE may immediately terminate this BAA and the Agreement.

3.2.2 Effect of Termination. Upon termination of the Agreement for any reason, BA shall, at the option of CE, return or destroy all PHI that BA or its agents or subcontractors still maintain in any form, and shall retain no copies of such PHI. If return or destruction is not feasible, as determined by CE, BA shall continue to extend the protections of this BAA to such information, and limit further use of

such PHI to those purposes that make the return or destruction of such PHI infeasible. If CE elects destruction of the PHI, BA shall certify in writing to CE that such PHI has been destroyed.

4. **Indemnification; Limitation of Liability.** To the extent permitted by law, BA shall indemnify, defend and hold harmless CE from any and all liability, claim, lawsuit, injury, loss, expense or damage resulting from or relating to the acts or omissions of BA in connection with the representations, duties and obligations of BA under this BAA. Any limitation of liability contained in the Agreement shall not apply to the indemnification requirement of this provision. This provision shall survive the termination of the BAA.

5. **Assistance in Litigation.** BA shall make itself and any subcontractors, employees or agents assisting BA in the performance of its obligations under the Agreement or BAA available to CE, at no cost to CE, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against CE, its Consultants, officers or employees based upon a claim of violation of HIPAA, the HITECH Act, or other laws related to security and privacy, except where BA or its subcontractor, employee or agent is named as an adverse party.

6. **Amendment to Comply with Law.** Because state and federal laws relating to data security and privacy are rapidly evolving, amendment of the Agreement or this BAA may be required to provide for procedures to ensure compliance with such developments. BA and CE shall take such action as is necessary to implement the standards and requirements of HIPAA, the HITECH Act, the Privacy Rule, the Security Rule and other applicable laws relating to the security or confidentiality of PHI. BA shall provide to CE satisfactory written assurance that BA will adequately safeguard all PHI. Upon the request of either party, the other party shall promptly enter into negotiations concerning the terms of an amendment to this BAA embodying written assurances consistent with the standards and requirements of HIPAA, the HITECH Act, the Privacy Rule, the Security Rule or other applicable laws. CE may terminate the Agreement upon thirty (30) days written notice in the event (i) BA does not promptly enter into negotiations to amend the Agreement or this BAA when requested by CE pursuant to this Section or (ii) BA does not enter into an amendment to the Agreement or BAA providing assurances regarding the safeguarding of PHI that CE, in its sole discretion, deems sufficient to satisfy the standards and requirements of applicable laws.

7. **No Third-Party Beneficiaries.** Nothing express or implied in the Agreement or BAA is intended to confer, nor shall anything herein confer upon any person other than CE, BA and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

8. **Interpretation.** The provisions of this BAA shall prevail over any provisions in the Agreement that may conflict or appear inconsistent with any provision in this BAA. This BAA and the Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HI TECH Act, the Privacy Rule and the Security Rule. Any ambiguity in this BAA shall be resolved in favor of a meaning that complies and is consistent with HIPAA, the HITECH Act, the Privacy Rule and the Security Rule. Except as specifically required to implement the purposes of this BAA, or to the extent inconsistent with this BAA, all other terms of the Agreement shall remain in force and effect.

9. **Entire Agreement of the Parties.** This BAA supersedes any and all prior and contemporaneous business associate agreements or addenda between the parties and constitutes the final and entire agreement between the parties hereto with respect to the subject matter hereof. Each party to this BAA acknowledges that no representations, inducements, promises, or agreements, oral or otherwise, with respect to the subject matter hereof, have been made by either party, or by anyone acting on behalf of either party, which are not embodied herein. No other agreement, statement or

promise, with respect to the subject matter hereof, not contained in this BAA shall be valid or binding.

10. **Regulatory References.** A reference in this BAA to a section of regulations means the section as in effect or as amended, and for which compliance is required.

11. **Identity Theft Program Compliance.** To the extent that CE is required to comply with the final rule entitled "Identity Theft Red Flags and Address Discrepancies under the Fair and Accurate Credit Transactions Act of 2003," as promulgated and enforced by the Federal Trade Commission (16 C.F.R. Part 681) ("**Red Flags Rule**"), and to the extent that BA is performing an activity in connection with one or more "covered accounts," as that term is defined in the Red Flags Rule, pursuant to the Agreement, BA shall establish and comply with its own reasonable policies and procedures designed to detect, prevent, and mitigate the risk of identity theft, which shall be consistent with and no less stringent than those required under the Red Flags Rule or the policies and procedures of CE's Red Flags Program. BA shall provide its services pursuant to the Agreement in accordance with such policies and procedures. BA shall report any detected "red flags," as that term is defined in the Red Flags Rule, to CE and shall, in cooperation with CE, take appropriate steps to prevent or mitigate identity theft.

IN WITNESS WHEREOF, the parties hereto have duly executed this BAA as of the BAA Effective Date.

"CE"

VistaRiver of King County, LLC

By: _____

Print Name: **Geoff Schackmann**

Title: **Managing Member**

Date: **12/1/21**

"BA"

Daiya Healthcare, PLLC

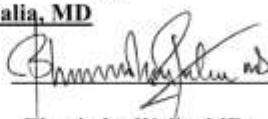
By: _____

Print Name: Nita Vellody

Date: **12/1/2021**

"BA"

Bhupinder Walia, MD

By: 

Print Name: Bhupinder Walia, MD

Date: **12/1/2021**

EXHIBIT C (cont.)

BUSINESS ASSOCIATE ADDENDUM / BACKUP MEDICAL DIRECTOR

This Business Associate Addendum ("**Addendum**" or "**BAA**") supplements and is made a part of the Medical Director Agreement ("**Agreement**") by and between **VistaRiver of King County, LLC**, a Washington corporation ("**Covered Entity**" or "**CE**") and **Bhupinder Walia, MD**, ("**Business Associate**" or "**BA**"), dated **Dec-01-2021**. This BAA is effective as of the Commencement Date of the Agreement ("**BAA Effective Date**"). This BAA is attached to and made a part of the Agreement.

RECITALS

CE is a "covered entity" under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("**HIPAA**") and, as such, must enter into so-called "business associate" contracts with certain contractors that may have access to certain patient medical information.

CE wishes to disclose certain information to BA pursuant to the terms of the Agreement, some of which may constitute Protected Health Information ("**PHI**") (defined below).

CE and BA intend to protect the privacy and provide for the security of PHI disclosed to BA pursuant to the Agreement in compliance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("**HIPAA**"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("**HITECH Act**"), and regulations promulgated thereunder by the U.S. Department of Health and Human Services ("**HIPAA Regulations**") and other applicable laws, including without limitation Oregon patient privacy laws.

As part of the HIPAA Regulations, the Privacy Rule and the Security Rule (defined below) require CE to enter into a contract containing specific requirements with BA prior to the disclosure of PHI (defined below), as set forth in, but not limited to, Title 45, Sections 164.314(a), 164.502(e) and 164.504(e) of the Code of Federal Regulations ("**C.F.R.**") and contained in this BAA.

NOW, THEREFORE, in consideration of the mutual promises below and the exchange of information pursuant to this BAA, CE and BA agree as follows:

AGREEMENT

12. Definitions

12.1 **Breach** shall have the meaning given under 42 U.S.C. § 17921(1) and 45 C.F.R. § 164.402.

12.2 **Business Associate** shall have the meaning given to such term under 42 U.S.C. § 17938 and 45 C.F.R. § 160.103.

12.3 **Covered Entity** shall have the meaning given to such term under 45 C.F.R. § 160.103.

12.4 **Data Aggregation** shall have the meaning given to such term under 45 C.F.R. § 164.501.

12.5 **Designated Record Set** shall have the meaning given to such term 45 C.F.R. § 164.501.

12.6 Electronic Protected Health Information means Protected Health Information that is maintained in or transmitted by electronic media.

12.7 Electronic Health Record shall have the meaning given to such term under 42 U.S.C. § 17921(5).

12.8 Health Care Operations shall have the meaning given to such term under 45 C.F.R. § 164.501.

12.9 Privacy Rule shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and E.

12.10 Protected Health Information or PHI means any information, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and (ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual, and shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. § 164.501. Protected Health Information includes Electronic Protected Health Information.

12.11 Security Rule shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and C.

12.12 Unsecured PHI shall have the meaning given to such term under 42 U.S.C. § 17932(h), 45 C.F.R. § 164.402 and guidance issued pursuant to the HITECH Act including, but not limited to the guidance issued on April 17, 2009 and published in 74 Federal Register 19006 (April 27, 2009), by the Secretary of the U.S. Department of Health and Human Services ("**Secretary**").

13. Obligations of Business Associate

13.1 Permitted Uses and Disclosures. BA shall not use or disclose PHI other than as permitted or required by the Agreement, this BAA or as permitted or required by law. Further, BA shall not use PHI in any manner that would constitute a violation of the Privacy Rule or the HITECH Act if so used by CE. However, BA may use or disclose PHI (i) for the proper management and administration of BA's business, (ii) to carry out BA's legal responsibilities, or (iii) for Data Aggregation purposes for the Health Care Operations of BA. If BA discloses PHI to a third party, BA must obtain, prior to making any such disclosure, (i) reasonable written assurances from such third party that such PHI will be held confidential as provided pursuant to this BAA and only disclosed as required by law or for the purposes for which it was disclosed to such third party, and (ii) a written agreement from such third party to immediately notify BA of any breaches of confidentiality of the PHI, to the extent it has obtained knowledge of such breach.

13.2 Prohibited Uses and Disclosures under HITECH. Notwithstanding any other provision in this BAA, BA shall comply with the following requirements: (i) BA shall not use or disclose PHI for fundraising or marketing purposes, except as provided under the Agreement and consistent with the requirements of 42 U.S.C. § 17936; (ii) BA shall not disclose PHI to a health plan for payment or health care operations purposes if CE has informed BA that the patient has requested this special restriction, and has paid out of pocket in full for the health care item or service to which the PHI solely relates, 42 U.S.C. § 17935(a); (iii) BA shall not directly or indirectly receive remuneration in exchange for PHI, except with the prior written consent of CE and as permitted by the HITECH Act, 42 U.S.C. § 17935(d)(2); however, this prohibition shall not affect payment by CE to BA for services provided pursuant to the Agreement.

13.3 Appropriate Safeguards. BA shall implement appropriate safeguards as are necessary to prevent the use or disclosure of PHI other than as permitted by the Agreement, this BAA, or other applicable laws. To the extent BA creates, maintains, receives or transmits Electronic PHI on behalf of CE, BA shall use administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of such Electronic PHI. BA shall comply with each of the requirements of 45 C.F.R. §§ 164.308, 164.310, and 164.312 and the policies and procedures and documentation requirements of the HIPAA Security Rule set forth in 45 C.F.R. § 164.316.

13.4 Mitigation. BA shall mitigate, to the extent practicable, any harmful effect that is known to BA of a use or disclosure of PHI in violation of this BAA.

13.5 Reporting of Improper Access, Use or Disclosure. BA shall promptly report to CE in writing of any access, use or disclosure of PHI not permitted by the Agreement, this BAA, or applicable laws; and any security incident, as defined in the Security Rule, of which it becomes aware. BA shall, following the discovery of any Breach of Unsecured PHI, notify CE in writing of such breach without unreasonable delay and in no case later than three (3) business days after discovery. The notice shall include the following information if known (or can be reasonably obtained) by BA: (i) contact information for the individuals who were or who may have been impacted by the Breach (*e.g.*, first and last name, mailing address, street address, phone number, email address); (ii) a brief description of the circumstances of the Breach, including the date of the Breach and date of discovery (as defined in 42 U.S.C. § 17932(c)); (iii) a description of the types of Unsecured PHI involved in the Breach (*e.g.*, names, social security numbers, date of birth, addresses, account numbers of any type, disability codes, diagnostic and/or billing codes and similar information); (iv) a brief description of what BA has done or is doing to investigate the Breach, mitigate harm to the individuals impacted by the Breach. BA shall pay the actual, reasonable costs of CE to provide required notifications.

13.6 BA's Subcontractors and Agents. BA shall ensure that any agents or subcontractors to whom it provides PHI agree in writing to the same restrictions and conditions that apply to BA with respect to such PHI, including without limitation, the duty to notify BA of the discovery of any Breach of Unsecured PHI without unreasonable delay and in no event later than sixty (60) days after discovery.

13.7 Access to PHI. To the extent BA maintains a Designated Record Set on behalf of CE, BA shall make PHI it maintains or maintained by its agents or subcontractors in Designated Record Sets available to CE for inspection and copying within ten (10) days of a request by CE to enable CE to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 C.F.R. § 164.524. If BA maintains an Electronic Health Record, BA shall provide such information in electronic format to enable CE to fulfill its obligations under the HITECH Act, including, but not limited to, 42 U.S.C. § 17935(e). BA may charge a reasonable fee based on its labor costs in responding to a request to access PHI and a cost-based fee for the production of non-electronic media copies. BA shall notify CE within five (5) business days of receipt of any request for access to PHI.

13.8 Amendment of PHI. To the extent BA maintains a Designated Record Set on behalf of CE, within ten (10) days of receipt of a request from CE or an individual for an amendment of PHI or a record about an individual contained in a Designated Record Set, BA or its agents or subcontractors shall make any amendments that CE directs or agrees to in accordance with the Privacy Rule. BA may charge a reasonable fee based on its labor costs in responding to a request to amend PHI and a cost-based fee for the production of non-electronic media copies. BA shall notify CE within five (5) business days of receipt of any request for amendment to PHI.

13.9 Accounting Rights. Within ten (10) days of notice by CE of a request for an accounting of disclosures of PHI, BA and its agents or subcontractors shall make available to CE the information

required to provide an accounting of disclosures to enable CE to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 C.F.R. § 164.528, and its obligations under the HITECH Act, including but not limited to 42 U.S.C. § 17935(c), as determined by CE. BA agrees to implement a process that allows for an accounting to be collected and maintained by BA and its agents or subcontractors for at least six (6) years prior to the request. However, accounting of disclosures from an Electronic Health Record for treatment, payment, or health care operations purposes are required to be collected and maintained for only three (3) years prior to the request, and only to the extent BA maintains an electronic health record and is subject to this requirement. At a minimum, the information collected and maintained shall include: (i) the date of the disclosure; (ii) the name of the entity or person who received PHI and, if known, the address of the entity or person; (iii) a brief description of the PHI disclosed; and (iv) a brief statement of the purpose of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individual's authorization, or a copy of the written request for disclosure. The accounting must be provided without cost to the individual or the requesting party if it is the first accounting requested by such individual within any twelve (12) month period. For subsequent accountings within a twelve (12) month period, BA may charge the individual or party requesting the accounting a reasonable fee based upon BA's labor costs in responding to the request and a cost-based fee for the production of non-electronic media copies, so long as BA informs the individual or requesting party in advance of the fee and the individual or requesting party is afforded an opportunity to withdraw or modify the request. BA shall notify CE within five (5) business days of receipt of any request by an individual or other requesting party for an accounting of disclosures. The provisions of this subparagraph 2.9 shall survive the termination of this BAA.

13.10 Governmental Access to Records. BA shall make its internal practices, books and records relating to the use and disclosure of PHI available to CE and to the Secretary for purposes of determining BA's compliance with HIPAA. BA shall make such internal practices, books and records available within five (5) business days of a request by CE for inspection for the purposes of determining compliance with this BAA.

13.11 Minimum Necessary. BA (and its agents or subcontractors) shall request, use and disclose only the minimum amount of PHI necessary to accomplish the purpose of the request, use or disclosure. Because the definition of "minimum necessary" is in flux, BA shall keep itself informed of guidance issued by the Secretary with respect to what constitutes "minimum necessary."

14. Term and Termination

14.1 Term. The term of this BAA shall be effective as of the BAA Effective Date and shall terminate when all of the PHI provided by CE to BA, or created or received by BA on behalf of CE, is destroyed or returned to CE.

14.2 Termination.

14.2.1 Material Breach by BA. Upon any material breach of this BAA by BA, CE shall provide BA with written notice of such breach and such breach shall be cured by BA within thirty (30) business days of such notice. If such breach is not cured within such time period, CE may immediately terminate this BAA and the Agreement.

14.2.2 Effect of Termination. Upon termination of the Agreement for any reason, BA shall, at the option of CE, return or destroy all PHI that BA or its agents or subcontractors still maintain in any form, and shall retain no copies of such PHI. If return or destruction is not feasible, as determined by CE, BA shall continue to extend the protections of this BAA to such information, and limit further use of

such PHI to those purposes that make the return or destruction of such PHI infeasible. If CE elects destruction of the PHI, BA shall certify in writing to CE that such PHI has been destroyed.

15. **Indemnification; Limitation of Liability.** To the extent permitted by law, BA shall indemnify, defend and hold harmless CE from any and all liability, claim, lawsuit, injury, loss, expense or damage resulting from or relating to the acts or omissions of BA in connection with the representations, duties and obligations of BA under this BAA. Any limitation of liability contained in the Agreement shall not apply to the indemnification requirement of this provision. This provision shall survive the termination of the BAA.

16. **Assistance in Litigation.** BA shall make itself and any subcontractors, employees or agents assisting BA in the performance of its obligations under the Agreement or BAA available to CE, at no cost to CE, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against CE, its Consultants, officers or employees based upon a claim of violation of HIPAA, the HITECH Act, or other laws related to security and privacy, except where BA or its subcontractor, employee or agent is named as an adverse party.

17. **Amendment to Comply with Law.** Because state and federal laws relating to data security and privacy are rapidly evolving, amendment of the Agreement or this BAA may be required to provide for procedures to ensure compliance with such developments. BA and CE shall take such action as is necessary to implement the standards and requirements of HIPAA, the HITECH Act, the Privacy Rule, the Security Rule and other applicable laws relating to the security or confidentiality of PHI. BA shall provide to CE satisfactory written assurance that BA will adequately safeguard all PHI. Upon the request of either party, the other party shall promptly enter into negotiations concerning the terms of an amendment to this BAA embodying written assurances consistent with the standards and requirements of HIPAA, the HITECH Act, the Privacy Rule, the Security Rule or other applicable laws. CE may terminate the Agreement upon thirty (30) days written notice in the event (i) BA does not promptly enter into negotiations to amend the Agreement or this BAA when requested by CE pursuant to this Section or (ii) BA does not enter into an amendment to the Agreement or BAA providing assurances regarding the safeguarding of PHI that CE, in its sole discretion, deems sufficient to satisfy the standards and requirements of applicable laws.

18. **No Third-Party Beneficiaries.** Nothing express or implied in the Agreement or BAA is intended to confer, nor shall anything herein confer upon any person other than CE, BA and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

19. **Interpretation.** The provisions of this BAA shall prevail over any provisions in the Agreement that may conflict or appear inconsistent with any provision in this BAA. This BAA and the Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HI TECH Act, the Privacy Rule and the Security Rule. Any ambiguity in this BAA shall be resolved in favor of a meaning that complies and is consistent with HIPAA, the HITECH Act, the Privacy Rule and the Security Rule. Except as specifically required to implement the purposes of this BAA, or to the extent inconsistent with this BAA, all other terms of the Agreement shall remain in force and effect.

20. **Entire Agreement of the Parties.** This BAA supersedes any and all prior and contemporaneous business associate agreements or addenda between the parties and constitutes the final and entire agreement between the parties hereto with respect to the subject matter hereof. Each party to this BAA acknowledges that no representations, inducements, promises, or agreements, oral or otherwise, with respect to the subject matter hereof, have been made by either party, or by anyone acting on behalf of either party, which are not embodied herein. No other agreement, statement or

promise, with respect to the subject matter hereof, not contained in this BAA shall be valid or binding.

21. Regulatory References. A reference in this BAA to a section of regulations means the section as in effect or as amended, and for which compliance is required.

22. Identity Theft Program Compliance. To the extent that CE is required to comply with the final rule entitled "Identity Theft Red Flags and Address Discrepancies under the Fair and Accurate Credit Transactions Act of 2003," as promulgated and enforced by the Federal Trade Commission (16 C.F.R. Part 681) ("**Red Flags Rule**"), and to the extent that BA is performing an activity in connection with one or more "covered accounts," as that term is defined in the Red Flags Rule, pursuant to the Agreement, BA shall establish and comply with its own reasonable policies and procedures designed to detect, prevent, and mitigate the risk of identity theft, which shall be consistent with and no less stringent than those required under the Red Flags Rule or the policies and procedures of CE's Red Flags Program. BA shall provide its services pursuant to the Agreement in accordance with such policies and procedures. BA shall report any detected "red flags," as that term is defined in the Red Flags Rule, to CE and shall, in cooperation with CE, take appropriate steps to prevent or mitigate identity theft.

IN WITNESS WHEREOF, the parties hereto have duly executed this BAA as of the BAA Effective Date.

"CE"

Heritage Hospice, LLC dba VistaRiver Hospice

By: _____

Print Name: **Geoff Schackmann**

Title: **Managing Member**

Date: **12/1/2021**

"BA"

Daiya Healthcare, PLLC.

By: _____

Print Name: Bhupinder Walia

Date: **12/1/2021**

COMPENSATION ADDENDUM: MEDICAL DIRECTOR

Compensation as Medical Director Hospice agrees to pay Primary Provider **$150/hour** for services rendered under this Agreement. Provider will send Hospice monthly invoices for services provided under this Agreement. Center will pay all invoices from the Provider within 30 days of receipt.

Appendix 12: MD Verification

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

12/24/2021

Subject: Credential Verification

To Whom It May Concern:

This verifies the status of the Physician And Surgeon License for Walia, Bhupinder Singh.

This site is a Primary Source for Verification of Credentials.

Credential Number:	MD60211392
Credential Type:	Physician And Surgeon License
First Credential Date:	04/07/2011
Last Renewal Date:	10/19/2021
Credential Status:	ACTIVE
Current Expiration Date:	11/18/2023
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 Records Office for information on actions before July 1998. This information comes directly from our database. It is updated daily.

Appendix 13: Hospice Analytics Excel Report

Appendix 14: MyCancerJourney Presentation

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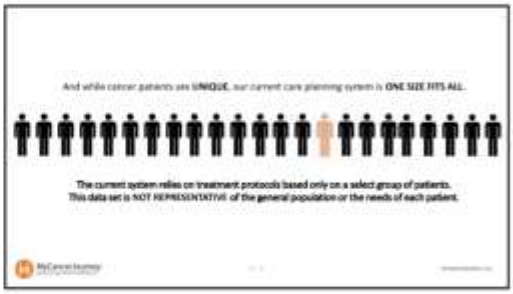

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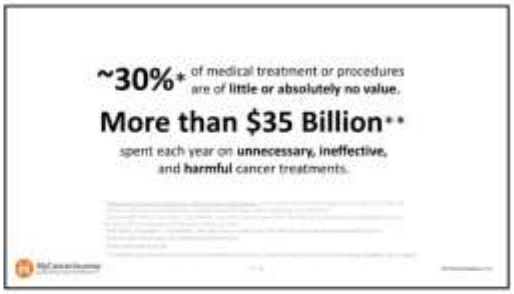

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SOLUTION

- Models based on data collected by cancer registrars from 500 hospitals, cancer treatment centers, ambulatory surgery centers, clinical laboratories, as well as physician and other outpatient offices
- Patient-specific survival curves based on the experience of
  - Demographic
  - Comorbid health (ACE27)
  - Tumor, Treatment
  - Survival information
- Excellent source of data for the study of prognostic factors, survival outcomes, and quality of care

6

CONSUMER APPROACH - MyCancerJourney

Navigator Consultation
Video consultation focused on patient goals and priorities.

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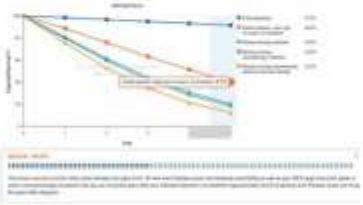
Bob; Outputs



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MYCANCER JOURNEY ECONOMIC ROI

A platform that supports transparency, resulting in a significant economic ROI, while improving quality of life

Lives		1,000,000
Patients with **Newly Diagnosed** Cancer		1,500
First-year spend per patient	$	160,000
Total first-year cancer spend	$	304,000,000
Estimated Annual Savings (30%)	**$**	**91,200,000**
Cost for MyCancerJourney	$	3,230,000
One-year Economic ROI X Investment		28

18

ISSUES WITH EVIDENCE BASE

Treatment guidelines are based on limited clinical trials.

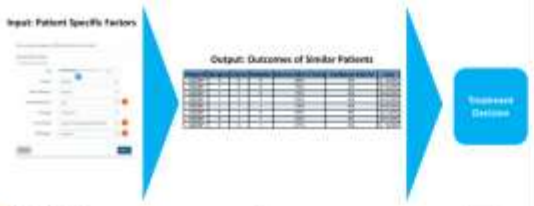
Low enrollment and participation of newly-diagnosed cancer patients in clinical trials can undermine the usefulness and generalizability of clinical trial results [1,2].

Clinical trials fail to take into account age, gender, comorbidity load, and cancer-related symptom severity. These are independent predictors of survival [3,4].

19

PERSONALIZED INFORMATION

What are real-world outcomes of people like me?



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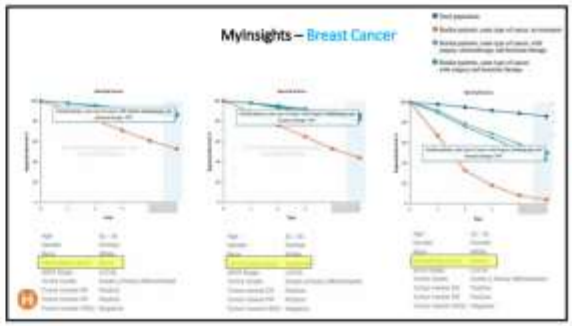

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THE CANCER SHADOW CURVE
DUE TO COVID-19

"The U.S. has already witnessed a **37% drop** in **cancer care diagnosis** compared to this same time period last year"

"We have experienced **massive drops** in cancer screenings."

Colonoscopy – 90% drop
Mammography – 87% drop
Pap Smear – 83% drop
CT Scans – 37% drop

Key Point: Severity of stage at initial diagnosis likely to increase next year – resulting in harder choices for patients and higher costs for payers

22

DISPARITIES IN
HEALTH LITERACY ARE WELL DOCUMENTED

- Low health literacy may exert its impact on outcomes, in part, via **reduced participation** during medical visits.
- Although patients with low and adequate health literacy are similarly interested in participating in medical decision making, low literate patients **ask fewer questions** and are **less likely to seek information** from physicians.

23

Discussing Survival Estimates

Survival paths are similar to the maps used when showing the path of a hurricane. These maps show a line indicating the predicted path of the hurricane, as well as a cone or range of uncertainty. The level of precision is greater in the short term, with uncertainty increasing over time. In other words, it's easier to predict where the hurricane will go in the next few hours, and harder to predict the path two days from now.

MyCancerJourney

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WHAT MYCANCERJOURNEY DOES:

- Provides information about treatment outcomes of similar patients
- Facilitates shared decision-making discussions including the tradeoffs of potential treatment options
- Focuses on outcomes that matter to people

MyCancerJourney

25

WHAT MYCANCERJOURNEY DOES NOT DO:

- Tell health providers how to practice medicine
- Substitute clinical judgment tailored to individual patients
- Replace clinical practice guidelines or provide clinical recommendations

MyCancerJourney

26

LEADERSHIP TEAM

ROBERT PALMER, MBA
President & CEO

JEFFREY HENDERSON, MD, MBA, FACP
Chief Medical Officer

JAL CALEB
Chief Information Officer

MIKE FLEMING
Chief Commercial Officer

SANDRA VAN TREASE, RPH, CPHQ, MBA
Advisor

MyCancerJourney

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THESE PATIENTS ARE IN CRISIS

Faced with **impossible** choices.

Flooded with **complex + contradictory** information.

Overwhelmed by fears and emotions.

Feeling **unprepared** to make good decisions.

MyCancerJourney

28

PERSONALIZED INFORMATION

What are real-world outcomes of patients similar to me?

Input: Patient Specific Factors

Output: Outcomes of Similar Patients

Treatment Decision

MyCancerJourney

29

30

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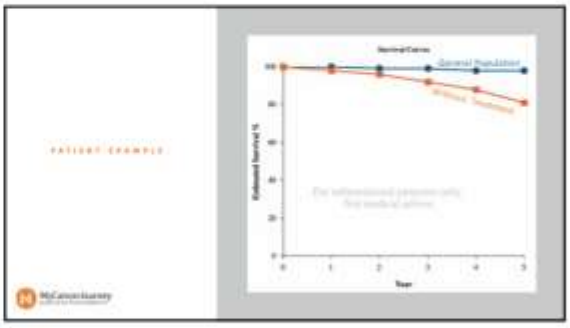
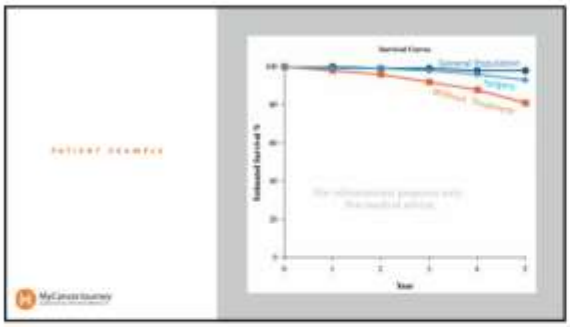
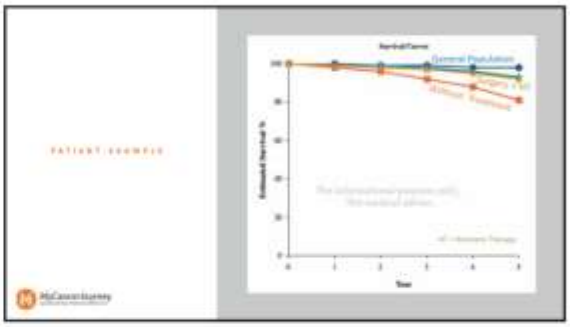


35

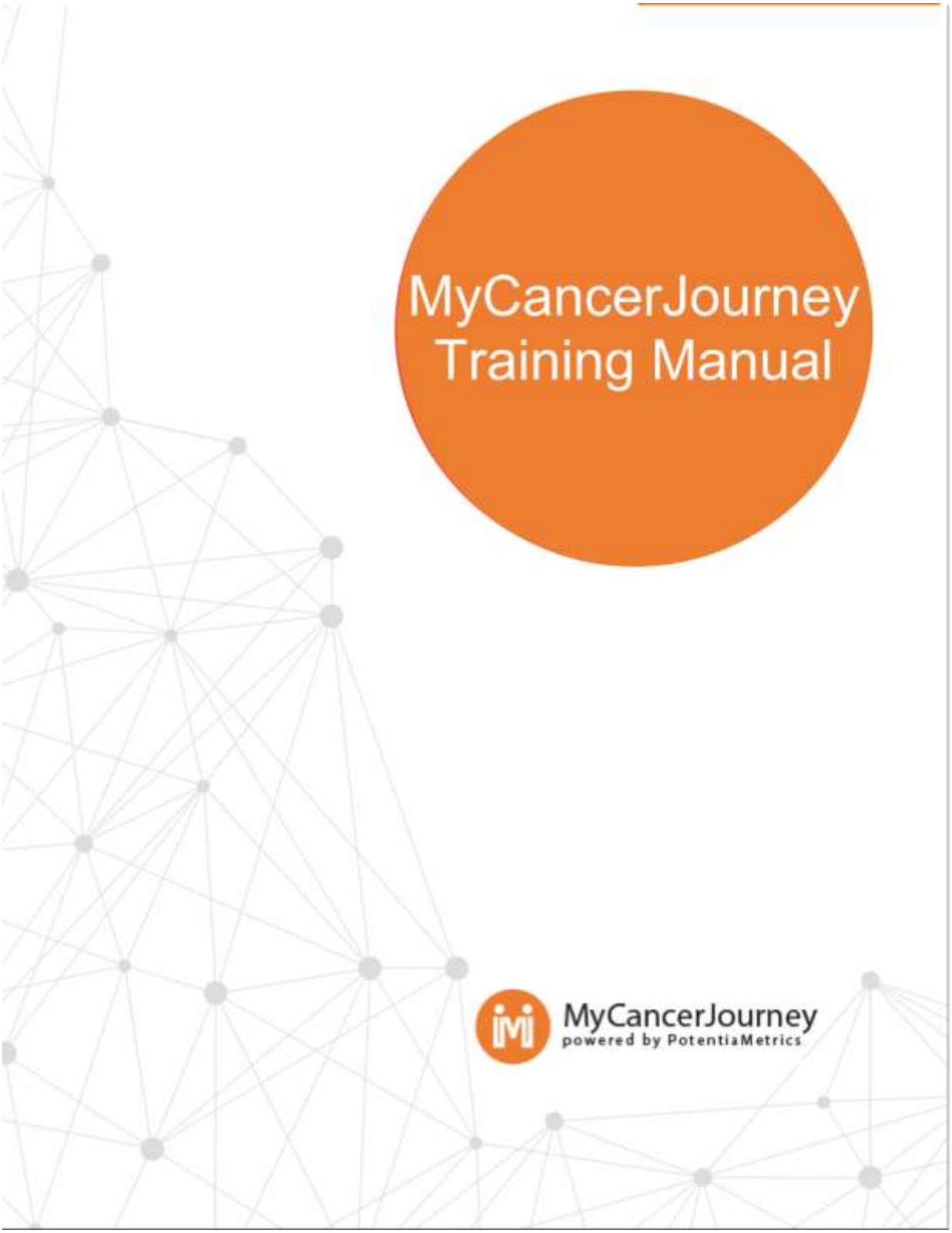

patient example
Survival Curves
General Population
Surgery
Without Treatment
Estimated Survival %
Year

36


patient example
Survival Curves
General Population
Surgery + RT
Without Treatment
Estimated Survival %
Year

37

Appendix 15: MyCancerJourney Training Manual



Appendix 16: MyCancerJourney References

MyCancer Journey

Reference Information

MyCancerJourney products support broad and momentous market opportunity, the reality that as much as 50% of healthcare expenditures are on ineffective and harmful treatments.[1,2,3] For the first time, we are providing access to outcomes data that is specific to each patient to support better treatment decisions, improved quality of life, while yielding significant cost savings to our customers.

The MyCancerJourney outcomes registry includes detailed information from over 2-million cases from over 500 hospitals and cancer treatment centers, ambulatory surgery centers, clinical laboratories, as well as physicians and other outpatient offices. Collection and reporting standards are in accordance with the National Program of Cancer Registries (NPCR); Centers for Disease Control and Prevention (CDC); North American Association of Central Cancer Registries (NAACCR); Surveillance, Epidemiology, and End Results Program (SEER) of the National Cancer Institute (NCI); and the American College of Surgeons (ACoS).

The MyCancerJourney analytic platform was developed and back tested over the past decade. The models have been validated by experts in healthcare analytics at University of Rotterdam, Erasmus. PotentiaMetrics has been recognized with multiple publications and awards, including The Harvard Health Policy Review, McKinsey & Company, South by Southwest (SXSW), Becker's Healthcare, MedCity Converge, and GuideWell Innovation.[4]

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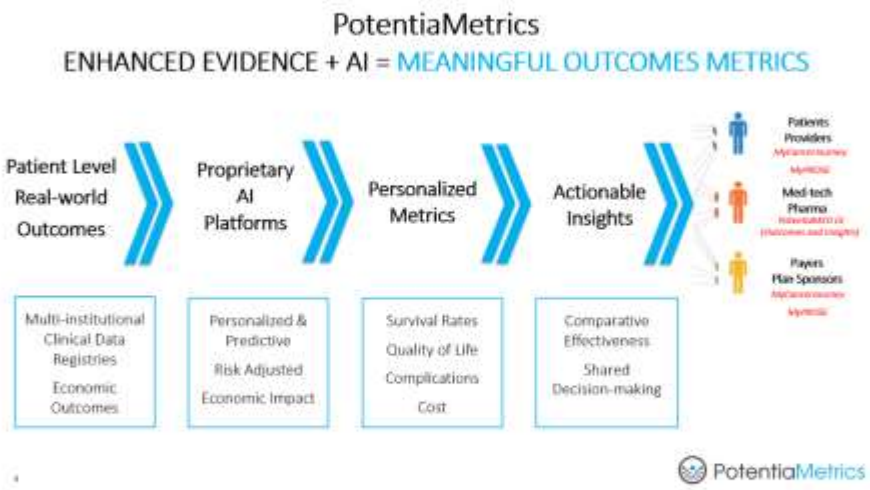
[1] Vera-Badillo FE, Shapiro R, Ocana A, Amir E, Tannock IF. Bias in reporting of end points of efficacy and toxicity in randomized, clinical trials for women with breast cancer, Ann Oncol. 2013;24:1238–1244

[2] Brawley OW, Goldberg P. How We Do Harm. A doctor breaks ranks about being sick in America. New York, NY: St. Martin's Griffin; 2011

[3] Leaf C. The Truth in Small Doses. Why We're Losing the War on Cancer-and How to Win It. Simon & Schuster; 2014

[4] Guidewell Innovation is holding company for BCBS Florida.



1. Market Need

A significant medical diagnosis is terrifying, and subsequent treatment choices are complex, with profound economic and quality of life implications. There are characteristically several different treatment options, depending on the age of the patient, overall severity of other medical conditions, severity of disease and increasingly genomic information.

The cost of employer-sponsored health care benefits are expected to approach $15,000 per employee next year, and these costs are rising at two times the rate of wage increases and three times general inflation.[5] These cost trends are unsustainable, and as a result, payers are increasing their efforts to manage costs.

Patients are different in many ways, there are frequently alternative treatments options that are also associated with trade-offs such as survival, quality of life and economic costs, yet our current system is largely based on adherence to treatment protocols based on a select group of patients. The existing clinical standards do not adequately address the unique patient and disease factors that implicate prognostication and influence other important considerations associated with treatment selection. Patients are frequently left with difficult choices, with survival, quality of life, functioning and economic costs all in the balance.

Personalization is the future of healthcare. Access to robust outcomes information can support personalized medicine, helping patients determine the extraordinarily complex interplay between patient variations, and the outcomes and potential side effects associated with various treatments. Personalized medicine employs advanced analytics, statistical modeling, deep learning (along with other approaches) to rigorously explore the composition of an individual patient's differentiating genetic, demographic, and patient-specific factors. The individual

[5] National Business Group on Health (NBGH) survey 2019 Large Employers' Health Care Strategy and Plan Design.

patient profile is then used as a starting point for measuring alternative treatments and expected outcomes to define a treatment plan.

PotentiaMetrics is combining relevant information with advances in analytics and computing power is providing new information and enhancing medical evidence. As progressive as advances in science and technology have been, the complexities of the real world exceed what can be adequately addressed, and the variations between individual patients, real human experiences, values, and situations require multiple forms of information and analytics to converge in supporting personalized decisions. Of these factors, different elements are of variegated levels of importance, based upon a specific individual's preferences and values. Healthcare decisions are among the most intimate and personal choices we make, and therefore reveal differences in basic, fundamental values. In the context of critical decisions, patients do not wish for their values to be merely tolerated, but want their values to authentically prevail.

As technological innovation in healthcare introduces new and exciting tools for capturing, analyzing, and applying complex and comprehensive outcomes data, a focal shift from clinical outcomes to real-world outcomes has become an increasingly relevant industry trend. As this trajectory has continued to advance, the process of analyzing outcomes of medical interventions has emerged out of its conventional, restrictive emphasis on treatments and into a new, immensely more perceptive emphasis on patients. Consequently, real-world health outcomes research, unlike clinical trial research, places a significant focus on the patient perspective, and rigorously analyzes inherent patient and practice heterogeneity to arrive at more comprehensive conclusions, ones which include elements related to the impact on quality of life, financial costs, and post-treatment functionality.

PotentiaMetrics platforms empower values-based healthcare decisions. One of our primary delivery methods is through Shared Decision Making (SDM) platforms. SDM is the process of interacting with patients who wish to be involved in arriving at an informed, values-based choice among two or more medically reasonable alternatives. SDM goes beyond "informed decision making," which refers to providing patients with evidence-based, balanced, and understandable information to inform decisions.[6] SDM creates a collaborative environment where the clinician's wisdom and experience into the disease are reconciled with the patient's goals and individual circumstances. In this environment clinicians help patients understand medical evidence about the decisions they are facing, and patients help providers understand their needs, values, and preferences regarding these decisions. Then, patients and providers together decide on a care plan consistent with medical science and personalized to each patient.[7,8]

SDM has the potential to provide numerous benefits for patients, clinicians, and the health care system, including increased patient knowledge, less anxiety over the care process, improved health outcomes, reductions in unwarranted variation in care and costs, and greater alignment

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[6] Briss P, Rimer B, Reilley B, et al. Promoting informed decisions about cancer screening in communities and health care systems. Am J Prev Med. 2004;26:67-80.

[7] Charles C, Gafni A, Whelan T. Shared decision-making in the medical encounter: what does it mean? (or it takes at least two to tango). Soc Sci Med. 1997;44:681-692.

[8] Charles C, Gafni A, Whelan T. Decision-making in the physician-patient encounter: revisiting the shared treatment decision-making model. Soc Sci Med. 1999;49:651-661.

of care with patients' values. Randomized trials consistently demonstrate the effectiveness of patient decision aids. A review of 86 studies showed that as compared with patients who received usual care, those who used decision aids had increased knowledge, more accurate risk perceptions, reduced conflict, and a greater likelihood of receiving care aligned with their values. Moreover, fewer patients were undecided or passive in the decision-making process, changes that are essential for patients' adherence to therapies.[9] SDM clarifies treatment options, compares the tradeoffs associated with different treatment options and how they impact quality of life and functioning. SDM is not clinical-decision support, nor does it replace clinical judgement or clinical guidelines.

MyCancerJourney

MyCancerJourney (MCJ) is a visionary solution for cancer patients with personalized and predictive outcomes information to improve survival and quality of life, while reducing complication rates, and costs. *MCJ* brings together the power of a massive (2 M lives) institutional longitudinal cancer data repositories and analytic platforms to create new opportunities for patients and providers to make shared-decisions about treatment options and obtain a better understanding of the derivative implications to quality of life.

Since a newly diagnosed cancer patient frequently has several treatment options, providing personalized information is critical. Research indicates patients want more personalized information to manage their care and that engaged patients make different treatment decisions, experience better outcomes, and incur lower costs.[10] For example, patients informed of treatment risks and outcomes were over 30% less likely to opt for aggressive treatment.[11] A recent study found that only 42% of women believed they had achieved their preferred level of control in decision making.[12] Of these women, 22% of women wanted to select their own cancer treatment, 44% wanted to select their treatment collaboratively with their physicians, and 34% wanted to delegate this responsibility to physicians.

Prognostic estimates and treatment decisions in cancer care are primarily based on the results from clinical trials and statistics published by the National Cancer Institute,[13] American Joint

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[12] Degner, Lesley F., Linda J. Kristjanson, David Bowman, Jeffrey A. Sloan, K. C. Carriere, John O'Neil, Barbara Bilodeau, Peter Watson, and Bryan Mueller. "Information needs and decisional preferences in women with breast cancer." Jama 277, no. 18 (1997): 1485-1492. Available at: https://jamanetwork.com/journals/jama/article-abstract/416136

[13] SEER Survival Monograph: Cancer Survival Among Adults: U.S. SEER Program, 1998-2001, Patient and Tumor Characteristics. Ries, LAG, Young JL, Keel GE, Eisner MP, Lin YD, and Horner MJ. NIH Pub. No. 07- 6215. 2007. Bethesda, MD, National Cancer Institute, SEER Program. Ref Type: Serial (Book,Monograph)

Committee on Cancer[14], and the American Cancer Society.[15] Data sets often relate mortality to site and morphologic spread of tumor at the time of diagnosis, and fail to include patient-specific factors, such as age, gender, comorbidity, and cancer-related symptom severity. The low participation of newly-diagnosed cancer patients in clinical trials, estimated to be 4%, undermines the usefulness and generalizability of the results.[16,17,18,19] Clinical trials are further marginalized with low participation by ethnic and racial minorities, resulting in poor generalizability, and a slow rate of scientific discovery.[20,21,22]

After receiving their diagnosis, patients are likely to agree to a treatment plan recommended by their doctors that may optimize efficacy and safety but may not consider their quality of life goals and priorities. In some cases, the treatment plan is effectively mandated by guidelines and patients' preferences are neither solicited nor considered. For example, the National Comprehensive Cancer Network (NCCN) frameworks use expert panels to rate treatment efficacy, quality and consistency of evidence of an overall treatment plan. These are all important considerations when choosing treatments. However, they do not necessarily include key factors that are personally relevant to an individual patient.

Comorbidity, or the other diseases, conditions, and illnesses that a cancer patient has at the time of diagnosis are also closely tied to optimal treatment decision-making and important to defining prognosis. Comorbidity analysis asks, "In addition to the cancer, what else is wrong with you?" Surprisingly, the burden of coexisting medical conditions can contribute mightily to prognosis and proper treatment selection for at least 70% of adults with newly diagnosed cancers.[23] Among men with prostate cancer, for instance, comorbidity is far and away more important than tumor size or spread, the usual factors doctors look for. Comorbidity is also relatively important for women with breast cancer because their overall survival rate is good, just as it is for men with prostate cancer.

There are a variety of comorbidities that help predict survival and impact treatment selection. Examples of common comorbid ailments include diabetes, heart disease, and depression. In fact, there are nearly 30 such comorbid conditions, which occur frequently enough and contribute to treatment decision-making and prognosis to warrant consideration at the time of

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[21] Swanson GM, Bailar JC, III. Selection and description of cancer clinical trials participants--science or happenstance? Cancer. 2002;95:950-959

[22] Newman LA, Roff NK, Weinberg AD. Cancer clinical trials accrual: missed opportunities to address disparities and missed opportunities to improve outcomes for all. Ann Surg Oncol. 2008;15:1818-1819

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cancer diagnosis. The combination of comorbid ailments within a cancer patient can determine how the patient will respond to a given therapy, or whether the patient should receive anti-cancer treatment aimed at a cure. In short, these other medical conditions can be instrumental in selecting the right treatment.

When considering cancer treatment among various options, the patient's comorbid ailments should be considered. For instance, one patient may be bedridden from congestive heart failure, making maximum medical or surgical or treatment hardly appropriate; the treatment could be fatal because of comorbidities. But another patient, young and otherwise healthy, could tolerate maximal medical or surgical treatment and the maximum treatment would be beneficial. What's more, in some cases, with cancers that are not aggressive, it may make much more sense to not treat at all and adopt a "watchful-waiting approach." In these situations, treatment, some analysts suggest, may simply make matters worse. People may have a better quality of life by forgoing cancer treatment. Doctors and patients need to understand that aggressive "all-out" treatment can be a mistake for some patients. In this way, the exclusion of comorbid health factors has not only impaired accurate assessment of prognosis and treatment effectiveness but also the humanistic care of patients. Now, with the analysis of data from large cancer registries, inclusion of comorbid health information allows for more precise descriptions of patients, creation of homogeneous patient groups, and survival estimates.

Surprisingly, huge numbers of cancer patients lack basic information, such as how long they can expect to live, whether their condition is curable or why they're being prescribed chemotherapy or radiation. In a study published last year in the Journal of Clinical Oncology, only 5 percent of cancer patients with less than six months to live had an accurate understanding of their illness. Thirty-eight percent couldn't remember ever talking to their doctor about their life expectancy.[24] And in a 2012 study in The New England Journal of Medicine, 69 percent of patients with metastatic lung cancer and 81 percent of people with advanced colorectal cancer thought they could still be cured, although both conditions are generally considered fatal.[25] Such misunderstandings can have profound consequences for patients and their caregivers. Patients who don't understand how long they have to live often choose overly aggressive therapy that can cause pointless pain and suffering.[26] Nearly one-third of cancer patients end up in the intensive care unit, or ICU, in the last month of life, according to the Dartmouth Atlas of Healthcare. Although intensive care can save the lives of younger, healthier people, it doesn't improve or lengthen the lives of people with terminal cancer. These last-ditch measures to extend life can leave families with extended grief and trauma.[27]

MyCancerJourney empowers cancer patients with usable information that is relevant to their specific clinical condition, to support decisions that enhance their quality and length of survival. *MyCancerJourney* provides patients with personalized information, based on the real-world outcomes of other patients with the same diagnosis, clinical factors, demographic and

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[24] "Article Tools." *American Society of Clinical Oncology Journals*, ascopubs.org/doi/abs/10.1200/jco.2015.63.6696.

[25] "Patients' Expectations about Effects of Chemotherapy for Advanced Cancer | NEJM." New England Journal of Medicine, www.nejm.org/doi/full/10.1056/NEJMoa1204410.

[26] Weeks, Jane C. "Relationship Between Cancer Patients' Predictions of Prognosis and Their Treatment Preferences." JAMA, American Medical Association, 3 June 1998, jamanetwork.com/journals/jama/fullarticle/187594.

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comorbidity factors to empower individuals to take more responsibility in their health and survivorship decisions. Knowledgeable patients make more informed decisions, and patients that are involved in decision-making are less likely to regret a treatment selection. MyCancerJourney supports shared decision making through providing prognostic treatment information to help patients make therapeutic decisions that maximize quality of life and value of care.

MyCancerJourney is the high-tech component of a high-tech/high-touch approach to cancer care. Trained cancer navigators are available to help patients manage their cancer journey, including managing their clinical schedule, and understanding available treatment options and possible complications associated with treatments. They guide the patient through the treatment process and provide patient education. Patient navigators have been shown to increase patient satisfaction, decrease ED utilization, increase adherence, lower stress, and improve care coordination.

MyCancerJourney aims to define treatment outcomes in everyday practice settings, not just in clinical trials.

What it does:

- Provides information to clarify treatment options
- Compares the benefits and harms
- Focuses on outcomes that matter to people

MyCancerJourney is meant to support human judgment - it cannot provide guidance by itself.

What it does not do:

- Tell health providers how to practice medicine
- Substitute clinical judgment tailored to individual patients
- Replace clinical practice guidelines or provide clinical recommendations

***MyCancerJourney* Observed Outcomes**

Since we completed the tech-transfer with Washington University School of Medicine, we have been recording *MyCancerJourney's* impact on patient treatment decisions. The following table

details the number of patients using the *MyCancerJourney* platform by cancer type, as well as their comparative treatment cost and survival rates. Patients who were supported by MyCancerJourney:

- 55% of selected different treatment options
- 40% ($2.6M) reduction in first-year treatment costs[28]
- Estimated 5-year survival difference of +0.7%[29]

We did not measure the differences in quality of life and functioning, but assume the group with less treatment experienced fewer complications and side effects. Costs were limited to the first year post diagnosis and did not capture non-direct costs such as cost from complications or missed work.

Cancer Type	# of Cases	Avg Costs without *MCJ*	Avg Costs with *MCJ*	Cost Difference	5 Year Survival without *MCJ*	5 Year Survival with *MCJ*	Survival Difference
Breast	29	95,590	59,289	-38.0%	75.7%	73.8%	-1.9%
OB GYN	14	92,483	58,058	-37.2%	45.4%	47.0%	+1.6%
GI	11	102,772	68,232	-33.6%	39.7%	40.8%	+1.1%
GU	13	49,872	22,058	-55.8%	61.6%	66.8%	+5.2%
Head & Neck	6	65,731	14,659	-77.7%	58.6%	58.3%	-0.2%
Lung	4	145,423	102,921	-29.2%	41.4%	43.4%	+2.0%

Company Value

PotentiaMetrics has a suite of unique data, developed tools, and an experienced team that provides substantial market opportunity, but the window of opportunity is limited. Market forces are driving innovation, resulting in a focus of both capital and talent on analytics applications. It is only a matter of time before competitive solutions are developed. The best opportunity to provide a robust commercial solution and capture notable market share is in the next three years, so we are moving fast.

Given the size and demand for personalized insights, it is remarkable and financially appealing that the markets we are focused on remain virtually untapped. Part of the reason there are few competitors is the complexity of the business, the need for a combination of industry expertise, access to unique datasets, and proprietary technology (all of which PotentiaMetrics has). Because we have already spent over a decade developing and improving our tools and datasets with expert input, PotentiaMetrics is poised to be an important player in the analytics field both now and in the future.

Many of our competitors reference information from published findings of Randomized Controlled Trials (RCT). RCTs remain the gold standard for evaluating cancer treatment efficacy. However, trials are not always feasible, practical, or timely and often don't adequately reflect patient heterogeneity and real-world clinical practice. Thus, it is very difficult to use the results from clinical trials to develop risk-adjusted prediction and treatment models for individual

[28] Multiple peer-reviewed sources used to estimate the first-year reimbursement.

[29] Survival analyses are driven by *MyInsights*, using Cox proportional hazards models derived from National Cancer Database (NCDB) cancer registry data of over 150,000 patients, and thus incorporate the actual outcomes of patients with the same diagnosis and similar clinical characteristics, demographic factors and comorbidities.

patients. In addition, funded research is often conducted in areas that are already being studied, while areas that are clinically important may remain understudied. Another problem with clinical trials is the long time required to complete a trial. It takes, on average, eight years for a clinical trial to complete. In addition, research has shown, potentially, an additional seventeen years for known best practices to be applied in clinical care. The velocity of change in the healthcare system and advances in technology overwhelms the archaic systems and structures in place to incorporate new knowledge. This focus of Dissemination & Implementation research is to accelerate the pace of translation of research findings to general practice.

The "evidence" aspect of evidence-based medicine is derived almost exclusively from randomized trials and meta-analyses. The majority of clinical trials in cardiovascular medicine to date have been designed to assess the efficacy and safety of administered therapies. Trials typically include an incredibly small minority of patients and exclude the care of patients in "routine" clinical practice. Thus, data included in RCTs do not include many types of treatments, or patients, seen in clinical practice. Additionally, the conclusions of RCTs consider the "average" randomized patient and fail to consider pertinent subgroups defined by severity of symptoms, illness, comorbidity, and other clinical nuances. Therefore, RTC outcomes are not representative of real-world populations and should be supplemented with other forms of evidence.

PotentiaMetrics combines Clinical Data Registry (CDR) data from centers to support the comparison and dissemination of outcomes and quality information. A Clinical Data Registry (CDR) is an observational database focused on a clinical condition, procedure, therapy, or population. Data is collected systematically for specified scientific, clinical, or policy purposes. The focus of clinical registries is on capturing data that reflects "real-world" clinical practice in large, representative patient populations. CDR's are managed by trained registrars who compile information from multiple systems and perform case review using standardized data elements that adhere to consistent data definitions and standards.

In the U.S. cancer registrars at over 1,500 cancer hospitals and treatment centers capture key demographic, comorbid health, tumor, treatment, and survival information for greater than seventy percent of all adult cancer patients. This information represents an excellent source of data for the study of prognostic factors, survival outcomes, and quality of care to provide a real-world view of clinical and economic, practice, patient outcomes, safety, and comparative effectiveness.

The continued rise in health care costs has prompted employers and plan sponsors to think differently about approaches to health benefits management, both near-term and long-term health care cost trends. Payers are also struggling to understand the clinical and economic outcomes of cancer treatments. Insurers are dealing with increasing regulation and mandates that are forcing them to explore ways to align more closely with the providers of care and the patient. Some estimates suggest that as much as one-third of all health care expenditures generate no clinical benefit. Hence, with the goal to stop treating patients with therapies that generate little, or no, clinical benefit it is not surprising that comparative effectiveness research has received considerable attention from payers and value-based benefit design is increasing in importance. For payers, incentives for change are structured around their three major functions: reimbursement, benefit plan design, and medical policy formation. Risk adjustment

is a critically important component of outcome reporting. Co-occurrence of other serious medical conditions complicates patient care and evaluation of treatment effectiveness. For instance, 83 percent of Medicaid patients have at least one chronic condition, and almost 25 percent have at least 5 comorbidities. Medicare patients with five or more chronic conditions account for 76 percent of all expenditures. Without adequate data items to measure potential risk factors, the ability of payers to evaluate risk-adjusted outcomes is limited and they frequently will reference clinical studies to attempt to model outcomes and cost for treatments. Even if they are able to understand the clinical and financial implications of a treatment, the payers are typically "pushing a string" with trying to impact clinical practice patterns and struggle to communicate evidence to clinical decision makers and patients.

PotentiaMetrics' unique data sources are an important component of our business. Most of our competitors are accessing either clinical study evidence or paid claims data. Randomized controlled trials remain the gold standard for evaluating cancer treatment efficacy. However, trials are not always feasible, practical, or timely and often do not adequately reflect patient heterogeneity and real-world clinical practice. Paid claims data do not contain the level of information or context required to support personalized care. Thus, it is very difficult to use the results from clinical trials and paid claims data to develop risk-adjusted prediction and treatment models for individual patients.

The precision of the information, the definition of the measures, and granularity of the information we use is critical and unique in the industry. A primary differentiator to PotentiaMetrics approach is taking the time and effort to obtain registry data from multiple institutions. While we do not take ownership of institutions outcomes data, we have obtained unique access, resulting in one of the world's largest databases of cancer patients inclusive of their underlying conditions. In addition to this registry data, we are developing our own significant proprietary database of longitudinal patient-reported outcomes, inclusive of underlying conditions.

Our analytics solutions are based on unique access to information by leveraging mature clinical registry databases and large repositories of underutilized information that has been collected by registers at the hospital for many years. This approach allows us to better compare outcomes and leverage specialized data and expertise and develop predictive models.

Patient level outcome data is the essential mechanism to make the leap from clinical efficacy to valid and credible comparative effectiveness analysis. Transparency is hard and the lack of trust among constituents is pervasive. PotentiaMetrics is in a unique position to convene otherwise competing providers to forge partnerships. The vision is to combine cancer data from centers from across the United States and eventually internationally to support the comparison and dissemination of outcomes and quality information.

PotentiaMetrics' proprietary analytic platforms have been developed over the last decade. PotentiaMetrics has a mature methodological framework, with the technology and experience to expand into new diagnosis groups and industries. This allows us to provide value to our customers quickly – our outcomes and insights are delivered in months not years. The company's success relies on small impactful teams of elite individuals with special skills, agility, adaptability, resourcefulness and innovation.

PotentiaMetrics team expertise includes a team with decades of specialized knowledge and vast contacts We have deep clinical, financial, and technical expertise that allows us to know

where to obtain the required data, how to build upon our data warehouse, and how to perform the necessary analysis. Because we are an independent firm, providers, patients, and customers (rightfully) perceive us to be a trustworthy firm with whom they can safely share information. Obtaining data is not enough, it must also yield meaningful and actionable insights. The power and relevance of our solutions is derived from the experience of highly skilled clinicians, statisticians, economists and engineers who have decades of experience in relevant fields. The PotentiaMetrics team understands the data, how to draw insight from it and present it intuitively to varied audiences, and the nuances that are so critical in developing targeted solutions.

External review

MyCancerJourney models have been validated by experts at Erasmus Medical Center, Rotterdam, Netherlands.

Academic publishing

Solowski, Nancy L., et al. "Patient and Physician Views on Providing Cancer Patient-Specific Survival Information." The Laryngoscope, vol. 124, no. 2, Nov. 2013, pp. 429–435., doi:10.1002/lary.24007.

Piccirillo, Jay F., and Anna Vlahiotis. "Comorbidity in Patients with Cancer of the Head and Neck: Prevalence and Impact on Treatment and Prognosis." Current Oncology Reports, vol. 8, no. 2, 2006, pp. 123–129., doi:10.1007/s11912-006-0047-z.

Piccirillo JF, Kallogjeri DK, Kukuljan S, Palmer R. The Development of MyCancerJourney and the Incorporation of Predictive Analytics to Improve Patient Care. Harvard Health Policy Review. Spring 2015 (Generating Signal from Noise: Big Data's Big Challenge); 14(2): 14-15.

Appendix 17: MyCancerJourney Contract

SOFTWARE AS A SERVICE SUBSCRIPTION AGREEMENT

THIS SOFTWARE AS A SERVICE ("SaaS") SUBSCRIPTION AGREEMENT, (this "Agreement"), is entered into effective as of December 1st, 2021 by and between MyCancerJourney, Inc., a Texas corporation ("MCJ") and VistaRiver of King County, LLC ("Customer"). From time to time herein, MCJ and Customer shall collectively be referred to as "parties," and individually, each as a "party."

The main activity of MCJ is to provide a database of health care information that can be used to help cancer patients understand their treatment options. MCJ also provides proprietary software solutions to community physicians, patients and families utilizing the same database to create a report of health care and treatment options to aid in understating their care options.

1. **Services.** Subject to the terms of this Agreement, and the timely payment in full of all Subscription Fees (defined below), during the Term (as defined below), MCJ shall use commercially reasonable efforts to provide to Customer the MCJ Platinum subscription on MyCancerJourney.com. Customer is choosing to pay the $75 profile fee. Customer is choosing to pay the $150 per month Platinum Subscription fee.
   The My Cancer Journey database contains approximately 2,000,000 unique health care records. The database is constantly being cleaned, pruned, and added to ensure accurate, all-encompassing information.

   "Free" Service: All agencies in the My Cancer Journey database are automatically included in the "Free" service, whichincludes placement in mycancerjourney.com search results and the search results of all participating hospitals. Each listing in the search results includes the agency name, address, and phone number.

   "Basic" Service: Includes everything in the "Free" Service, plus an expanded directory listing to provide more information about the agency, including: a short description of the agency, the agency's own logo, and the "Verified" stamp that conveys to the public that the data for the agency is completely accurate. "Basic subscription" also provides preferential placement in mycancerjourney.com search results and in the search results ofthe case manager report utility, used by case managers in participating hospitals, placing agencies in this serviceabove agencies in the "Free" service.

   "Platinum" Service: Includes everything in the "Basic" Service, plus a link to the agency's website directly within the search results listing. A unique profile page is created for each agency that signs up for the "Platinum" Service that includes pictures, and expanded description of the agency, a map (using Google maps), and an embedded video (if provided by the Customer). "Platinum" service also provides preferential placement in mycancerjourney.com search results and in the search results of the case manager report utility, used by case managers in participating hospitals, placing agencies in this service above agencies in the "Basic" service.

   No right or license under any patent, copyright, trademark, or other intellectual property right is granted by, or is to be inferred from, any provision of this Agreement. MCJ hereby reserves all rights in and to the Services not expressly granted in this Agreement. Nothing in this Agreement shall limit in any way MCJ's right to develop, use, license, create derivative works of or otherwise exploit the Service or to permit third parties to do so.

   Customer agrees that its purchase of subscription(s) for the Services is neither contingent upon the delivery of any future functionality or features nor dependent upon any oral or written public comments made by MCJ with respect to future functionality or features. Upon expiration or termination of this Agreement or upon expiration of the Term, the rights and access granted hereunder will automatically terminate.

2. **MCJ's Rights and Obligations.**

(a) Customer may elect to purchase additional features, functionality, or capabilities by entering into a mutually agreed upon and signed amendment to this Agreement.

(b) For the avoidance of doubt, MCJ will not be obligated to provide the following in connection with the Services, unless provided for in a separate statement of work signed by the parties and payment of the applicable fees as set forth in such statement of work: (i) training, configuration, or implementation services; (ii) custom development or custom upgrades; or (iii) any new products or services.

(c) The subscription granted in Section 1 above is conditioned upon Customer's compliance with the terms and conditions of this Agreement. Customer may use the Services solely for its own internal business purposes, in compliance with applicable law, and shall not: (i) create derivative works based on the Services; (ii) modify, reverse engineer, translate, disassemble, or decompile the Services, or cause or permit others to do so; (iii) access the Services in order to (A) build a competitive product or service, or (B) copy any ideas, features, functions, or graphics of the Services; and (iv) remove any title, trademark, copyright, and/or restricted rights notices or labels from the Services. Violation of any provision of this Section shall be the basis for immediate termination of this Agreement by MCJ.

(d) MCJ Responsibilities. MCJ shall endeavor to respond to Customer's support inquiries within a reasonable time,provided that Customer supplies MCJ with any information and/or materials reasonably requested, including withoutlimitation any information needed to replicate, diagnose, and correct any error or other problem reported by Customer relating to the access or use of the Services. Information that MCJ may request to aid in the diagnosis and resolution efforts may include: (i) the name and contact information of the reporting person; (ii) symptoms of the suspected failure; (iii) any testing performed by Customer with respect to the suspected failure; and (iv) whether use of the Services may be temporarily suspended by MCJ for testing purposes. MCJ shall respond only to support inquiries originated by Customer, and Customer shall be responsible for responding to the support inquiries of its authorized users.

(e) Customer Support. MCJ will provide on-going customer support for Customer ("Customer Support"). Customer Support shall be provided primarily via e-mail at [support@MCJconcierge.com], during business hours of 8am-5pm PST Monday-Friday. Any additional or dedicated customer support resources may be provided and will be subject to negotiation under a separate statement of work.

(f) Reserved Rights. MCJ reserves the right in its sole discretion to decline Customer or any authorized user of Customer access and use of the Services to Customer. MCJ further reserves the right in its sole discretion to terminate Customer's subscription to access and use the Services, at any time, for reasons including, but not limited to, a breach or other violation of the terms and conditions set forth in this Agreement; abuse of the Services or MCJ's underlying systems; illegal or misrepresentative use of the Services or underlying systems; and acts or circumstances detrimental to MCJ, its other customers, associates, business partners, suppliers, or others, whether or not such circumstances are directly under the control of Customer. MCJ shall promptly communicate to Customer its decision to terminate Customer's subscription to access and use the Services pursuant to this Section as well as, if it so chooses, the relevant reason(s) for such termination. Customer agrees to provide any assistance reasonably requested by MCJ in connection with such termination. Termination under this Section 2 shall be without any liability to Customer whose access and use subscription is terminated.

3. Customer's Rights and Obligations.

(a) Use of the Services. Customer is solely responsible for all Customer Content and activity occurring under Authorized User accounts for access to the Services and shall comply with all applicable local, state, national, and foreign laws related to data privacy and the transmission of technical or personal data, including personally identifiable information. "Customer Content" means certain data, content, or materials provided by Customer when using the Services. Customer is solely responsible for the accuracy, quality, integrity, legality, reliability, appropriateness, and copyright of all Customer Content. Customer shall obtain and maintain any rights, consents,

and approvals required to grant MCJ and its vendors the right to access and use any Customer Content for the purposes described herein. Customer shall: (i) notify MCJ immediately of any unauthorized use of any password or account or any other known or suspected breach of security; (ii) report to MCJ immediately, and use reasonable efforts to stop immediately, any copying or distribution of the Services of any of the content in the Services that is known or suspected by MCJ; and (iii) not allow a user to impersonate another user or provide false identity information to gain access to or use the Services.

(b) Restrictions on Use. Customer shall not (i) license, grant, sell, resell, transfer, assign, distribute or otherwise commercially exploit or make available to any third party the Services in any way; (ii) modify or make derivative works based upon the Services; or (iii) create Internet "links" to the Services or "frame" or "mirror" any Services. In addition, Customer shall not (i) use the Services to store or transmit infringing, libelous, or otherwise unlawful or tortious material, or to store or transmit material in violation of third-party privacy rights, (ii) use the Services to store or transmit Malicious Code, (iii) interfere with or disrupt the integrity or performance of the Services or third-party data contained therein or any systems or networks or violate the regulations, policies, or procedures of such networks used with the Services, (iv) attempt to gain unauthorized access to the Service or its related systems or networks, the MCJ data or the data of any other MCJ customers, or (v) harass or knowingly or intentionally interfere with another MCJ customer's use and enjoyment of the Services. Any conduct by Customer that in MCJ's sole discretionrestricts or inhibits any other MCJ customer from using or enjoying the Services is expressly prohibited. Customer willuse commercially reasonable efforts to prevent unauthorized access to, or use of, the Services, and notify MCJ promptly of any such unauthorized access or use. Customer shall be responsible for obtaining and maintaining all telephone, computer hardware, and other equipment needed for access to and use of the Services and all charges related thereto.

(c) Fees. Customer agrees to pay the Subscription Fees and any other fees as set forth in this Agreement and/or invoiced to Customer.

(d) Trademark License. Customer hereby grants MCJ a limited right to use any and all trademarks, logos, and branding materials of Customer as may be requested in providing the Services pursuant to this Agreement, subject to the prior written approval of Customer. MCJ acknowledges that such Customer trademarks remain the proprietary property of Customer and that MCJ shall have no right to use any such trademarks outside the scope of this Agreement.

4. Term and Fees.

(a) The Initial Term. The initial term of this Agreement commences as of the Start Date and, unless terminated earlier pursuant any of the Agreement's express provisions, will continue in effect until one year from such date (the "Initial Term"). "Start Date" means January 1st, 2023, the date on which the SaaS Services shall be made availableto Customer.

(b) Subscription Fees. The subscription fees for the Services provided pursuant to this Agreement (the "Subscription Fees") shall be $150 per month for the "Platinum" Service of the term.

MCJ may charge Customer interest on the outstanding balance of any overdue Subscription Fees, charges, or expenses at a rate equal to 1.5% per month or the highest rate permitted by applicable law, whichever is lower. A service charge will be assessed with respect to any returned or dishonored checks of Customer. Customer will reimburse MCJ for all reasonable costs incurred (including reasonable attorneys' fees) in collecting past due amounts owed by Customer. All payment obligations will survive termination of this Agreement. If balances remain unpaid for thirty (30) days, Customer acknowledges and agrees that MCJ may cease providing Services under this Agreement.

(c) Renewal. This Agreement will automatically renew for additional successive one year terms unless earlier terminated pursuant to this Agreement's express provisions or either party gives the other party written notice of non-renewal at least thirty (30) days prior to the expiration of the then-current term (each a "Renewal Term" and, collectively, together with the Initial Term, the "Term").

(d) Fee Increase. MCJ may increase the Subscription Fees up to 5% (five percent) annually for the Services upon thirty (30) calendar days' written notice to Customer; provided, however, no increase in the Subscription Fees shall

apply to the then-current term unless otherwise agreed to by the parties.

(e) Taxes. Fees do not include taxes (including sales, use, and VAT) or customs, duties, excise taxes, or tariffs. Federal, state and local sales, use and excise taxes and all similar taxes and duties are the sole responsibility of Customer.

5. Termination. In addition to any other express termination right set forth elsewhere in this Agreement:

(a) MCJ may terminate this Agreement, effective on written notice to Customer, if Customer: (i) fails to pay any amount when due hereunder, and such failure continues more than thirty (30) days after MCJ's delivery of written notice thereof; or (ii) breaches any of its obligations under Section 4 or Section 5;

(b) Either party may terminate this Agreement, effective on written notice to the other party, if the other party materially breaches this Agreement, and such breach: (i) is incapable of cure; or (ii) being capable of cure, remains uncured thirty (30) days after the non-breaching party provides the breaching party with written notice of such breach; and

(c) Either party may terminate this Agreement, effective immediately upon written notice to the other party, if the other party: (i) becomes insolvent or is generally unable to pay, or fails to pay, its debts as they become due; (ii) files or has filed against it, a petition for voluntary or involuntary bankruptcy or otherwise becomes subject, voluntarily or involuntarily, to any proceeding under any domestic or foreign bankruptcy or insolvency law; (iii) makes or seeks to make a general assignment for the benefit of its creditors; or (iv) applies for or has appointed a receiver, trustee, custodian, or similar agent appointed by order of any court of competent jurisdiction to take charge of or sell any material portion of its property or business.

(d) Effect of Termination. Upon suspension or termination of this Agreement, Customer must pay all Subscription Fees and any other fees to the date of termination a provided herein. Customer will have the time period set forth in Section 6(b) to request and/or remove any Customer Data that it or its Authorized Users provided through the Services. Following such period, MCJ may destroy such Customer Data. In the event such Customer Data is destroyed, and upon the request of Customer, MCJ shall provide a written notice of certification of such destruction.

(e) Survival. Following termination or expiration of this Agreement, the following sections shall survive: 4 (Term and Fees), 6 (Intellectual Property Rights), 7 (Confidentiality), 8 (Warranties), 9 (Limitation of Liability), 11 (Indemnification), 13(d) (Governing Law), and any other terms which by their nature extend beyond the effective date of such termination.

6. Intellectual Property Rights.

(a) General. All right, title, and interest in, to, and under the Services, MCJ's Confidential Information, including, without limitation, all modifications, enhancements, and intellectual property rights thereto, shall belong solely to MCJ and/or its applicable licensors.

(a) Ownership of Customer Content. Customer exclusively owns all right, title, and interest in, to, and under the Customer Content and Customer Confidential Information and Customer shall be solely liable for the accuracy, quality, integrity, legality, reliability, appropriateness, and intellectual property ownership or right to use of all such data, information, and materials. "Customer Data" includes any Customer-specific content created by MCJ for Customer using data, information, or materials provided by Customer and its Authorized Users to MCJ. Customer hereby licenses to MCJ the limited right to use or modify the Customer Data delivered by Customer to MCJ solely for the purpose of permitting MCJ to perform the Services requested by Customer hereunder. MCJ may de-identify and/or aggregate any data and such de-identified and/or aggregated data shall be proprietary to MCJ. Among Customer and its Authorized Users, the parties agree and acknowledge that, with respect to the Customer Data, Customer, and not the Authorized User(s), shall own such Customer Data.

(b) Return of Data. In the event of termination or expiration of the Agreement, and if legally permissible and requested by Customer within thirty (30) days of such termination or expiration, MCJ agrees to: (i) return to Customer the Customer Content; or (ii) destroy or permanently erase the Customer Content. After such 30-day period, MCJ will have no other further obligation to maintain or provide access to Customer Content, and may destroy the Customer Content and permanently erase the Customer Content without any liability to Customer.

(c) Suggestions. MCJ shall exclusively own all right, title, and interest in, to, and under any suggestions, ideas, enhancement requests, recommendations, or other feedback provided by Customer relating to the Services.

7. Confidentiality.

(a) Each party acknowledges that it will have access to certain confidential information of the other party, including the terms and conditions of this Agreement. "Confidential Information" includes all information identified by a party as confidential. Each party's Confidential Information shall (i) remain the sole property of that party and (ii) be used by the other party only as described herein and may not be disclosed, provided, or otherwise made available to any other third party except that such Confidential Information may be disclosed to the other party's employees or agents who have a need to know in the scope of their work during the time they are performing services under this Agreement and are under the other party's security and control. Confidential Information does not include (i) information that the recipient can establish was already known to the recipient at the time it was disclosed in connection with this Agreement, (ii) information that is developed independently by the recipient or received from another third party lawfully in possession of the information and having no duty to keep the information confidential, (iii) information that becomes publicly known other than by a breach of this Agreement, or (iv) information disclosed in accordance with a valid court order or other valid legal process. Each party agrees to hold the Confidential Information of the other party in strictest confidence and not to copy, reproduce, distribute, publish, or disclose such Confidential Information to any person except as expressly permitted by this Agreement.

(b) With respect to the Services subscribed to by Customer, the definition of Confidential Information set forth in the Agreement shall include the Customer Content and the Services (including all underlying software and systems of MCJ used with the Services), subject to the exceptions set forth in the Agreement.

8. Warranties.

(a) MCJ represents and warrants to Customer that the Services will be performed in a manner consistent with industry standards and in compliance with any specifications and requirements set forth in this Agreement. Customer's exclusive remedy for breach of the foregoing limited warranty shall be for MCJ to update and correct such Services not in compliance with such specifications and requirements, at no cost to Customer. The foregoing limited warranty shall not apply to performance issues or defects in the Services that result from factors outside MCJ's reasonable control, that resulted from any actions or inactions of Customer or its Authorized Users, or that resulted from Customer's equipment or any third-party equipment not within the control of MCJ.

(b) MCJ does not guarantee the security of any information transmitted to or from Customer over the Internet, including through the use of e-mail. Access to the Internet, if employed, is Customer's sole responsibility and the responsibility of Internet provider(s). MCJ does not accept any responsibility for failure of service due to Internet facilities, including related telecommunications or equipment.

(c) EXCEPT AS SET FORTH IN THIS SECTION 9, THE SERVICES ARE PROVIDED "AS IS", AND MCJ DOES NOT MAKE ANY REPRESENTATIONS OR WARRANTIES THAT THE FUNCTIONS PERFORMED BY THE SERVICES WILL MEET CUSTOMER'S REQUIREMENTS, THAT THE OPERATION OF THE SERVICES WILL BE UNINTERRUPTED OR ERROR FREE, OR THAT ANY DEFECTS IN THE SERVICES WILL BE CORRECTED. TO THE EXTENT PERMITTED BY APPLICABLE LAW, THE FOREGOING LIMITED WARRANTY IS IN LIEU OF ALL OTHER WARRANTIES OR CONDITIONS, EXPRESS OR IMPLIED, AND MCJ DISCLAIMS ANY AND ALL OTHER WARRANTIES OR CONDITIONS, WHETHER EXPRESS, IMPLIED, ORAL, OR WRITTEN, INCLUDING, WITHOUT LIMITATION, ANY AND ALL IMPLIED WARRANTIES OF MERCHANTABILITY, REASONABLE CARE, AND/OR FITNESS FOR A PARTICULAR PURPOSE (WHETHER OR NOT MCJ KNOWS, HAS REASON TO KNOW, HAS BEEN ADVISED, OR IS OTHERWISE IN FACT AWARE OF ANY SUCH PURPOSE). TO THE EXTENT PERMITTED BY APPLICABLE LAW, MCJ FURTHER DISCLAIMS ANY AND ALL WARRANTIES, CONDITIONS, AND/OR REPRESENTATIONS OF TITLE AND NON-INFRINGEMENT. NO ORAL OR WRITTEN INFORMATION OR ADVICE GIVEN BY MCJ OR ITS EMPLOYEES SHALL CREATE A WARRANTY OR IN ANY WAY INCREASE THE SCOPE OF MCJ'S OBLIGATIONS HEREUNDER. No action for breach of the limited warranty set forth in this Section 9 may be commenced more than one (1) year following the expiration of the Term.

9. Limitation of Liability. NOTWITHSTANDING ANYTHING TO THE CONTRARY SET FORTH IN THIS AGREEMENT, MCJ'STOTAL CUMULATIVE LIABILITY UNDER THIS AGREEMENT, OR AT LAW WITH RESPECT TO ANY SERVICES PROVIDED BY MCJ (WHETHER NEGLIGENT OR OTHERWISE), WILL BE LIMITED TO THE TOTAL FEES PAID (LESS ANY REFUNDS OR CREDITS) BY CUSTOMER TO MCJ UNDER THIS AGREEMENT IN THE PRECEDING TWELVE (12) MONTH PERIOD. IN NO EVENT WILL MCJ BE LIABLE TO CUSTOMER UNDER, IN CONNECTION WITH, OR RELATED TO THIS AGREEMENT FOR ANY SPECIAL, INCIDENTAL, PUNITIVE, INDIRECT, OR CONSEQUENTIAL DAMAGES, HOWEVER CAUSED AND WHETHER BASED ON BREACH OF CONTRACT, WARRANTY, TORT, PRODUCT LIABILITY, OR OTHERWISE, INCLUDING NEGLIGENCE, AND WHETHER OR NOT MCJ HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGE. THE PARTIES ACKNOWLEDGE AND AGREE THAT THE FOREGOING LIMITATIONS OF LIABILITY ARE A CONDITION AND MATERIAL CONSIDERATION FOR THEIR ENTRY INTO THIS AGREEMENT.

10. Indemnification. CUSTOMER SHALL INDEMNIFY, DEFEND, and HOLD HARMLESS MCJ AND ITS OFFICERS, DIRECTORS, EMPLOYEES, AND AGENTS FROM AND AGAINST ANY AND ALL CLAIMS, DEMANDS, LOSSES, DAMAGES, LIABILITIES, COST, OR EXPENSE (INCLUDING REASONABLE ATTORNEYS' FEES) ARISING FROM OR ASSOCIATED WITH (1) ANY ACTIONS OR OMISSIONS OF CUSTOMER OR CUSTOMER'S AUTHORIZED USERS, (2) THE BREACH OF THIS AGREEMENT BY CUSTOMER, (3) NON-COMPLIANCE WITH ANY FEDERAL, STATE, OR LOCAL LAWS OR REGULATIONS, OR (4) ANY INTELLECTUAL PROPERTY OR CONTENT PROVIDED BY CUSTOMER TO MCJ. THIS INDEMNITY SHALL SURVIVE THE TERMINATION OR EXPIRATION OF THIS AGREEMENT.

(a) Export laws and regulations of the United States and any other relevant local export laws and regulations apply to Customer's use of the Services. Customer agrees that such export control laws govern its use of the Services, and Customer agrees to comply with all such export laws and regulations (including "deemed export" and "deemed re-export" regulations). Customer agrees that no data, information, program, and/or materials resulting from Customer's use of the Services (or direct product thereof) will be exported, directly or indirectly, in violation of these laws, or will be used for any purpose prohibited by these laws. Customer shall indemnify MCJ and its suppliers for any violation of export laws and regulations by Customer.

(b) Release of Claims. MCJ shall not be liable for loss, injury, or damage of any kind to any person or entity resulting from any use, condition, performance, defect, or failure in the Services. Customer releases and waives on behalf of Customer and its authorized users all claims, known or unknown, against MCJ, its parent, subsidiaries, affiliated companies, agents, or content providers, and the directors, trustees, officers, shareholders, employees, agents, and representatives of each of the foregoing, from any and all claims, damages, liabilities, costs, and expenses arising out of Customer's use of the Services.

11. Access and Monitoring. MCJ and its subcontractors may access Customer's account and Customer Content as necessary to identify or resolve technical problems or respond to complaints about the Services or as may be required by law. MCJ shall also have the right, but not the obligation, to monitor the Services to determine Customer's compliance with the Agreement. Without limiting the foregoing and with two (2) days prior notice, MCJ shall have the right to remove any material submitted to the Services that MCJ finds to be in violation of the provisions of this Agreement.

12. Third Party Applications.

(a) MCJ shall have no obligation to provide Customer Support for any customized software or any third-party ERP applications not part of the Services. Further, in the event that any Service is deployed in conjunction with any other software products, including, but not limited to, web servers, browsers, third party databases, and operating systems, MCJ shall have no obligation to provide Customer Support for these other products, or for ensuring the correct interoperation with these products. Further, MCJ shall not be responsible for providing Customer Support: (i)

for problems caused by Customer's use of or access to the Services other than as intended; (ii) for any use in violation of this Agreement; or (iii) for any unauthorized modifications made to the Services by Customer or any third party. In the event the Customer Support provided are traced to Customer's or a third party's errors, unauthorized use, or system changes, fees and expenses for said Customer Support services may be billed to Customer at MCJ's then current rates and shall be paid promptly by Customer.

(b) Any third-party applications and/or work products that are software shall be subject to the same subscription limitations of this Agreement and any additional limitations.

13. Miscellaneous Provisions.

(a) MCJ's relationship with Customer under this Agreement shall be that of an independent contractor, and nothing in this Agreement or the arrangements for which it is made shall make MCJ, or anyone furnished or used by MCJ in the provision of the Services, an employee, joint venture, partner, or servant of Customer. This Agreement is intended for the sole and exclusive benefit of the parties and is not intended to benefit any third party.

(b) In no event will MCJ be liable or responsible to Customer, or be deemed to have defaulted under or breached this Agreement, for any failure or delay in fulfilling or performing any term of this Agreement when and to the extent such failure or delay is caused by any circumstances beyond MCJ's reasonable control (a "Force Majeure Event"), including acts of God, flood, fire, earthquake or explosion, war, terrorism, invasion, riot or other civil unrest, embargoes or blockades in effect on or after the date of this Agreement, national or regional emergency, strikes, labor stoppages or slowdowns or other industrial disturbances, passage of Law or any action taken by a governmental or public authority, including imposing an embargo, export or import restriction, quota or other restriction or prohibition or any complete or partial government shutdown, or national or regional shortage of adequate power or telecommunications or transportation. Either party may terminate this Agreement if a Force Majeure Event continues substantially uninterrupted for a period of 30 (thirty) days or more.

(c) In the event of any failure or delay caused by a Force Majeure Event, MCJ shall give prompt written notice to Customer stating the period of time the occurrence is expected to continue and use commercially reasonable efforts to end the failure or delay and minimize the effects of such Force Majeure Event.

(d) Governing Law. This Agreement shall be exclusively governed by and construed in accordance with the laws of the State of Texas, exclusive of its rules governing choice of law and conflict of laws. If legal action is commenced by either party to enforce or defend its rights under this Agreement, such action shall be brought exclusively in the Circuit Court located in Marion County, Texas, and the parties agree to submit to the jurisdiction of such courts. This Agreement is the complete and exclusive agreement between the parties with respect to the subject matter hereof, superseding and replacing all prior agreements, communications, and understandings (both written and oral) regarding such subject matter. The headings and captions of this Agreement are inserted for convenience and do not define, limit, or describe the scope and intent of this Agreement or any particular section, paragraph, or provision

(e) This Agreement may only be amended or modified by a writing specifically referencing this Agreement which has been signed by authorized representatives of the parties. MCJ shall not be in default by reason of any failure in performance of this Agreement or if such failure arises, directly or indirectly, out of causes reasonably beyond the direct control or foreseeability of MCJ, including but not limited to, default by subcontractors or suppliers, failure of Customer to provide promptly to MCJ accurate information and materials, as applicable, acts of God or of a public enemy, acts of terrorism, United States or foreign governmental acts in either a sovereign or contractual capacity, labor, fire, power outages, road icing or inclement conditions, flood, epidemic, restrictions, strikes, and/or freight embargoes.

(f) If any provision of this Agreement is held to be illegal, invalid, or unenforceable, that provision shall be severed or reformed to be enforceable, and the remaining provisions hereof and thereof shall remain in full force.

No delay or omission by MCJ in the exercise or enforcement of any of its powers or rights hereunder shall constitute a waiver of such power or right. A waiver by MCJ of any provision of this Agreement must be in writing and signed by such party, and shall not imply subsequent waiver of that or any other provision.

(g) Customer agrees that its payment and other obligations under this Agreement are absolute and unconditional and not subject to any abatement, reduction, setoff, defense, counterclaim, or recoupment due or alleged to be due as a result of any past or future claim that Customer may have against MCJ. Customer agrees that it will use its best efforts to cooperate with MCJ, and will execute and deliver any and all documents in addition to those expressly provided for herein that may be necessary or appropriate to afford MCJ the opportunity to adequately provide the Services.

(h) All notices under this Agreement shall be in writing and delivered by overnight delivery service or certified mail, return receipt requested. Notices delivered personally shall be deemed given upon documented receipt or refusal by recipient to accept receipt. Customer agrees that MCJ may publicly refer to Customer (both in writing and orally) as a client, and may identify Customer as a client, among other places, on its website, in press releases, and in sales materials and presentations.

MyCancerJourney, Inc.	VistaRiver of King County, LLC
Signature: DocuSigned by: Bobby Palmer	Signature: DocuSigned by: Geoff Schackmann
Name: Bobby Palmer	Name: Geoff Schackmann
Title: Owner	Title: Managing Member
Date: 12/1/2021	Date: 12/1/2021

Appendix 18: Alante Primary Care and Palliative PCP Services

ALANTÉ™

ELEVATING CARE

A HEALTHIER APPROACH TO HEALTHCARE

WHY US?

ALANTÉ specializes in preventive healthcare and managing the chronically ill. We blend physicians and nurse practitioners with technology to provide extensive and efficient care delivery services across the continuum utilizing rigorous systems and processes.

Our unparalleled expertise includes:

1. Comprehensive longitudinal care for the chronically ill.
2. Robust preventive wellness programs: AWVs, TCM, CPO, ACP, CCM, RPM, ABIs.
3. Medical home models lead by board certified nurse practitioners.
4. Nurse practitioner driven palliative care programs.
5. Hospice and home health care plan oversight and supervision
6. Closure of quality measure gaps.
7. Utilization management through reduction of avoidable ED, OBS, in-patient and return to acute (RTA) events.

WHAT WE DO

ALANTÉ contracts with physicians, hospice, home health, skilled nursing facilities, assisted living facilities, ACOs and Medicare Advantage plans to close the gap in preventive wellness and managing the chronically ill through infrastructure, processes and systems.

Our services are provided in the home or all living situations and we become the conduit for the long-term care plan for the patient across all healthcare services.

ALANTÉ integrates telehealth/telemedicine with in-person visits to promote patient engagement, efficient care, and un-paralled outcomes.

Services Include:

- Annual Wellness Visits (AWVs)
- Transitional Care Management (TCM)
- Chronic Care Management (CCM)
- Hospice and home health care plan oversight
- Remote Patient Monitoring (RPM)
- Palliative Care Program
- Preventive wellness care and services
- Closure of quality measure gaps
- Comprehensive Care Management Support of "High Cost/ High Need" Populations
- Acute/Episodic Preventive Visits
- Rapid response program for changes in condition
- 24/7 care coordination across "Medical Neighborhood" and immediate access to PCP 24/7

TRANSITION CARE MANAGEMENT

ALANTÉ's TCM in-home visits are essential to develop an appropriate care plan to support the transition to hospice for the patient after an inpatient hospital or skilled nursing episode.

Key Patient, Physician and Health Plan Benefits:

- All active social, phycological and physical needs impacting a persons' health are identify an appropriate hospice care plan for the patient while providing hospice education to patient, family and care giver to assist in the best transition to hospice
  - TCM visits are the most effective way to reduce return to acute (RTAs) for hospice patients
- Interventions developed to support the patients end-of-life wishes and patient goals

ALANTE™ A HEALTHIER APPROACH TO HEALTHCARE

ALANTÉ: HOSPICE CARE SERVICES

ALANTÉ works with the hospice multidisciplinary team to develop a comprehensive care plan for the patient. They also coordinate and review the patient status reports, labs, and other studies, necessary contact with other health care professionals involved in the patient care, and revision or continuation of the patient care plans for hospice team.

Services Include:

- Transitional Care Management (TCM)
- Hospice supervisory and care plan oversight
- Medication management and reconciliation
- Monthly review of patient status, labs and other studies
- Remote Patient Monitoring (RPM) if medically necessary
- Assistance in closure of quality measure gaps to enhance patient outcomes
- In-home visits by board-certified nurse practitioners
- Hospitalization intervention team for rapid response to prevent avoidable hospitalizations
- immediate access to PCP 24/7

ALANTÉ: PALLIATIVE CARE PROGRAM

ALANTÉ works with hospice to develop a comprehensive Palliative Care Programs focused on coordinating care for late-stage, chronically ill patients struggling with daily living and disease management. The programs enhance the quality of life of the patient through comprehensive symptom management program and patient education.

Services Include:

- Transitional Care Management (TCM)
- Coordinated care by a Board - Certified Nurse Practitioner delivered in the home Tailored care program based on patient needs and condition
- Communication and coordination with the patient's primary care practitioner and specialists
- Medication management and reconcilation
- Symptom management such as: pain, shortness of breath, fatigue, nausea/vomiting, loss of appetite and stress and anxiety
- Disease specific education
- Dedicated family and caregiver support
- Advanced care planning
- Social worker support
- Chronic care management
- Remote Patient Monitoring (RPM)
- Acute rapid response team to prevent avoidable hospitalizations
- 24/7 care coordination across "Medical Neighborhood" and immediate access to PCP 24/7

ALANTÉ: CHRONIC CARE MANAGEMENT FOR PALLIATIVE CARE PATIENTS

The Centers for Medicare & Medicaid Services (CMS) recognizes Chronic Care Management (CCM) as a critical component of primary care that contributes to better health and care for individuals.

ALANTÉ uses a team of specially trained care coordinators who engage with the patients, provider and family to ensure the medical, psychosocial, functional, and environmental determinants are included in a customized Care Plan.

Chronic Care Management uses a structured Care Plan and non-face-to-face services to ensure coordination and communication of care for eligible patients with two or more chronic conditions.

Chronic Care Management's primary focus is on chronic conditions, however acute conditions are taken into consideration in the development of the care plan.

The Care Plan is developed, monitored and modified based on the patient's specific health care needs, goals, and objectives for health and wellness.

Definitive goals are to assign one Practitioner and use a Care Team to oversee the plan of care, engage the patient in his or her healthcare, and prevent symptom exacerbation associated with the patient's chronic conditions.

ALANTÉ™ A HEALTHIER APPROACH TO HEALTHCARE

ALANTÉ™

C. Mark Hansen, CEO

HANSEN@SANTEPARTNERS.COM | HTTPS://ALANTEHEALTH.COM/

Appendix 19: Alante Primary Care and Palliative PCP Services Overview

Alante Primary Care and Palliative PCP Services
Washington Hospice CON Proposal
LuAnn Bright

Transitional Care	Palliative Care	Hospice Care
Transitional Care is provided as a bridge between acute hospitalizations and home for patients with chronic illnesses at high risk for readmission.	Palliative Care offers coordination of care to late-stage, chronically ill patients struggling with daily living and disease management to enhance the best quality of life through comprehensive symptom management program and patient education.	Hospice Care offers personalized care, comfort, and dignity to qualifying individuals by providing expert symptom management and assisting with the goals and options for end-of-life care. An individual is considered terminally ill if the medical prognosis is that the individual's life expectancy is 6 months or less if the illness runs its normal course.
Focus includes: 1. Preventing re-hospitalization 2. Medication Reconciliation 3. Symptom management 4. Identification of additional care needs during the transitional care phase 5. Evaluation of Social Determinants of Health 6. Recommendations and referrals for additional care support needs HH/PT/OT/SLT/DME 7. Chronic Care Management discussions and referral	Focus includes: 1. Coordinated care by a Board - Certified Nurse Practitioner delivered in the home 2. Communication and coordination with the patient's primary care practitioner and specialists 3. Medication management 4. Symptom management such as: a. Pain b. Shortness of breath c. Fatigue d. Nausea/vomiting e. Loss of appetite f. Stress and anxiety	Focus includes: 1. Hospice is a model of high-quality, compassionate care for people suffering from a life-limiting illness. 2. Expert medical care, pain and symptom management, and emotional and spiritual support tailored to the patient's needs and wishes 3. Hospice end-of-life care requires a highly skilled, interprofessional team that includes; a. clinicians b. Primary doctors c. Specialists' d. Nurse Practitioners e. Specialty trained nursing staff f. home health aids e. Social Workers

8. Transitional Care is typically provided for 30 days after discharge from the inpatient setting. 9. Telehealth/virtual visits available with a clinician.	5. Disease specific education 6. Dedicated family and caregiver support 7. Advanced Care Planning 8. Robust programs tailored to identify patient conditions and needs 9. Social worker support 10. Chronic Care Management may be offered concurrently 11. Remote Patient Monitoring 12. "24/7" PCP access	f. Pharmacists g. Chaplain/clergy h. Hospice Volunteers 4. The hospice Medical Director or the physician member of the hospice shall certify the individual as terminally ill 5. Medicare pays for attending physician services *provided by nurse practitioners* to Medicare beneficiaries who have elected the hospice benefit and who have selected a nurse practitioner as their attending provider 6. Support for family and caregiver with grief and bereavement even after they experience the loss of their loved one 7. Intensive NP care plan oversight to minimize re-hospitalization 8. Education for patient/family/caregiver on "what to expect" 9. Availability of Hospice Clinical Team "24/7"
		Quality Focus and Outcomes: 1. Promote the delivery of patient-centered, high quality, and safe care

Alante Primary Care and Palliative PCP Services
Washington Hospice CON Proposal
LuAnn Bright

		2. Compliance with The Hospice Quality Reporting Program (HQRP) by: * Hospice Item Set (HIS) *Consumer Assessment of Healthcare Providers and Systems® (CAHPS®) Hospice Survey. *Administrative Data (Medicare claims)
* The HQRP was established under section 1814(i)(5) of the Social Security Act. The HQRP includes data submitted by hospices through the Hospice Item Set (HIS) data collection tool, data from Medicare hospice claims, and an experience of care survey, the Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey. All Medicare-certified hospice providers must comply with both of these reporting requirements. The HQRP is currently "pay-for-reporting," meaning it is the timely submission and acceptance of complete data that determines compliance with HQRP requirements. Performance level is not a consideration when determining market basket updates (referred to as Annual Payment Updates (APU)). Reporting compliance is determined by successfully fulfilling both the CAHPS® Hospice Survey requirements and the HIS data submission requirements.		

Focus includes: 10. Preventing re-hospitalization 11. Medication Reconciliation 12. Symptom management 13. Identification of additional care needs during the transitional care phase 14. Evaluation of Social Determinants of Health	Focus includes: 13. Coordinated care by a Board - Certified Nurse Practitioner delivered in the home 14. Communication and coordination with the patient's primary care practitioner and specialists 15. Medication management 16. Symptom management such as:	Focus includes: 10. Hospice is a model of high-quality, compassionate care for people suffering from a life-limiting illness. 11. Expert medical care, pain and symptom management, and emotional and spiritual support tailored to the patient's needs and wishes 12. Hospice end-of-life care requires a highly skilled,

Alante Primary Care and Palliative PCP Services
Washington Hospice CON Proposal
LuAnn Bright

15. Recommendations and referrals for additional care support needs HH/PT/OT/SLT/DME 16. Chronic Care Management discussions and referral 17. Transitional Care is typically provided for 30 days after discharge from the inpatient setting. 18. Telehealth/virtual visits available with a clinician.	g. Pain h. Shortness of breath i. Fatigue j. Nausea/vomiting k. Loss of appetite l. Stress and anxiety 17. Disease specific education 18. Dedicated family and caregiver support 19. Advanced Care Planning 20. Robust programs tailored to identify patient conditions and needs 21. Social worker support 22. Chronic Care Management may be offered concurrently 23. Remote Patient Monitoring 24. "24/7" telephone support	interprofessional team that includes; a. clinicians b. Primary doctors c. Specialists' d. Nurse Practitioners e. Specialty trained nursing staff f. home health aids e. Social Workers f. Pharmacists g. Chaplain/clergy h. Hospice Volunteers 13. The hospice Medical Director or the physician member of the hospice shall certify the individual as terminally ill 14. Medicare pays for attending physician services *provided by nurse practitioners* to Medicare beneficiaries who have elected the hospice benefit and who have selected a nurse practitioner as their attending provider 15. Support for family and caregiver with grief and bereavement even after they experience the loss of their loved one 16. Intensive NP care plan oversight to minimize re-hospitalization 17. Education for patient/family/caregiver on "what to expect"

		18. Availability of Hospice Clinical Team "24/7"

Appendix 20: Alante Professional Service Agreement

Draft Agreement for Discussion Purposes

Professional Physician Services Agreement

This Professional Services Agreement for Clinical Services (this "Agreement") is made and entered into as of the signature dates set forth below, to be effective as of _____, 2022 (the "Effective Date"), between ALANTÉ PRIMARY CARE AND PALLIATIVE CARE, LLC, an Washington limited liability company, ("Alanté PC") and VISTA RIVER OF KING COUNTY, LLC, a Washington limited liability company ("Vista River Hospice").

1. Purpose of Agreement. Alanté PC operates as a provider of subcontracted clinical staff who provide services under the supervision of physicians and other qualified healthcare professionals for value-based healthcare programs offered by Medicare, Medicaid, other federal and state healthcare programs, and private health insurance plans and employs nurse practitioners ("NP") who are licensed under laws of the State of Washington. Vista River owns and operates a hospice agency within the State of Washington, which is duly licensed by the Washington Department of Health Services to provide interdisciplinary care and support to terminally ill patients. Hospice care is primarily for palliative rather than curative.

The parties wish to contract for Alanté PC's provision of NP's professional services.

2. Other Agreements. Alanté PC represents that, to the best of its knowledge: (a) neither it nor its NP will breach any other agreement with a third party by entering into this Agreement with Alanté PC; and (b) neither it nor its NP is a party to any other agreement with a third party that will affect its or their ability to perform the duties and responsibilities under this Agreement.

3. Alanté PC's Responsibilities. Alanté PC shall have the following responsibilities under this Agreement:

(a) Services. Alanté PC, through their employed NPs, shall provide professional services (the "Services") pursuant to the schedule agreed upon by Alanté PC and Vista River Hospice as described in **Attachment A**.

(b) Professional Conduct. The NP shall (i) practice in accordance with applicable standards of professional conduct for a Registered Nurse Practitioner in the State of Washington, (ii) conduct herself or himself ethically and shall act to advance the best interest and reputation of Vista River Hospice, (iii) at all times, conduct herself or himself in a professional and appropriate manner in dealing with staff and patients of Vista River Hospice, and (iv) demonstrate active support for Vista River Hospice's mission, vision, and values including, without limitation, the provision of excellent patient care.

(c) Billing for the Professional Component of the Services. All fees and income earned by the NP for the Services shall constitute the income of Alanté PC, and Alanté PC shall be responsible for billing and collecting for such Services. Alanté PC shall be the owner of any and all collections and accounts receivable arising from such fees and income, and Vista River Hospice shall have no ownership interest therein.

(d) Medical Staff and Panel Membership. The NP shall obtain and maintain privileges on Vista River Hospice's Medical Staff and such other medical staffs and managed care panels as Vista River Hospice may from time to time reasonably require in its discretion.

(e) Licensure. The NP providing the Services shall at all times be licensed to practice medicine in the State of Washington with no restrictions on that license which materially affect her or his ability to perform the Services.

(f) Medicare and Medicaid Programs. Alanté PC and its NP shall be participating providers under the federally funded health care programs served by Vista River Hospice, including the Medicare, Medicaid, TRICARE, Veteran's Administration, and CHP+ programs. Neither Alanté PC nor its NP shall have been suspended or excluded by, or have had civil monetary penalties or other sanctions imposed upon them through, those programs. Alanté PC hereby agrees to immediately notify Vista River Hospice of any threatened, proposed, or actual sanction or exclusion from any federally funded health care program against Alanté PC or its NP.

(g) Nondiscrimination. Consistent with Vista River Hospice's charitable and nonprofit objectives, as well as to ensure compliance with all federal and state laws and regulations, the NP shall see and treat patients regardless of their ability or inability to pay for services on the same basis as all other similarly situated patients of Vista River Hospice. Further, the NP shall not illegally discriminate in performing the Services on the basis of race, color, national origin, religion, ancestry, gender, sexual orientation, marital status, age, disability, physical or mental disability, health status, medical diagnosis, insurance coverage, utilization of medical or mental health services or supplies, payor status, or on any other basis prohibited by applicable law.

(h) Record Keeping. The NP shall maintain, on a timely basis as may reasonably be required by Vista River Hospice, legible, accurate, and complete records of all medical services performed by her or him. Alanté PC agrees that medical records of patients shall be treated as confidential so as to comply with all applicable federal and state laws and regulations regarding the confidentiality of such medical records. Alanté PC and its NP also shall comply with all Vista River Hospice's policies and requirements related to the preparation, control, and maintenance of such medical records and reports.

(i) Professional Liability Insurance. At its expense, Alanté PC shall obtain and maintain for the term of this Agreement professional liability insurance general liability insurance in such amounts and under such terms as may be required by applicable laws.

(j) Peer Review / Quality Improvement. Alanté PC shall ensure that its NP shall comply and cooperate with reasonable programs and requirements for peer review, quality improvement, and utilization review that Vista River Hospice may reasonably require during the term of this Agreement.

(k) Cooperation with Vista River Hospice's Billing. The NP shall provide Vista River Hospice's designated personnel with adequate information in a timely manner to allow Vista River Hospice to bill for all services associated with the Services, as necessary. The NP shall sign all accurate forms and reasonable substantiation required for Vista River Hospice's submission of its bills to third party payors.

(l) Confidential Information. During and after the term of this Agreement, Alanté PC and its NP shall keep secret and retain in strictest confidence, and shall not use for the benefit of themselves or others, except in their performance of this Agreement, all confidential matters and trade secrets known to it relating to the business and operation of Vista River Hospice, including, without limitation, patient lists, pricing policies, operational methods, marketing plans or strategies, product development techniques or plans, business acquisition plans, new personnel acquisition plans, and other business affairs relating to the business and operations of Vista River

Hospice, and shall not disclose them to anyone outside of Vista River Hospice and its affiliates except: (i) as required by court order or process, provided that Vista River Hospice shall have been afforded reasonable opportunity to contest such order or process; (ii) to the extent such information is already in the public domain other than through wrongful disclosure by them; or (iii) upon the express prior written consent of Vista River Hospice.

(m) Compliance with Laws, Rules, Regulations, and Standards. Alanté PC and its NP shall comply with all laws, rules, regulations and standards applicable to the Services provided hereunder, including, but not limited to: (i) the laws, rules, regulations and standards of any local, county, state, or federal governmental agency, or any other person having authority to administer, regulate, accredit, or otherwise set standards for Alanté PC, its NP, or Vista River Hospice; and (ii) third party payors.

(n) Notice of Acts and Omissions. Alanté PC shall immediately notify Vista River Hospice of any known acts or omissions by the NP, alleged or actual, which could result in claims of legal liability, whether justified or unjustified. Alanté PC also shall promptly notify Vista River Hospice of: (i) any disciplinary proceedings that may be filed involving any of its NP providing the Services; and (ii) any malpractice actions filed against its NP providing the Services.

(o) Required Referrals of Vista River Hospice Patients. While providing the Services under this Agreement, Alanté PC and its NP shall refer all Vista River Hospice patients who require medically necessary services, as well as all patients of Vista River Hospice who request services, to the particular providers, practitioners, or suppliers designated by Vista River Hospice, unless: (i) the patient expresses a preference for a different provider, practitioner, or supplier; (ii) the patient's insurer designates another provider, practitioner, or supplier; or (iii) the referral is not in the patient's best medical interests in the NP's professional judgment. Except as set forth in the preceding sentence, this Agreement does not create any obligation or requirement that Vista River Hospice refer patients to the NP or that Alanté PC or its NP refer patients to Vista River Hospice or to any health care facility affiliated with Vista River Hospice.

4. Vista River Hospice Responsibilities. Vista River Hospice shall have the following responsibilities under this Agreement:

(a) Facilities. Vista River Hospice shall allow access to the facilities and personnel reasonably necessary for Alanté PC's and its NP's provision of the Services.

(b) Professional Liability Insurance. At its expense, Vista River Hospice shall obtain and maintain for the term of this Agreement professional liability insurance and comprehensive general liability insurance in such commercially reasonable amounts and under such terms as may be required by applicable laws.

5. Term. The term of this Agreement shall begin on the Effective Date and shall continue for a period of one year ("Initial Term") and then automatically renew for additional one year terms ("Renewal Term"), unless earlier terminated as provided below.

6. Termination. This Agreement may be terminated:

(a) By either Alanté PC or Vista River Hospice, with or without cause, for any reason or for no reason, upon 60 days' written notice to the other party;

(b) By either Alanté PC or Vista River Hospice, for cause, in the event of a material breach by the other party of its obligations hereunder that has not been cured following 10 days' notice (which period may be extended by the non-breaching party without waiving the material breach); or

(c) By mutual consent of Alanté PC and Vista River Hospice at any time.

7. Liability for Own Acts. The parties intend that each party shall be separately responsible for his/her/its own acts, omissions, and liabilities.

8. Independent Contractor Status. The NP shall not be eligible to participate in Vista River Hospice's benefits plans such as health, dental, and disability insurance or any other benefits which Vista River Hospice, in its sole discretion, may offer to employees from time to time. Alanté PC shall be an independent contractor of Vista River Hospice for all purposes stated herein and contemplated by the parties to this Agreement. ALANTÉ PC'S NP IS NOT ENTITLED TO WORKERS COMPENSATION BENEFITS, AND ALANTÉ PC AND ITS NP ARE OBLIGATED TO PAY ALL FEDERAL AND STATE INCOME TAX ON ANY MONEYS EARNED BY THEM PURSUANT TO THIS AGREEMENT. ALANTÉ PC SHALL INDEMNIFY AND HOLD VISTA RIVER HOSPICE HARMLESS FROM ALL TAXES, INTEREST, AND PENALTIES OWED BY ALANTÉ PC AND/OR ITS NP AS A RESULT OF THEIR FAILURE TO TIMELY WITHHOLD OR PAY ANY SUCH TAXES.

9. Notices. Any notices required or permitted to be given under this Agreement shall be in writing and shall be deemed to be given upon personal delivery or upon being sent by certified U.S. mail, postage prepaid, return receipt requested, and addressed as follows or to such other address as a party may designate in writing:

If to Vista River Hospice: 29100 SW Town Center Loop W Suite 130
Wilsonville, OR 97070
Attn: Geoff Schackmann, Managing Member

If to Alanté PC: 8502 E. Princess Drive, Suite 200
Scottsdale, AZ 85255
Attn: Shelley Christiansen, Corporate Paralegal

10. Dispute Resolution. Any dispute concerning this Agreement shall be subject to mandatory, binding arbitration before any private dispute resolution/arbitration group upon which the parties agree, with the parties using their best efforts to complete such arbitration as quickly as is reasonably practical. If the parties are unable to agree on such an arbitration group, the arbitration shall be conducted through the American Health Lawyers Association in compliance with its Rules of Arbitration. The cost of arbitration shall be shared equally by the parties. The Arbiter shall have the power, within his/her discretion, to equitably award attorney fees, expert witness fees, and other costs to the substantially prevailing party. The Arbiter has no authority to award punitive damages or other damages not measured by the prevailing party's actual damages, and may not, in any event, make any ruling, finding or award that does not conform to the provisions of this Agreement.

11. Access to Books, Documents, and Records by the U.S. Department of Health and Human Services. The following clause is included because of the possible application of Section 1861(v)(1)(I) of the Social Security Act to this Agreement. But if that section should be found inapplicable to this Agreement, then this clause shall be deemed not to be a part of this Agreement and shall be null and void. Until the expiration of four years after the furnishing of services under this agreement, the parties shall make available, upon written request, to the Secretary of the Department of Health and Human Services or to the Comptroller General, or any of their duly authorized representatives, this Agreement and books, documents, and records of the parties as are necessary to certify the nature and extent of the costs hereunder.

12. Future Legislation and Interpretations. The parties to this Agreement are of the opinion that all of the terms of this Agreement comply with present law; however, the parties are mindful of continuous discussions regarding possible healthcare legislation at the federal and state levels. Furthermore, the parties are aware that federal and state regulations are subject to periodic interpretations and court decisions that could affect this Agreement. In the event of future legislation, court decision, governmental regulation, policy, or governmental interpretation thereof that applies to this Agreement and prohibits or invalidates any of its provisions, or causes Vista River Hospice or Alanté PC not to qualify under or otherwise be in violation of any Medicare or Medicaid reimbursement regulations, or other laws, then the parties shall either forthwith cause to be made to this Agreement such amendments as may reasonably be required to bring its terms back into compliance with the law or, in the alternative, terminate this Agreement.

13. Miscellaneous.

(a) This Agreement contains the entire agreement of the parties and supersedes all prior agreements, oral or written, between the parties with respect to the subject matter hereof. There are no understandings, representations, or side agreements, oral, written, or implied, among the parties other than those set forth in this Agreement.

(b) Waiver by a party of a breach of provision of this Agreement by the other party shall not operate or be construed as a waiver of any subsequent breach by the other party. No extension of time for performance of any obligations or acts shall be deemed an extension of the time for performance of any other obligations or acts.

(c) This Agreement is for personal services and may not be assigned, in whole or in part, by Alanté PC without the prior written consent of Vista River Hospice. Any such assignment or delegation without such consent shall be null and void and shall constitute a material breach of this Agreement.

(d) This Agreement shall inure to the benefit of, and be binding upon, the successors and assigns of Vista River Hospice and Alanté PC.

(e) Alanté PC acknowledges that it has been advised to obtain and has ample opportunity to consult with legal counsel and other advisers of its choosing concerning this Agreement.

(f) Alanté PC agrees not to disclose the terms of this Agreement to third parties except to its shareholders, officers, employees, financial advisors, accountants, and attorneys.

(g) This Agreement may not be amended except in writing signed by both parties.

(h) This Agreement shall be construed and interpreted under the laws of the State of Washington.

(i) If any provision of this Agreement is held to be invalid or unenforceable by a court of competent jurisdiction, such invalidity or un-enforceability shall not affect the enforceability of the remainder of this Agreement.

(j) Any covenant or provision herein that requires or might require performance after the termination or expiration of this Agreement, including, but not limited to, payment, confidentiality, and records access, shall survive any termination or expiration of this Agreement.

(k) This Agreement may be executed in one or more copies or counterparts, each of which when signed shall be an original, but all of which together shall constitute one instrument.

VISTA RIVER HOSPICE:

Geoff Schackmann, Managing Member

Date: 12/29/2021

ALANTÉ PC:

_____

[NAME AND TITLE]

Date: _____

Attachment A
Schedule and Services

Schedule. The NPs shall provide the Services at a schedule agreed to jointly by Alanté PC and Vista River Hospice.

Hospice Services. Alanté PC works with the hospice multidisciplinary team to develop a comprehensive care plan for the patient and to provide Care Plan Oversight (CPO) for those patients that require complex and multidisciplinary care modalities They also coordinate and review the patient status reports, labs, and other studies, and make necessary contact with other health care professionals involved in the patient care, and make recommendations for revisions or continuation of the patient care plans for hospice team.

Under the supervision of the Chief Clinical Officer, the Nurse Practitioner (NP) is responsible for providing an extensive range of services that may include, but is not limited to the following:

- Transitional Care Management (TCM)
- Hospice supervisory services
- Medication management and reconciliation
- Monthly review of patient status, labs and other studies, if applicable
- Remote Patient Monitoring (RPM) if medically necessary
- Assistance in closure of quality measure gaps to enhance patient outcomes
- In-home visits by board-certified nurse practitioners
- Hospitalization intervention team for rapid response to prevent avoidable hospitalizations
- Immediate access to PCP 24/7

Palliative Care Services. Alanté PC works with hospice to develop a comprehensive Palliative Care Program owned and administered by Alanté PC focused on coordinating care for late-stage, chronically ill patients struggling with daily living and disease management. The program is designed to enhance the quality of life of the patient through comprehensive symptom management and patient /Family education.

Under the supervision of the Chief Clinical Officer, the Nurse Practitioner (NP) is responsible for providing an extensive range of services that includes, but is not limited to the following:

- Transitional Care Management (TCM)
- Coordinated care by a Board - Certified Nurse Practitioner delivered in the home tailored care program based on patient needs and condition
- Communication and coordination with the patient's primary care practitioner and specialists
- Medication management and reconciliation
- Symptom management such as: pain, shortness of breath, fatigue, nausea/vomiting, loss of appetite, stress and anxiety
- Disease specific education
- Dedicated family and caregiver support

- Advanced care planning
- Social worker support
- Chronic Care Management (CCM)
- Remote Patient Monitoring (RPM)
- Acute rapid response team to prevent avoidable hospitalizations
- 24/7 care coordination across "Medical Neighborhood" and immediate access to PCP 24/7

- The NP must adhere to the Scope of Practice requirements for the state in which they practice as an Advanced Practice Registered Nurse as outlined by applicable state law, licensing, and regulations.

All Services shall be performed in accordance with:

- Applicable federal, state, and local laws and regulations;

- Guidelines and conditions for certification by and participation in public and other third party payor programs providing reimbursement for patient care delivered at the Vista River Hospice; and

- Standards of (a) licensing and accreditation agencies to which Vista River Hospice's operations are accountable or to whose evaluation Vista River Hospice voluntarily submits and (b) the medical community in Vista River Hospice's service area.

Appendix 21: Employee Benefits Guide 2020-2021

VISTARIVER HOSPICE

ALANTÉ™

SANTÉ®

encore communities

clearbrook inn | the ridge | laurel cove
country meadows | northwoods lodge

aleca

2021 - 2022 EMPLOYEE BENEFITS INFORMATION GUIDE

MEDICAL | RX | DENTAL | VISION | LIFE / AD&D | DISABILITY | EAP | FSA | AFLAC | 401K

TABLE OF CONTENTS | 2021 - 2022

We encourage you to read the entire Information guide before you enroll

This is a summary of your benefits only. Certain restrictions and exclusions apply. For exact terms and conditions, please refer to your Summary Plan Description (SPD) or Certificate of Coverage. If information in this summary differs from the legal contract, the legal contract is the ruling document. SPDs or Certificates of Coverage are available from Payroll/Benefits.

Welcome to your 2021 - 2022 Employee Benefits Information Guide for the November 1st, 2021 – October 31st, 2022 Plan Year.

Dear Associates:

We are pleased to offer you a robust selection of benefit options for the 2021-2022 plan year. Our comprehensive benefits package provides an opportunity to enhance your retirement savings, as well as provide an important safety net for you and your family if health-related needs arise.

Please take a moment to review the summary of benefits outlined in this booklet to assist you if selecting the appropriate benefits for you and your family.

Thank you for your continued contribution and commitment to our mission, for the good of our communities, and those we serve.

If you have any questions, please contact your Human Resources Coordinator.

Sincerely,

Human Resources

VISTARIVER HOSPICE

ALANTÉ™ SANTÉ® encore communities clearbrook inn | the ridge | laurel cove country meadows | northwoods lodge aleca

This Guide provides highlights of the benefit plans offered to you by **Santé Operations**, and in no way serves as the actual plan description or plan document. Certain restrictions and exclusions apply. For exact terms and conditions, please refer to the Plan Document, Contract or the Summary of Benefits & Coverage (SBC). The plan documents will always govern the benefits that **Santé Operations** provides for you. **Santé Operations** reserves the right to modify any or all of these plans at any time. Please see Human Resources for more information.

The information provided in this Guide is advisory, and is provided for general informational purposes only. This information should not be considered legal or tax advice or legal or tax opinion on any specific facts or circumstances. Readers and participants are urged to consult their legal counsel and tax advisor concerning any legal or tax questions that may arise.

Hays

Below is the contact information and resources for the benefit plans offered.

For questions about benefits/coverage, ID cards, claims and participating providers, please reach out to the applicable insurance company:

MEDICAL, RX & DENTAL
Aetna-Allied
Group # A19183
www.alliedbenefit.com
800.288.2078

FLEXIBLE SPENDING ACCOUNT (FSA)
HealthEquity
www.healthequity.com
866.382.3510

VISION
Vision Service Plan
Group # TBD
www.vsp.com
800.877.7195

GROUP LIFE, VOLUNTARY LIFE, VOLUNTARY SHORT TERM DISABILITY & LONG TERM DISABILITY
Mutual of Omaha
Group # G000BM4F
www.mutualofomaha.com
800.877.5173

EMPLOYEE ASSISTANCE PROGRAM (EAP AND GRIEF SUPPORT)
Mutual of Omaha
Group # G000BM4F
www.mutualofomaha.com/eap
800.316.2796

ACCIDENT, CRITICAL ILLNESS & HOSPITAL INDEMNITY PLAN
Aflac
Group # 23635
www.aflacgroupinsurance.com
800.433.3036

RETIREMENT 401(K)
Foster & Wood
www.fosterandwood.com
Advisors: Tim Wood or Dave Foster
971-266-3134

For questions about the available benefits plans, escalated claims assistance and general employee benefits guidance, please contact our Employee Benefits Consultants, Hays Companies:

Drew Butler – Employee Benefits Service
dbutler@hayscompanies.com
206.902.1901

Hays
All. Together. Certain.

BENEFIT ELIGIBILITY

All regular, full-time employees who work a minimum of 30 hours or more per week are eligible for insurance benefits on the first of the month after completing 60 days of employment. Dependents eligible for coverage include your spouse and any of your children up to age 26. You can enroll in benefits during your waiting period (the first 60 days of employment), during open enrollment, and within 30 days of a qualifying event.

IF YOUR NEEDS CHANGE

The decisions you make with regard to your health care benefits, life, and disability coverage remain in effect throughout the year. However, as events occur in your life, your benefits needs may also change. If you experience a "life event" you can make certain changes to these benefits. The chart below lists the instances in which you can change these benefits, and the specific IRS-defined qualifying change in status. Some benefits may have more stringent restrictions regarding changes. Contact the benefits office for specific plan information.

Important Note: You only have 30 days from the date of the life event to make a change. Changes will require you to provide appropriate documention as applicable (e.g. birth certificate, marriage license, divorce papers, etc). To make changes, please log in to your Paychex system.

SITUATION	APPLICABLE QUALIFYING CHANGE IN STATUS
ADDING A DEPEDENT	• Marriage. • Birth or adoption of a child. • Receipt of a qualified medical child support order requiring that coverage for a dependent child is provided.
REMOVING A DEPENDENT	• Divorce (including annulment). • Death of a Spouse or Child. • A dependent child reaching max age of coverage.
CHANGE IN HEALTH CARE COVERAGE	• You or your spouse or dependent child becomes entitled to Medicare, Medicaid. • A change in employment status (yours or your spouse's) that results in a loss or (gain) of coverage. • You, your spouse or dependent child become eligible for other health care coverage. • A significant change in contributions under your spouse's employer's plan as defined by the plan administrator. • A change in benefit elections by your spouse during his or her employer's annual open enrollment (held at a different time other than Santé's open enrollment).
OTHER EVENTS	• A change in your dependent care situation (applies to Dependent Care FSA only) • Moving , which results in you no longer living in an area where your elected medical plan is available • A dependent moving to the U.S. from another country

MEDICAL BENEFITS: Aetna-Allied

The Company offers employees a choice of two medical benefit options through Allied. The plans are available nationwide to all employees living within the United States. Both medical plans have the same excellent network of providers. When in-network providers are used, out-of-pocket expenses are lower and no claim forms are required. Members may also choose to go outside of the provider network for health care services. Members choosing out-of-network benefits will have reduced benefits and higher out-of-pocket expenses.

HELPFUL HIGHLIGHTS

Member Resources

Visit Member Resources to explore coverage and provider information even before your plan is active. Find tips and tools to help you choose a doctor, manage your costs, know your care options and more. Get started at www.alliedbenefit.com. *Please remember, when your provider is confirming your eligibility, they will need to contact Allied and not Aetna.*

Finding a Medical Provider in our Aetna PPO Network

Step 1: Visit www.alliedbenefit.com

Step 2: Click on connect in the PPO section to enter the Aetna search tool.

Step 3: Start with the zip code or city and state where you would like to search. Then click Search.

Step 4: Type or click the type of provider you would like to use.

Step 5: Narrow your search by selecting the provider type.

Step 6: Browse through the search results to obtain more information on the provider matches.

MEDICAL DEFINITIONS

The following terms are defined to help you understand your medical benefits summaries:

Deductible: The annual deductible must be paid in full before coinsurance is applied in some instances. Copays do not apply toward the deductible.

Coinsurance: After the deductible has been satisfied, the plan will pay according to the coinsurance level shown and according to the benefits for in and out-of-network coverage. Coinsurance (sharing of costs between the insurance carrier and member) will continue to apply until a member has reached the coinsurance maximum for the health plan.

Coinsurance Maximum: In-network, this is the maximum amount a member will have to pay under the health plan, excluding the deductible and copays. For the out-of-network benefits, the member is also responsible for those charges above usual, customary and reasonable charges.

Out-of-pocket Limit: The most you could pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit, the plan will usually pay 100 percent of the allowed amount. The out-of-pocket limit includes all of your network payments.

Preventive Care: Routine health care, including screenings, checkups and patient counseling to prevent or discover illness, disease or other health problems.

Formulary: Each insurance carrier has developed a formulary, which is a list of quality, generic and brand medications included in their prescription drug program. Each formulary drug is reviewed for safety, effectiveness, quality, and is based on the Food and Drug Administration (FDA) guidelines.

Internet Access: You have access to Allied's website 24 hrs a day, seven days a week at www.alliedbenefit.com.

Customer Service: Contact toll free at 866-455-8727

MEDICAL BENEFITS: Aetna-Allied

	AETNA-ALLIED MEDICAL PPO 5000		AETNA-ALLIED MEDICAL PPO 2000	
	In-Network	Non-Network	In-Network	Non-Network
Coinsurance				
After Deductible	Allied pays 80% You pay 20%	Allied pays 50% You pay 50%	Allied pays 80% You pay 20%	Allied pays 50% You pay 50%
Annual Deductible (per calendar year)				
Individual	$5,000	$6,000	$2,000	$4,000
Family	$10,000	$12,000	$4,000	$8,000
Out of Pocket Maximum (Includes deductible and coinsurance)				
Individual	$8,000	$14,000	$7,000	$12,000
Family	$16,000	$28,000	$14,000	$24,000
Office Visit				
Preventive Services	100% coverage	Deductible, 50%	100% coverage	Deductible, 50%
Primary Care Office Visit	$20 copay	Deductible, 50%	$20 copay	Deductible, 50%
Specialty Office Visit	$35 copay	Deductible, 50%	$35 copay	Deductible, 50%
Inpatient Hospitalization	Deductible and 20%	Deductible, 50%	Deductible and 20%	Deductible, 50%
Outpatient Hospitalization	Deductible and 20%	Deductible, 50%	Deductible and 20%	Deductible, 50%
Virtual Office Visit	$0	Deductible, 50%	$0	Deductible, 50%
Hospital Services				
Urgent Care	$75 copay	Deductible, 50%	$75 copay	Deductible, 50%
Emergency Room Visit	$400 copay	$400 copay	$400 copay	$400 copay
Labs & Imaging Tests (e.g., X-rays)	Deductible and 20%	Deductible, 50%	Deductible and 20%	Deductible, 50%
Major Diagnostic Services (MRI, CT, PET, etc.)	Deductible and 20%	Deductible, 50%	Deductible and 20%	Deductible, 50%
Prescription Drugs				
Tier 1	$5 Copay	Not Covered	$5 Copay	Not Covered
Tier 2	$35 Copay		$35 Copay	
Tier 3	$60 Copay		$60 Copay	
Tier 4	$100 Copay		$100 Copay	
Maximum Lifetime	Unlimited		Unlimited	

DENTAL BENEFITS: Aetna-Allied

Santé offers employees dental coverage through the Aetna PPO Network. There are two plans available. The PPO Low Plan only covers services obtained through In-Network Providers. The PPO High Plan covers services through In-Network and Non-Network Providers. When in-network providers are used, out-of-pocket expenses are lower and no claim forms are required.

	PPO LOW PLAN (IN-NETWORK ONLY PLAN)	PPO HIGH PLAN (IN-NETWORK BENEFITS)
Annual Benefit Maximum	$1,000	$1,250
Annual Deductible (Per Calendar Year)	Individual: $75 Family: $225 (Waived for Preventive Care)	Individual: $50 Family: $150 (Waived for Preventive Care)
Preventive Care (Basic Cleanings / Exams) 2 Per Year	100%	100%
Basic Care (Restorations / General Services / Simple Extractions / Periodontics / Endodontics)	80%	80%
Major Care (Inlays / Onlays / Crowns / Implants / Dentures)	50%	50%
Orthodontia Lifetime Maximum (Child Only)	Not Covered	$1,000
Orthodontic Care (Child Only)	Not Covered	50%

Finding a Dental Provider in our Aetna PPO Network

-Step 1: Visit www.alliedbenefit.com

Step 2: Click on connect in the Dental section to enter the Aetna search tool.

Step 3: Star with the zip code or city and state where you would like to search. Then click Search.

Step 4: Click on Dental Care or type in search bar.

Step 5: Narrow your search by selecting the provider type.

Step 6: Browse through the search results to obtain more information on the provider matches.

VISION BENEFITS: Vision Service Plan

Vision insurance is provided through Vision Service Plan. The VSP Choice Plan is a full-service plan that offers choice, flexibility, and maximum value through a VSP Network Provider.

	BENEFIT	FREQUENCY
Exam	$10 Copay	One exam every 12 months
Prescription Glasses - Frames	• $170 featured frame brands allowance • $150 frame allowance • 20% savings on amount over allowance • $150 Walmart / Sam's Club frame allowance • $80 Costco frame allowance	One set every 12 months
Prescription Glasses - Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Impact- resistant lenses for dependent children	One set every 12 months
Contacts (Instead of Glasses)	• $150 allowance for contacts; copay does not apply • Up to $60 copay for contact lens exam (fitting & evaluation)	Once every 12 months
Primary Eyecare	• $0 copay for retinal screening for members with diabetes • $20 copay per exam for additional exams & services for members with diabetes, glaucoma, or age-related macular degeneration • Treatment & diagnosis of eye conditions, including pink eye, vision loss, and cataracts • Limitations & coordination with your medical coverage may apply.	As needed
Lightcare	• $150 allowance for ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses, instead of prescription glasses or contacts; $25 copay	One set every 12 months

EXTRA SAVINGS:

- Glasses & Sunglasses
  - Extra $20 to spend on featured frame brands. Go to vsp.com/offers for details.
  - 20% savings on additional glasses & sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.
- Routine Retinal Screening
  - No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam.
- Laser Vision Correction
  - Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.

GROUP TERM LIFE: Mutual of Omaha

Each regular full-time employee working at least 30 hours per week has a 100% company paid term life and AD&D policies through Mutual of Omaha. This chart provides you a brief summary of the key benefits of the life coverage available.

LIFE BENEFITS	
BENEFIT AMOUNT	$10,000
AGE REDUCTIONS	35% benefit reduction at age 65, with an additional 15% reduction at age 70. Age reductions apply to the benefit amount after proof of good health.
DURING DISABILITY	If you become disabled before age 60, coverage will continue and premium may be waived.
ACCELERATED BENEFIT	If you are terminally ill, you may be able to receive a portion of your life coverage benefit as a lump sum.
CONVERSION	If you terminate employment, you may be able to convert coverage to an individual policy.

VOLUNTARY TERM LIFE: Mutual of Omaha

All active, full-time employees who work at least 30 hours per week have the option to elect additional life and AD&D insurance for themselves, their spouse and children. The rates for the benefits you elect for yourself and your spouse are based on your age or spouse's age and benefit amount. You have the option to convert or port your life coverage if your employment ends. **NEW HIRES:** As a new employee of Santé, you are eligible and have a one time opportunity to purchase life insurance up to the Guaranteed Issue amount without any medical questions. If you do not elect coverage at this time, you will be able to purchase life insurance during the next open enrollment but will be subject to evidence of insurability (a medical questionnaire).

BENEFITS	EMPLOYEE	SPOUSE	CHILD(REN)
BENEFIT AMOUNT	You may choose to purchase benefits in increments of $10,000 up to lesser of 5x salary or $500,000	You may choose to purchase benefits in increments of $5,000 up to a maximum of $100,000 not to exceed 50% of employee amount	For eligible children 14 days or older, you may choose to up to $10,000
MINIMUM	$10,000	$5,000	$2,000
GUARANTEED ISSUE	$200,000	$40,000	$10,000
MAXIMUM	$500,000	100% of Employee amount up to $100,000	$10,000
AGE REDUCTIONS	50% benefit reduction at age 70		Not Applicable

VOLUNTARY SHORT TERM DISABILITY: Mutual of Omaha

Short-term disability coverage is through Mutual of Omaha and is an employee-paid voluntary product. Premiums are based on employee age and amount of coverage. Short-Term Disability provides active full-time employees, working at least 30 hours per week, with weekly short-term disability (STD) benefit payments if they are unable to work because of a covered non- occupational accident or sickness.

BENEFITS	
WEEKLY BENEFIT	60% of your predisability earnings up to $1,500
BENEFIT AMOUNT	Primary Weekly Benefit less other income sources
DEFINITION OF EARNINGS	Earnings Prior to Disability, Annual Salary
ELIMINATION PERIOD	Benefits begin on the 8th day for accident and 8th day for sickness
BENEFIT PAYMENT PERIOD	Up to 25 weeks
PRE-EXISTING CONDITIONS	3/6 pre-existing condition limitations

LONG-TERM DISABILITY INSURANCE (LTD): Mutual of Omaha

Long-term disability coverage is through Mutual of Omaha and is an employer-paid product. LTD provides additional income security to all active full-time employees who are unable to work because of an extended illness or disability.

BENEFITS	
MONTHLY BENEFIT	60% of your predisability earnings up to $6,000
BENEFIT AMOUNT	Primary monthly benefit less other income sources
DEFINITION OF EARNINGS	Earnings Prior to Disability, Annual Salary
ELIMINATION PERIOD	180 Days
OWN OCCUPATION PERIOD	2 Years
MAXIMUM BENEFIT PAYMENT PERIOD	To Social Security Normal Retirement Age
PRE-EXISTING CONDITION	3/12 pre-existing condition limitations

GROUP ACCIDENT POLICY: Aflac

Group Accident coverage is a simple way to add extra protection for unexpected costs due to an accident/injury. It can complement existing medical coverage and help narrow gaps in coverage caused by out-of- pocket expenses such as deductibles, co-payments, and non-covered medical services.

BENEFITS:

- $200 per insured person per accident for ER/Urgent Care treatment in 7 days of the accident ($250 benefit with x-ray).

- $100 doctor's office visit for initial treatment within 7 days of accident.

- $25 wellness benefit per insured person payable once in first year.

- Various benefit payments by Aflac for other specific listed treatments and diagnosis per benefit brochure $50 health screening benefit payable once per calendar year per insured person.

GROUP CRITICAL ILLNESS POLICY: Aflac

Group Critical Illness coverage is a smart way to bridge the gaps in medical coverage. This lump-sum benefit payout can help address the financial consequences of certain covered conditions. BENEFITS:

- 100% benefit payment per insured for initial diagnosis of: heart attack, stroke, major organ transplant, kidney failure, bone marrow transplant, sudden cardiac arrest, internal cancer, coma.

- 25% benefit payment for coronary artery bypass surgery and non-invasive cancer.

- Benefit Amounts – Employee: $20,000, Spouse: $10,000, Child(ren): $10,000.

COVERED CONDITIONS:

- Certain Cancers
- Stroke
- Heart Attack
- 22 Listed Conditions
- Coronary Artery Bypass Graft
- Kidney Failure
- Alzheimer's Disease
- Major Organ Transplant

Guaranteed-issue coverage is offered to all eligible applicants during the initial enrollment and for new hires thereafter. At the group's first anniversary, late enrollees are eligible to enroll on a guaranteed-issue basis.

Cancer Diagnosis Limitation - Benefits are payable for cancer and/or non-invasive cancer as long as the insured: Is treatment-free from cancer for at least 12 months before the diagnosis date; and Is in complete remission prior to the date of a subsequent diagnosis, as evidenced by the absence of all clinical, radiological, biological, and biochemical proof of the presence of the cancer.

GROUP HOSPITAL INDEMNITY POLICY: Aflac

Focus on recovery during a hospital stay – not your out-of-pocket costs. A hospital confinement due to an illness or injury can happen to anyone. Chances are when it occurs you will have unplanned expenses to pay. Will you be prepared? Hospital Indemnity coverage benefit payments are made directly to you, no matter what other coverage you may have, and can be used however you choose. These benefit payments can help pay for out-of-pocket healthcare costs or other household expenses which can pile up during a hospital stay. Hospital Indemnity coverage helps provide financial peace of mind.

BENEFITS	
HOSPITAL CONFINEMENT	$1,000 per hospital confinement; $150 per day hospital confinement for max 31 days $150 per day hospital intensive care confinement for max 10 days; $75 per day intermediate intensive care step-down unit confinement for max 10 days per covered sickness or covered accident; $50 health screening benefit payable once per calendar year per insured person.

Guaranteed-issue coverage is offered to all eligible applicants during the initial enrollment and for new hires thereafter. Late enrollees are eligible to enroll on a guaranteed-issue basis.

Cancer Diagnosis Limitation - Benefits are payable for cancer and/or non-invasive cancer as long as the insured: Is treatment-free from cancer for at least 12 months before the diagnosis date; and Is in complete remission prior to the date of a subsequent diagnosis, as evidenced by the absence of all clinical, radiological, biological, and biochemical proof of the presence of the cancer.

FLEXIBLE SPENDING ACCOUNT (FSA): HealthEquity

Flexible Spending Accounts (FSA) provide you a before-tax method of paying for certain qualified expenses. After you decide how much you want to set aside each pay period for your medical and/or dependent care spending account(s), the money is deducted on a pre-tax basis thus eliminating federal income tax, social security tax and state tax on the amount you allocate to your spending accounts. A feature of the Flexible Spending Accounts is a debit card that virtually eliminates paying up front for eligible expenses.

If you have questions regarding your FSA account through HealthEquity, please call (866) 382-3510.

Medical Spending Account allows you to use pre-tax dollars to be reimbursed for out-of-pocket health care expenses that are not covered by a health, dental or vision insurance policy. Examples include deductibles and co-pays for health, prescription drug, dental and vision services, LASIK surgery, and certain over-the-counter supplies. The maximum annual amount you can set aside in a Medical Spending Account is $2,750. There may be certain instances which would preclude you from enrolling in a medical FSA - please consult your tax specialist.

The Dependent Care Spending Account allows you to use pre-tax dollars for work-related day care expenses of your children or dependent adults. The maximum annual amount you can set aside in a Dependent Care Spending Account is up to $5,000 (or $2,500 if married and filing separately and is prorated based on the number of months left in the plan year). The Dependent Day Care Spending Account is the alternative to the Federal Childcare Tax Credit.

EMPLOYEE ASSISTANCE PROGRAM (EAP): Mutual of Omaha

For long-term disability members.

Life is stressful, and sometimes the constant challenges can become overwhelming. When you have unresolved problems, it can take a serious toll on both your work and home life. To help you through difficult times, we offer a Employee Assistance program as part of our long-term disability plan.* The program offers members and their families personal and confidential support that's available 24 hours a day, 7 days a week. It also includes 3 basic face to face visits with a counselor at no cost to you. With just one call, you can also get the following types of assistance:

BENEFITS:

- Counseling Services
- Help with financial and legal issues
- Family Support
- Help with relationships, coping and depression

CONVENIENT, CONFIDENTIAL SUPPORT:

The Member Assistance program provides confidential support whenever you need it at no cost to you. The program includes the following services:

- Toll-free Member Assistance line
- 24/7 access to liveandworkwell.com
- Referrals for face-to-face counseling
- Legal Services
- Referral to helpful resources

To contact Mutual of Omaha's EAP, please visit www.mutualofomaha.com/eap or call 800-316-2796

401(k) RETIREMENT: Foster & Wood

The Santé 401(k) Profit Sharing and Employee Retirement Plan, administered by Foster & Wood, provides a convenient way to save and invest for your future while providing valuable tax savings today. You can begin contributing to the Plan after 60 days following your date of hire as long as you have attained age 18 and have met the eligibility requirements.

ENROLLMENT PERIOD: Once a Santé associate meets the aforementioned eligibility criteria, he/she will be automatically enrolled in the plan, at 1%*, beginning on the 1st day of the next quarter. Effective dates are: January 1, April 1, July 1 and October 1. *Associates are able to increase his/her contribution greater than 1%, or associates may "opt-out" of the plan, should he/she choose not to participate.

ASSOCIATE CONTRIBUTION:

- Can contribute up to 90% of income
- Max of $19,500
- If you are 50 years or older, you can contribute an additional $6,000
- 100% immediate vesting for employee contributions

Through Foster & Wood, Santé's 401k plan advisor, participants have access to personalized financial advice, including one on one counseling. Associates can call or email Tim Wood or Dave Foster with questions about our plan, how to most appropriately invest for his/her situation, as well as questions about how much income he/she might need when they retire. Unlike many advisors in the United States, Foster & Wood serves our plan as a fiduciary. Because they do not have any conflicts of interest, any advice they provide is solely in the associate's best interest given his/her family's situation.

PET ISURANCE: Nationwide

You care about your pets and consider them members of your family. So, whether your family includes kids with two feet or kids with four paws – or both – you know what responsibility looks like. So why not give your pets the best health care available?

The **My Pet Protection** suite of pet insurance plans is composed of the only plans specifically designed for employees, and gives you superior protection at an unbeatable price, featuring:

- 90% back on vet bills
- Exclusivity – unavailable to the general public
- One set price, regardless of the pet's age
- A wellness plan option that includes spay/neuter, preventive dental cleaning and more

Prices available online through your enrollment portal at: www.petinsurance.com

EMPLOYEE CONTRIBUTIONS

Santé contributes a significant portion toward the cost of your benefits. Below you will find the Employee Contribution Amounts effective November 1, 2021 – October 31, 2022.

MEDICAL	AETNA-ALLIED PPO 5000	AETNA-ALLIED PPO 2000
PER PAY PERIOD PLAN COST		
Employee Only	$40.00	$105.00
Employee + Spouse	$385.00	$480.00
Employee + 1 Child	$90.00	$165.00
Employee + 2 Children	$145.00	$222.50
Employee + 3 or More Children	$195.00	$275.00
Employee + Family	$375.00	$575.00

DENTAL	AETNA-ALLIED LOW PLAN	AETNA-ALLIED HIGH PLAN
PER PAY PERIOD PLAN COST		
Employee Only	$5.62	$10.25
Employee + Spouse	$15.62	$26.31
Employee + Child(ren)	$19.11	$37.03
Employee + Family	$30.72	$58.98

VISION	VSP
PER PAY PERIOD PLAN COST	
Employee Only	$2.04
Employee + Spouse	$5.83
Employee + Child(ren)	$6.47
Employee + Family	$11.36

BASE LIFE/AD&D and LONG TERM DISABILITY: 100% Paid by Santé.

VOLUNTARY LIFE/AD&D & SHORT TERM DISABILITY: 100% paid by Employees at a nominal cost. Rates are available in the Paychex Benetrac system.

ACCIDENT, CRITICAL ILLNESS & HOSPITAL INDEMNITY: 100% paid by Employees at a nominal cost. Rates are available in the Paychex Benetrac system.

HIPAA Privacy Notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Plan Responsibilities
The Plan is required by law to maintain the privacy of your personal health information and to provide you with this notice of privacy practices and legal duties. The Plan reserves the right to change or amend the terms of this notice and to make any new provisions effective to all of the personal health information that the Plan maintains about you. If this notice is revised, you will be provided with a revised notice via U.S. mail. If this notice is being provided to you electronically, you may obtain a paper copy of this notice by contacting Human Resources.

Your Rights
You have a right to know how the Plan may use or disclose your personal health information. There are certain uses and disclosures of your personal health information that the Plan is permitted or required to make by law without your permission. For all other uses and disclosures, the Plan must first obtain your permission. In addition, you have the following rights.

- The right to request that additional restrictions be placed on the Plan's disclosures of your personal health information. However, the Plan is not required to agree to any such restrictions that you may request.
- The right to access, inspect and copy your personal health information the Plan maintains in its files about you. You also have the right to have the Plan correct or amend any information that contains an error. Requests to access or amend your personal health information should be provided to the contact person provided in this notice.
- The right to receive an accounting of the disclosures of your personal health information that the Plan makes for purposes other than activities related to your treatment, or the Plan's payment functions or other health care operations.
- The right to request that you receive communications of personal health information in a confidential manner.

Uses and Disclosures of Personal Health Information
The Plan may use and disclose personal health information for the following purposes, without your permission.

- Uses of Personal Health Information
- To carry out treatment functions, such as to health care providers to provide you with treatment.
- To carry out payment functions, such as those activities related to fulfilling the Plan's responsibilities for coverage and providing you benefits under the Plan. Such activities may include, but are not limited to reviewing health care services with respect to medical necessity, coverage under the policy, appropriateness of care, or justification of charges.
- To carry out health care operations, such as those activities related to carrying out the Plan's business functions. These activities may include, but are not limited to, reviewing the competence of qualification of health care professionals, conducting quality assessment activities, amending, replacing or adding benefits, and placing contracts for stop –loss insurance or reinsurance.

- To business associates, such as service providers that the Plan has contracted with to perform various functions, such as administrative functions to pay your medical claims. Such business associates are required by law to agree in writing to contract terms requiring the business associate to appropriately safeguard your information.
- In situations permitted or required by law, including but not limited to the following:
  - As authorized by and to the extent necessary to comply with workers' compensation or other no-fault laws.
  - To a health oversight agency for activities including audits or civil, criminal or administrative proceedings.
  - To a public health authority for purposes of public health activities (such as the Food and Drug Administration to report consumer product defects).
  - To a law enforcement official for law enforcement purposes or in response to a court order or in the course of any judicial or administrative proceeding.
  - To organ procurement organizations, or to other entities for approved research purposes.
  - To a government authority, including a social service or protective services agency, authorized to receive reports of abuse neglect or domestic violence.
  - To avert a serious threat to someone's health or safety.

Purposes to Which You Have Not Objected
In certain limited circumstances, the Plan may use or disclose your personal health information after the Plan has given you the opportunity to object and you have failed to do so. For example, disclosure of protected health information to family members, other relatives and your close personal friends if the information is directly relevant to the family or friend's involvement with your care or payment of care, and you have either agreed to the disclosure or have been given an opportunity to object and have failed to do so.

Written Authorization
All other uses or disclosures of your personal health information will be made only with your written authorization, and any authorization that you give the Plan may be revoked by you at any time.

Complaints
You may complain either directly to the Plan or the Secretary of Health and Human Services if you believe that your rights with respect to the protection of your personal health information have been violated. To file a complaint with the Plan, you may submit a statement, in writing, that includes as many details as possible (including names and dates, where relevant). The complaint should be filed with Human Resources. You will not be retaliated against in any way for filing a complaint.

Practice Regarding Confidentiality and Security
The Plan restricts access to nonpublic personal information about you to those employees who need to know the information in order to provide the Plan's products and services to you. The Plan maintains physical, electronic, and procedural safeguards that comply with federal regulations to guard nonpublic personal information.

To Obtain Further Information
To obtain further information about your privacy rights or to file a complaint, please contact Human Resources.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) Special Enrollment Notice

This notice is being provided to insure that employees understand their right to apply for group health insurance coverage. Employees should read this notice even if they plan to waive coverage at this time.

Loss of Other Coverage
If an employee is declining coverage for himself/herself or his/her other dependents (including his/her spouse) because of other health insurance or group health plan coverage, the employee may be able to enroll himself/herself and his/her dependents in this plan if the employee or his/her dependents lose eligibility for that other coverage (or if the employer stops contributing toward the employee or his/her dependents' other coverage). However, the employee must request enrollment within 31 days after his/her or his/her dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: An employee waived coverage because he/she was covered under a plan offered by his/her spouse's employer. The spouse terminates his/her employment. If the employee notifies Employer within 31 days of the date coverage ends, the employee and his/her eligible dependents may apply for coverage under Employer's health plan.

Marriage, Birth, or Adoption
If an employee has a new dependent as a result of a marriage, birth, adoption, or placement for adoption, the employee may be able to enroll himself/herself and his/her dependents. However, the employee must request enrollment within 31 days after the marriage, birth, or placement for adoption.
Example: When an employee was hired by Employer, the employee was single and chose not to elect health insurance benefits. One year later, the employee marries. The employee and his/her eligible dependents are entitled to enroll in this group health plan. However, the employee must apply within 30 days from the date of his/her marriage.

Medicaid or CHIP
If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired by us, your children received health coverage under CHIP and you did not enroll them in our health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage.

Women's Health and Cancer Rights Act Notice

This Notice generally explains the protections available to patients who choose to have breast reconstruction in connection with a mastectomy.

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and,
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the employer's group health plan. If you would like more information on WHCRA benefits, contact the Plan Administrator.

Newborns' and Mothers' Health Protection Act of 1996

The Newborns' Act and its regulations provide that health plans and insurance issuers may not restrict a mother's or newborn's benefits for a hospital length of stay that is connected to childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. However, the attending provider (who may be a physician or nurse midwife) may decide, after consulting with the mother, to discharge the mother or newborn child earlier.
The Newborns' Act, and its regulations, prohibits incentives (either positive or negative) that could encourage less than the minimum protections under the Act as described above.

A mother cannot be encouraged to accept less than the minimum protections available to her under the Newborns' Act and an attending provider cannot be induced to discharge a mother or newborn earlier than 48 or 96 hours after delivery. In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing the length of stay not in excess of 48 hours or 96 hours, as the case may be.

The Mental Health Parity and Addiction Equity Act of 2008

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires group health plans to apply the same treatment limits on mental health or substance-related disorder benefits as they do for medical and surgical benefits. The MHPAEA also extends this parity requirement to inpatient and outpatient services, whether in-network or out-of-network, and to emergency care services and prescription drugs.

MHPAEA revised the definition of "mental health benefits" to include substance use disorder benefits. The MHPAEA also requires group health plans to apply the same beneficiary financial requirements to mental health or substance use disorder benefits as they apply for medical and surgical benefits, including limits on deductibles, co-payments and out-of-pocket expenses. Plan administrators are also required to make the criteria for "medical necessity" determinations with respect to mental health and substance use disorder benefits available to plan participants, beneficiaries or providers upon request.

Genetic Information Non-Discrimination Act of 2008

The Genetic Information Non-Discrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, Santé Operations, LLC will generally never require a benefits participant to provide any genetic information when responding to any request for medical information in connection with enrollment in any **Santé Operations, LLC** benefits plan or accessing any of your **Santé Operations, LLC** plan benefits. Genetic information as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic test, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

For more information about GINA, visit www.dol.gov/ebsa/faqs/faq-GINA.html

New Health Insurance Marketplace Coverage Options and Your Health Coverage

General Information
In 2015, the Health Insurance Marketplace provides U.S. citizens the ability to purchase medical insurance through a controlled online environment.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace takes place each year between October 15th and December 7th for coverage beginning on January 1, of the following year.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing **if your employer does not offer coverage** to you at all **or does not offer coverage that meets certain standards.** If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your Box 1 W-2 earnings for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution-as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

1 An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

General Notice of COBRA Continuation Rights

This Notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. Please read it carefully.

Introduction
You are receiving this Notice because you have recently become covered (or may soon become covered) under a group health plan (the "Plan"). This Notice contains important information about your rights to COBRA continuation coverage, which is a temporary extension of coverage under the Plan.

What is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event". Specific qualifying events are listed later in this Notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for this coverage.
If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happen:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B or both); or,
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happen:

- The parent/employee dies;
- The parent/employee's hours of employment are reduced;
- The parent/employee's employment ends for any reason other than his or her gross misconduct;
- The parent/employee becomes entitled to Medicare benefits (under Part A, Part B or both;
- The parents become divorced or legally separated; or,
- The child is no longer eligible for coverage under the Plan as a "dependent child".

When is COBRA Coverage Available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualified event has occurred. When the qualifying event is the end of employment or reduction of hours, disability, death of an employee or the employee's becoming entitled to Medicare benefits, the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events
For the other qualifying events, such as divorce or legal separation or the dependent child losing eligibility under the Plan, you must notify the Plan Administrator within 31 days of the qualifying event occurring. You must provide this notice, along with any requested documentation to: Human Resources, 300 S. 18th St. Mt. Vernon WA 98274.

How is COBRA Coverage Provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualifying beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage.

When the qualifying event is the death of the employee, the employee becoming entitled to Medicare benefits, divorce or legal separation, or a dependent child losing eligibility under the Plan, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is the end of employment or reduction in the employee's hours of employment and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his or her employment terminates, COBRA continuation coverage for his spouse and dependent children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event.

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage
If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and any family members covered under the Plan may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability must have started at some time before the 60th day of COBRA continuation coverage and must last until the end of the 18-month period of coverage. You must provide this notice of disability, along with any requested documentation to: Human Resources, 300 S. 18th St. Mt. Vernon WA 98274.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, provided notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits, becomes divorced or legally separated or if the dependent child is no longer eligible as a dependent child under the Plan, but only if this second event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Questions
Questions concerning your Plan or your COBRA coverage continuation rights should be addressed to the Plan contact, as shown in the section below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA) and any other laws or regulations affecting group health plans, contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa.

Keep the Plan Informed of Any Address Changes
To protect your rights and the rights of your family, you should keep the Plan Administrator informed of any changes in the addresses of covered family members. You should also keep a copy for your records of any notices you send to the Plan Administrator.

Plan Contact Information
Santé Operations, LLC
1220 20th Street Southeast
Suite 310
Salem, OR 97302
Cindy Taylor, HR
360.621.5214

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage using funds from their Medicaid or CHIP programs. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs but you may be eligible to buy individual insurance coverage through the Health Insurance Marketplace. Form more information visit healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2017. You should contact your State for further information on eligibility.

ALABAMA – Medicaid
www.myalhipp.com
1-855-692-5447

ALASKA – Medicaid
http://health.hss.state.ak.us/dpa/programs/medicaid/
Outside of Anchorage 1-888-318-8890
Anchorage 907-269-6529

ARKANSAS – Medicaid
https://myarhipp.com/
1-855-MyARHIPP (855-692-7447)

COLORADO – Medicaid
www.colorado.gov/hcpf
In State 1-800-866-3513
Out Of State 1-800-221-3943

FLORIDA – Medicaid
www.flmedicaidtplrecovery.com/
1-877-357-3268

GEORGIA – Medicaid
http://dch.georgia.gov/
1-800-869-1150

INDIANA – Medicaid
www.in.gov/fssa
1-800-889-9949

IOWA – Medicaid
www.dhs.state.ia.us/hipp/
1-888-346-9562

KANSAS – Medicaid
www.kdheks.gov/hcf/
1-800-792-4884

KENTUCKY – Medicaid
http://chfs.ky.gov/dms/default.htm
1-800-635-2570

LOUISIANA – Medicaid
www.lahipp.dhh.louisiana.gov
1-888-695-2447

MAINE – Medicaid
www.maine.gov/dhhs/ofi/public-assistance/index.html
1-800-977-6740, TTY 1-800-977-6741

MASSACHUSETTS – Medicaid & CHIP
www.mass.gov/MassHealth
1-800-462-1120

MINNESOTA – Medicaid
www.dhs.state.mn.us/id_006254
1-800-657-3739

MISSOURI – Medicaid
www.dss.mo.gov/mhd/participants/pages/hipp.htm
573-751-2005

MONTANA – Medicaid
http://medicaid.mt.gov/member
1-800-694-3084

NEBRASKA – Medicaid
www.ACCESSNebraska.ne.gov
1-855-632-7633

NEVADA – Medicaid
http://dwss.nv.gov/
1-800-992-0900

NEW HAMPSHIRE – Medicaid
www.dhhs.nh.gov/oii/documents/hippapp.pdf
603-271-5218

NEW JERSEY – Medicaid & CHIP
Medicaid: www.state.nj.us/humanservices/dmahs/clients/medicaid/
609-631-2392
CHIP: www.njfamilycare.org/index.html
1-800-701-0710

NEW YORK – Medicaid
www.nyhealth.gov/health_care/medicaid/
1-800-541-2831

NORTH CAROLINA – Medicaid
www.ncdhhs.gov/dma
919-855-4100

NORTH DAKOTA – Medicaid
www.nd.gov/dhs/services/medicalserv/medicaid/
1-800-755-2604

OKLAHOMA – Medicaid & CHIP
www.insureoklahoma.org
1-888-365-3742

OREGON – Medicaid & CHIP
www.oregonhealthykids.gov www.hijossaludablesoregon.gov
1-800-699-9075

PENNSYLVANIA – Medicaid
www.dpw.state.pa.us/hipp
1-800-692-7462

PHODE ISLAND – Medicaid
www.ohhs.ri.gov
401-462-5300

SOUTH CAROLINA – Medicaid
www.scdhhs.gov
1-888-549-0820

SOUTH DAKOTA – Medicaid
http://dss.sd.gov
1-888-828-0059

TEXAS – Medicaid
www.gethipptexas.com/
1-800-440-0493

UTAH – Medicaid & CHIP
http://health.utah.gov/medicaid
http://health.utah.gov/chip
1-866-435-7414

VERMONT – Medicaid
www.greenmountaincare.org/
1-800-250-8427

VIRGINIA – Medicaid & CHIP
www.coverva.org/programs_premium_assistance.cfm
Medicaid: 1-800-432-5924
CHIP: 1-855-242-8282

WASHINGTON – Medicaid
http://hrsa.dshs.wa.gov/premiumpymt/pages/idex.aspx
1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
www.dhhr.wv.gov/bms/
1-877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid & CHIP
www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
1-800-362-3002

WYOMING – Medicaid
http://health.wyo.gov/healthcarefin/equalitycare
307-777-7531

Important Notice from Santé Operations, LLC About Your Prescription Drug Coverage and Medicare

You may disregard this notice if you are NOT eligible for Medicare Part D or will not become eligible for Medicare within the next 12 months.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with **Santé Operations, LLC** and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

- **Santé Operations, LLC** has determined that the prescription drug coverage offered by Carrier/Company plan name Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore **considered Creditable Coverage**. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current coverage, as outlined below, will not be affected.

The CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/) will outline the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current Santé Operations, LLC coverage, be aware that you and your dependents will not be able to get this coverage back (except during certain open enrollment periods).

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Santé Operations, LLC and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...
Contact the person listed below for further information. Note that you will receive this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Santé Operations, LLC changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:
- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Plan Contact Information
Santé Operations, LLC
1220 20th Street Southeast, Suite 310
Salem, OR 97302
Cindy Taylor, HR, 360.621.5214

Appendix 22: Intake and Admission

INTAKE PROCESS
Policy No. 2-022.1

PURPOSE

To establish the process for acceptance and entry of patients into hospice.

POLICY

Referrals will be accepted 24 hours a day, seven (7) days per week. Personnel will be available 24 hours a day to accept patients into hospice.

Heritage Hospice will accept only those patients whose needs can be met by the services it provides and who meet the hospice admission criteria.

PROCEDURE

1. Hospice referrals will be documented on a referral and intake form.
2. Referrals for hospice services may be accepted by clinicians, including the Executive Director/Administrator, Clinical Supervisor, nurses, social worker or others, as deemed appropriate by the Executive Director/Administrator.
3. Referral information may be accepted by any of the following methods:
   A. Telephone
   B. Fax
   C. Original written order
   D. Secure email
4. Referrals may be accepted from any of the following individuals:
   A. Doctors of Medicine, Osteopathy, Podiatry, Psychiatry, Dentistry, or Dental Surgery
   B. Discharge planners from inpatient and/or outpatient services
   C. Social service agencies
   D. Individual patients or their family/caregivers
   E. Clinical and/or insurance company representative
   F. Other home health care organizations

5. During scheduled working hours (office hours are from 8:00 a.m. to 5:00 p.m. Monday through Friday), calls will first be received by the switchboard operator. Patient referral calls will be transferred to an intake specialist designated to accept referrals.

   A. Intake personnel will document information regarding patient demographics, diagnoses, services needed, medications, attending physician, hospitalization, etc., in order to make the initial determination whether the patient's needs can be met by hospice and if he/she meets eligibility criteria. (See "Admissions Criteria and Process" Policy No. 2-023.) The information will be reviewed for completeness.

   B. When payer source is private insurance, the insurance coverage will be verified and an insurance information form will be completed.

   C. Intake information will be given to the Clinical Supervisor to accept the referral information and complete the Referral and Intake Form.

   D. If the referral call is not from a physician, the physician (or other authorized licensed independent practitioner) will be contacted to confirm service needs, as well as the patient's medical prognosis and supporting documentation, and to obtain verbal orders.

   E. The Clinical Supervisor will assign personnel and schedule an assessment visit.

   F. If hospice service cannot be provided due to the patient not meeting hospice admission criteria, intake personnel will give the referral source the names of other agencies that can provide the required services and notify the attending physician. A log will be maintained on all patients who cannot be serviced.

6. After business hours (weekends, evenings, and holidays), a referral source will have access to hospice through its answering service.

   A. The answering service will contact the on-call nurse via telephone.

   B. The on-call nurse will complete the intake information from the referral source and relay the information

      1. If the referral is on the weekend or a holiday, the on-call nurse will determine if the patient needs to be seen.

      2. If the patient must be seen, the on-call nurse will schedule an initial visit on the weekend or the holiday to determine hospice appropriateness.

      If the patient can wait until the next business day, the on-call nurse will bring the intake information into the office for scheduling by the Clinical Supervisor.

ADMISSION CRITERIA AND PROCESS
Policy No. 2-023.1

PURPOSE

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

POLICY

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

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

Patients will be accepted for care based on adequacy and suitability of hospice personnel, resources to provide required services, and a reasonable expectation that the patient's hospice care needs can be adequately met in the patient's place of residence.

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

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

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

The patient will be referred to other resources if Heritage Hospice cannot meet his/her needs.

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

Admission Criteria

1. Heritage Hospice will admit a patient only on recommendation of the medical director in consultation with, or input from, the patient's attending physician, if any. The information can be obtained from the hospice nurse or others sharing the attending physician's knowledge of the patient. The patient's physician (or other authorized licensed independent practitioner) must order and approve the provision of hospice care, be willing to sign or have a representative who is willing to sign the death certificate, and be willing to discuss the patient's resuscitation status with the patient and family/caregiver.

2. The patient must identify a family member/caregiver or legal representative who agrees to be a primary support caregiver if and when needed. Exceptions may be made for patients without such an identified individual and who are independent in their activities of daily living (ADLs). These individuals will require a specific plan to be developed at time of admission with the social worker to plan for when they are no longer independent.

3. The patient must have a life-limiting illness with a life expectancy of six (6) months or less, as determined by the attending physician and hospice Medical Director, utilizing standard clinical prognosis criteria in the organization's intermediary Local Coverage Determinations.

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

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

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

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

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

9. The patient must reside within the geographical area that Heritage Hospice serves.

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

11. Eligibility criteria will be continually reviewed by the interdisciplinary team to ensure appropriateness of hospice care.

12. At the time of admission, before start of care, treatment, procedure or administering medication, blood or blood products, the clinician will verify patient identification by utilizing two (2) patient identifiers. Acceptable identifiers may be patient's name, telephone number, insurance/Medicare number, photo ID, etc.

PROCEDURE

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

2. The Clinical Supervisor will assign hospice personnel to conduct assessments of eligibility for services within 24 hours or the time frame requested by the referral source, based on the information regarding the patient's condition or as ordered by the physician (or other authorized licensed independent practitioner).

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

   A. Patient's geographical location

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

   C. Hospice personnel's education and experience

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

   E. Urgency of identified need for assessment

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

   A. Such notification and approval will be documented.

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

5. Heritage Hospice hospice personnel will attempt to make a first contact prior to the patient's hospital discharge, if possible or appropriate. The initial home visit will be made within 24 hours or within the time frame requested by the referral source, or as ordered by the physician (or other authorized licensed independent practitioner). The purpose of the initial visit will be to:

   A. Explain the hospice philosophy and program of care with the patient and family/caregiver

   B. Explain the patient's rights and responsibilities and grievance procedure

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

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

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

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

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

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

I. Give patient information about Durable Power of Attorney for health care, if the patient has not already done so

6. During the initial visit, the admitting clinician will review the accuracy of patient identification with at least two (2) identifiers, the patient's eligibility for hospice services, according to the admission criteria and standard prognosis criteria to determine/confirm further:

   A. Level of services required and frequency criteria

   B. Eligibility (according to organization admission criteria)

   C. Accuracy of patient identification with two (2) identifiers, e.g. picture ID, telephone number, DOB, insurance/Medicare card, etc.

   D. Source of payment

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

   A. Nature and goals of care and/or service

   B. Hours during which care or service are available

   C. Access to care after hours

   D. Care costs, if any, to be paid by the patient

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

   F. Safety information

   G. Infection control information including hand and respiratory hygiene practices

   H. Emergency management plans

   I. Available community resources

   J. Complaint/grievance process

   K. Advance Directives

   L. Availability of spiritual counseling in accordance with religious preference

   M. Other hospice personnel involved in care

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

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

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

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

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

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

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

14. The hospice registered nurse will contact the physician for clinical information in writing to certify patient for hospice care and to establish an initial plan of care.

15. The hospice registered nurse will complete an initial assessment during this visit or within 48 hours after the election of hospice care (unless the physician, patient or representative requests that the initial assessment be completed in less than 48 hours.) (See "Initial Assessment" Policy No. 2-029.)

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

17. If the patient is accepted for hospice care, a comprehensive assessment of the patient will be performed no later than five (5) calendar days after the election of hospice care. A plan of care will be developed by the attending physician, the Medical Director or physician designee and the hospice team. It will them be submitted to the attending physician for signature. The patient's wishes/desires will be considered and respected in the development of the plan of care. (See "Comprehensive Assessment" Policy No. 2-030.)

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

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

Appendix 23: Charity Care Policy

CHARITY CARE
Policy No. 4-027.1

PURPOSE

To help patient's access to hospice care regardless of payor source and identify the criteria to be applied when accepting patients for charity care.

POLICY

Patients may be eligible for charity care at the time of admission to VistaRiver Hospice or during the period when they receive hospice services, consistent with the Income Guidelines set forth.

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

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

The organization will consistently apply the charity care policy.

PROCEDURE

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

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

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

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

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

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

7. After acceptance for charity care, the patient's ability to pay will be reassessed by the social worker prior to each recertification period.

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

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

ELIGIBILITY

1. Patients must meet Medicare Hospice eligibility requirements.
2. Patients must be uninsured, or underinsured and possess no alternative payor source.
3. Patient must have limited financial assets.
4. Patients income to be eligible for full charity care must be at or below 200% of the Federal Poverty Guidelines as adjusted for family size. (See Exhibit 1)
5. Patients must apply for government assistance programs for which they may qualify. If a patient is ineligible for or has been denied governmental assistance patient may be eligible for charity care.
6. Income between 200%-300% of the Current Federal Poverty Guideline Level
7. For patients with income between 200%-300% of the current federal poverty level (after all funding possibilities have been exhausted or denied and all personal financial resources and assets have been reviewed for possible funding for pay for charges), VistaRiver sliding fee schedule will be applied. VistaRiver sliding fee schedule will determine the amount of be written off as charity care.

Income as a % of Federal Poverty Guidelines	% Paid by Patient
Less than or equal to 200% of the Federal Poverty	0%
Greater than 200% of the Federal Poverty Limits but less than or equal to 250% of the Federal Poverty Limits	25%
Greater than 250% of the Federal Poverty Limits but less than or equal to 300% of the Federal Poverty Limits	50%
Greater than 300% of the Federal Poverty Limits but less than or equal to 400% of the Federal Poverty Limits	75%
Greater than 400% of the Federal Poverty Limits	100%

Exhibit 1: Sliding-fee schedule

2021 Federal Poverty Level Guidelines

Persons in household	100%	133%	138%	150%	200%	250%	300%	400%	500%
1	12,880	17,130	17,774	19,320	25,760	32,200	38,640	51,520	64,400
2	17,240	22,929	23,791	25,860	34,480	43,100	51,720	68,960	86,200
3	21,960	29,207	30,305	32,940	43,920	54,900	65,880	87,840	109,800
4	26,500	35,245	36,570	39,750	53,000	66,250	79,500	106,000	132,500
5	31,040	41,283	42,835	46,560	62,080	77,600	93,120	124,160	155,200
6	35,580	47,321	49,100	53,370	71,160	88,950	106,740	142,320	177,900
7	40,120	53,360	55,366	60,180	80,240	100,300	120,360	160,480	200,600
8	44,660	59,398	61,631	66,990	89,320	111,650	133,980	178,640	223,300

Add $4,540 for each additional person over 8 years of age under 100% FPL

Resource: https://aspe.hhs.gov/poverty-guidelines

Revised: January 2021

Appendix 24: Patient Rights and Responsibility Policy

HOSPICE PATIENT RIGHTS (WAC 246-330-125)

All patients have the following rights:

1. To be treated and cared for with dignity and respect
2. To be protected from abuse and neglect
3. To access protective services
4. To have confidentiality, privacy, security, spiritual care, and not restricted from communication with others.
5. If communication restrictions are necessary for patient care and safety, the facility must document and explain the restrictions to the patient and family.
6. To be informed and agree to their care. [Implied is patient or their representative is given information about the procedure, the risks, and benefits, so that they may give informed consent.]
7. To be involved in all aspects of their care including refusing care and treatment and resolving problems with care decisions.
8. To have family input in care decisions, in compliance with existing legal directives of the patient or existing court-issued legal orders.
9. To be informed of any unanticipated outcomes.
10. To complain about their care and treatment without fear of retribution or denial of care.
11. To have timely complaint resolution. DOH 655-009
12. To be provided with a written statement of their patient rights.
13. If the facility participates in any research, investigation, or clinical trials they must not hinder a patient's access to care if he refuses to participation
14. Receive effective pain management and symptom control and quality services from VistaRiver Hospice for services identified in the plan of care;
15. Be cared for by appropriately trained or credentialed personnel, contractors and volunteers with coordination of services;
16. A statement advising of the right to ongoing participation in the development of the plan of care;
17. Choose his or her attending physician;
18. A statement advising of the right to have access to the department's listing of licensed hospice agencies and to select any licensee to provide care, subject to the individual's reimbursement mechanism or other relevant contractual obligations;
19. A listing of the total services offered by the hospice agency and those being provided to the patient;
20. Refuse specific services;
21. The name of the individual within VistaRiver Hospice responsible for supervising the patient's care and the manner in which that individual may be contacted;

22. Be treated with courtesy, respect, and privacy;
23. Be free from verbal, mental, sexual, and physical abuse, neglect, exploitation, discrimination, and the unlawful use of restraint or seclusion;
24. Have property treated with respect;
25. Privacy and confidentiality of personal information and health care related records;
26. Be informed of what VistaRiver Hospice charges for services, to what extent payment may be expected from health insurance, public programs, or other sources, and what charges the patient may be responsible for paying;
27. A fully itemized billing statement upon request, including the date of each service and the charge. Agencies providing services through a managed care plan are not required to provide itemized billing statements;
28. Be informed about advanced directives and POLST and VistaRiver Hospice's scope of responsibility;
29. Be informed of VistaRiver Hospice's policies and procedures regarding the circumstances that may cause the agency to discharge a patient;
30. Be informed of VistaRiver Hospice's policies and procedures for providing backup care when services cannot be provided as scheduled;
31. A description of VistaRiver Hospice's process for patients and family to submit complaints to VistaRiver Hospice about the services and care they are receiving and to have those complaints addressed without retaliation;
32. Be informed of the department's complaint hotline number to report complaints about the licensed agency or credentialed health care professionals; and
33. Be informed of the DSHS end harm hotline number to report suspected abuse of children or vulnerable adults.
34. VistaRiver Hospice must ensure that the patient rights under this section are implemented and updated as appropriate.

Phone Numbers:

Department of Health Complaint Hotline Number: 800-633-6828

DSHS End Harm Hotline number: 866-363-4276

Appendix 25: Lease Agreement

LEASE AGREEMENT

THIS LEASE AGREEMENT (hereinafter, the "Lease") is made as of January 1, 2022 (the "Execution Date"), by and between Sante Parners, LLC, a Washington limited liability company ("Landlord") and VistaRiver of King County, LLC, an Washington limited liability company ("Tenant"). Landlord hereby leases and rents to Tenant and Tenant hereby leases and rents from Landlord the property located at 17201 15th Ave NE, Shoreline, Washington 98115 and more fully described in Exhibit A hereto (hereinafter, the "Premises") upon the following terms and conditions:

1. **INITIAL TERM; RENEWAL TERMS.** The "Initial Term" of this Lease shall be five (5) years, beginning at 12:00 am (Pacific Time) on January 1st, 2023 (the "Commencement Date"), and, unless earlier terminated in accordance with the terms hereof, ending at 12:00 am (Pacific Time) on the fifth (5th) anniversary of the Commencement Date. The Initial Term, together with any of the exercised Renewal Terms (as defined below), may hereinafter be referred to as the "Term." Tenant shall have the right to renew this Lease beyond the Initial Term for two successive five (5) year terms (each a "Renewal Term") by giving notice of the exercise of its renewal option at least one hundred twenty (120) days prior to the expiration of the Initial Term or the applicable Renewal Term. If an Event of Default has occurred and is continuing (a) on the date of the giving of notice of its intent to renew the Lease, then the notice shall be ineffective; or (b) on the date the applicable Renewal Term is to commence, then the Renewal Term shall not commence and this Lease shall expire as of the end of the Initial Term or the first Renewal Term as applicable.

2. **USE; CONDITION OF THE PREMISES**. The Premises are to be used solely for office space. After the Commencement Date, Tenant shall neither use nor permit to be used the Premises, or any part thereof for any purpose or purposes other than the Permitted Use without the prior written consent of Landlord, which shall not be unreasonably withheld, conditioned or delayed. Tenant agrees that the Premises shall not be used for any unlawful purpose. Tenant shall not commit or suffer to be committed any waste on the Premises, nor shall Tenant cause or permit any nuisance thereon. Tenant further covenants and agrees that Tenant's use of the Premises and maintenance, alteration and operation thereof shall at all times conform to all applicable and lawful local, state, and federal ordinances, rules and regulations; Tenant may, however, contest the legality or applicability of any such ordinance, rule or regulation in good faith, with due diligence, without prejudice to Landlord's rights hereunder, and at Tenant's own expense. Tenant agrees that it has inspected the Premises before signing this Lease and thus that the Premises are accepted AS IS, WHERE IS, without warranty or representation of any kind, express or implied, as to condition of the Premises.

3. **ANNUAL RENT; CPI ADJUSTMENTS**. The initial annual rent ("Rent") is the amount of Six Thousand Dollars ($6,000.00). Rent is payable in equal monthly installments in advance on the first day of each month (the "Rent Due Date") at Landlord's address as set forth below or at such other place as may be designated by Landlord from time to time, in the amount of Five Hundred and Zero Cents ($500.00) each month. Commencing on January 1st, 2022 and continuing on each anniversary of such date, the annual Rent shall be increased by an annual amount equal to the percentage increase in the United States Department of Labor, Bureau of

Labor Statistics Revised Consumer Price Index for All Urban Consumers (1982-84=100), U.S. City Average, All Items (the "CPI Index") during the then most recent twelve (12) month period. In no event shall the annual Rent be reduced as a result of a decline in the CPI Index. In the event that the CPI Index is not available at the time in question, the index designated by such Department as the successor to such index, and if there is no index so designated, an index for an area in the United States that most closely corresponds to the entire United States, published by such Department, or if none, by any other instrumentality of the United States.

4. **INTENTIONALLY OMITTED.**

5. **LATE FEES**. If any payment of any sums required to be paid or deposited by Tenant to or for the benefit of Landlord under this Lease shall become overdue for a period of ten (10) days beyond the date on which they are due and payable as provided for in this Lease, a late charge equal to five percent (5%) of the overdue amount shall become immediately due and payable to Landlord, and said late charge shall be payable on the first day of the month next succeeding the month during which such late charge becomes payable. Such late charge shall compensate Landlord only for loss of interest on the payments due Landlord and shall be in addition to any and all other amounts, including damages, to which Landlord may be entitled pursuant to this Lease or at law or in equity. If non-payment of any late charge shall occur, Landlord shall have, in addition to all other rights and remedies, all rights and remedies provided for herein and by law in the case of non-payment of rent. No failure by Landlord to insist upon the strict performance by Tenant of Tenant's obligations to pay late charges shall constitute a waiver by Landlord of its rights to enforce the provisions of this Section in any instance thereafter.

6. **INTENTIONALLY OMITTED.**

7. **ASSIGNMENT OR SUBLETTING**. Tenant agrees that Tenant will not assign, sublet, or transfer the Premises or any part thereof without the Landlord's prior written consent, which consent shall not be unreasonably withheld, conditioned or delayed. Subject to the restrictions on transfers set forth herein, this Lease shall inure to the benefit of and be binding upon Landlord and Tenant and their respective successors and permitted assigns. The definitions of "Landlord" and "Tenant" herein refer to the Landlord and Tenant at the time in question.

8. **INSURANCE**. Tenant shall at all times keep and maintain with respect to the Premises, through an insurance carrier qualified to do business in the State of Washington, such insurance policies as Tenant reasonably deems appropriate, including without limitation a commercial general liability insurance policy with a limit of not less than $1,000,000 per occurrence for injury to, illness of, or death of persons or damage to property occurring in, upon or about the Premises. The policies must name Landlord as a named insured or loss payee. Evidence of insurance shall be deposited with Landlord. All insurance policies carried by either party covering the Premises, including without limitation contents, fire and casualty insurance, shall expressly waive any right of subrogation on the part of the insurer against the other party. The parties hereto agree that their policies will include such waiver clause or endorsement so long as the same are obtainable without extra cost, and in the event of such an extra charge the other party, at its election, may pay the same, but shall not be obligated to do so. To the extent that either Landlord or Tenant may have claims against the other for fire or casualty damage to the Premises

or any portion thereof (including business interruption caused thereby), which claims are covered by insurance payable to and protecting the claiming party, the claiming party hereby agrees to exhaust all claims under such insurance before asserting any claims against the other party. The foregoing shall apply to claims for damage whether such damage is caused, wholly or partially, by the negligence or other fault of the other party or its agent, employees, subtenants, licensees or assignees. Tenant shall pay all of the insurance premiums for insurance policies maintained by Tenant. Notwithstanding anything to the contrary contained in this Section 7, Tenant's obligations to carry the insurance provided for herein may be brought within the coverage of a so-called blanket policy or policies of insurance carried and maintained by Tenant; provided, however, that the coverage afforded Landlord will not be reduced or diminished or otherwise be different from that which would exist under a separate policy meeting all other requirements of this Lease by reason of the use of such blanket policy of insurance.

9. **INTENTIONALLY OMITTED.**

10. **CONDEMNATION.** If, during the Term, all or substantially all of the Premises or any material portion thereof is taken or condemned for a public or quasi-public use, either Landlord or Tenant shall have the right to terminate this Lease by notice given to the other party hereto. For purpose hereof, a 'material portion' of the Premises shall be deemed to have been so taken if, as a result of any such taking, the access to, use or operation thereof is materially adversely affected in Tenant's reasonable judgment. All damages awarded in connection with the taking of the Premises shall vest in Landlord. All damages awarded in connection with the taking of the leasehold estate shall vest in Tenant but only to the extent such damages do not diminish the award otherwise payable to Landlord.

11. **UTILITIES, MAINTENANCE, REPAIRS, IMPROVEMENTS**. Landlord shall pay for all utilities, maintenance or repairs other than those specifically requested by Tenant. Tenant shall be responsible for its own internet, phone or other requested services that are brought onto premises by Tenant.

12. **HAZARDOUS SUBSTANCES.** Tenant shall not generate, dispose of, release, use, handle, possess or store any hazardous substances upon the Premises except in accordance with applicable laws, rules and regulations. Tenant shall, at its sole cost and expense, promptly remove or clean up any hazardous substances introduced onto the Premises by Tenant or with its permission or at its sufferance. Such removal or cleanup shall be in compliance with all applicable laws and regulations. Tenant hereby agrees to indemnify and hold Landlord harmless and agrees to defend Landlord from all losses, damages, claims and liabilities and fines, including costs and reasonable attorneys' fees, of any nature whatsoever in connection with the actual or alleged presence upon the Premises of any hazardous substance introduced by Tenant or with its permission or at its sufferance.

13. **DEFAULT**. The occurrence of any of the following events, acts or circumstances shall constitute an "Event of Default" under this Lease:

(i) failure by Tenant to pay in full any Rent or any other monetary obligation under this Lease when due, and the continuance of such failure for ten (10) days after Landlord has given Tenant written notice of such failure;

(ii) failure by Tenant to observe, perform or comply with any of the terms, covenants, agreements or conditions contained in this Lease (other than as specified in clause (i)) and the continuance of such failure for thirty (30) days after Landlord has given Tenant notice of such failure. If Tenant has promptly commenced and diligently pursued remedial action within said thirty (30) day period but has been unable to cure its default (except for any default that can be reasonably cured by the payment of money) prior to the expiration thereof, said thirty (30) day period shall be extended for the minimum time reasonably required for the completion of Tenant's remedial action;

(iii) the making by Tenant of an assignment for the benefit of its creditors or the commencement of proceedings in a court of competent jurisdiction for the reorganization, liquidation or involuntary dissolution of Tenant or for the adjudication of Tenant as a bankrupt or insolvent or for the appointment of a receiver of Tenant's property, which proceedings are not dismissed and any receiver, trustee or liquidator appointed therein is not discharged, within thirty (30) days after the institution thereof;

(iv) the abandonment of the Premises by Tenant other than as a result of any repair or reconstruction following damage or destruction to, or any condemnation or taking of, the Premises, or

(v) if there is any generation, disposal, release or use of any hazardous substance upon or from the Premises in violation of the terms of this Lease or applicable local, state or federal law.

14. **LANDLORD'S REMEDIES.** Upon the occurrence and during the continuance of any Event of Default, Landlord, in addition to the other rights or remedies it may have, shall have the immediate right of re-entry without any additional notice to Tenant. Should Landlord elect to re-enter, as herein provided, or should it take possession pursuant to legal proceedings or pursuant to any notice provided for by law, Landlord may either terminate this Lease or it may from time to time, without terminating this Lease, relet the Premises or any part thereof for the account of Tenant for such term or terms, which may be for a term shorter than or for a term extending beyond the Term, and at such rental or rentals and on such other terms and conditions as Landlord, in its reasonable discretion, may deem advisable. Should Landlord at any time terminate this Lease as a result of any Event of Default, in addition to any other remedy it may have, Landlord may recover from Tenant all damages incurred by reason of such Event of Default, including the cost of recovering the Premises. Whether or not Landlord elects to terminate this Lease, Landlord may terminate Tenant's right to possession of the Premises by any lawful means, in which case all of Tenant's rights in this Lease shall terminate and Tenant shall immediately surrender possession of the Premises to Landlord. Any termination of this Lease by Landlord upon the occurrence and during the continuance of an Event of Default shall not in any event terminate Tenant's obligation to pay rent and other amounts owed by Tenant pursuant to this Lease for the full Term.

15. **LIMITATION ON LIABILITY AND INDEMNIFICATION**. Landlord shall not be liable for any damage or injury to Tenant, or any other person, or to any property occurring on the Premises, unless such damage is due to the negligence or unlawful act of Landlord. Tenant hereby indemnifies, releases, and holds harmless Landlord and its agents from and against any and all suits, actions, claims, judgments, and expenses arising out of or relating to any damage or injury occurring on the Premises or in connection with this Lease, except for those acts described above.

Any damages which Tenant shall seek to recover from Landlord shall be limited to Landlord's interest in the Premises.

16. **WAIVER AND SEVERABILITY**. No failure of Landlord to enforce any term of this Lease shall be deemed a waiver, nor shall any acceptance of a partial payment of Rent (or any partial payment marked "payment in full" or a similar designation) be deemed a waiver of Landlord's right to the full amount thereof. In the event that any part of this Lease is deemed to be unenforceable by a court of law, the remaining parts of this Lease shall remain in full force and effect as though the unenforceable part or parts were not written into this Lease.

17. **NOTICES**. Any notice which either Landlord or Tenant may or is required to give, may be given by mailing the same, postage prepaid, to Tenant at the Premises or to Landlord at the address shown below the parties' signatures on this Lease or at such other places as may be designated by the parties from time to time.

18. **NO MODIFICATION**. This Lease represents the entire and final agreement of the parties with respect to the subject matter hereof. No modifications may be made to this Lease unless Landlord and Tenant agree to same in writing.

19. **GOVERNING LAW; ATTORNEY'S FEES; CONSTRUCTION**. This Lease shall be governed by the laws of the State of Washington. In any legal action to enforce or interpret any term under this Lease, the prevailing party shall be entitled to all costs incurred in connection with such action, including reasonable attorney's fees and court costs. Tenant acknowledges that it has read this Lease and has had the opportunity to review it with legal counsel of its choice. Accordingly, in the event of a dispute with respect to this Lease, no provision shall be construed against Landlord as the drafter of this Lease. Any act or event which is due hereunder on a day which is not a business day shall be due on the next succeeding business day.

[Signature page follows]

IN WITNESS WHEREOF, the parties hereto have caused this Lease to be signed by a person duly authorized, as of the Execution Date.

"LANDLORD"

Sante Partners, LLC

By: _____
Mark Hansen, CEO

"TENANT"

VistaRiver of King County, LLC

By: _____
Geoff Schackmann, Managing Member

LANDLORD'S ADDRESS FOR NOTICES:

1220 20th St SE #310
Salem, OR, 97302-1205

TENANT'S ADDRESS FOR NOTICES:

29100 SW Town Center Loop W
Suite 130
Wilsonville, OR 97070

ACKNOWLEDGEMENTS

State of Oregon)
) ss
County of Marion)

On this ___ day of _____, 2021 before me personally appeared _____, to me personally known, and acknowledged said instrument to be his/her free and voluntary act and deed on behalf of _____, for the uses and purposes named therein and on oath stated that s/he was authorized to execute said instrument on behalf of said limited liability company.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal this day and year first written above.

_____
Notary Public in and for the State of Oregon
My Commission Expires: _____

State of Oregon)
) ss
County of Marion)

On this ___ day of _____, 2021 before me personally appeared _____, to me personally known, and acknowledged said instrument to be his/her free and voluntary act and deed on behalf of _____, for the uses and purposes named therein and on oath stated that s/he was authorized to execute said instrument on behalf of said limited liability company.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal this day and year first written above.

_____
Notary Public in and for the State of Oregon
My Commission Expires: _____

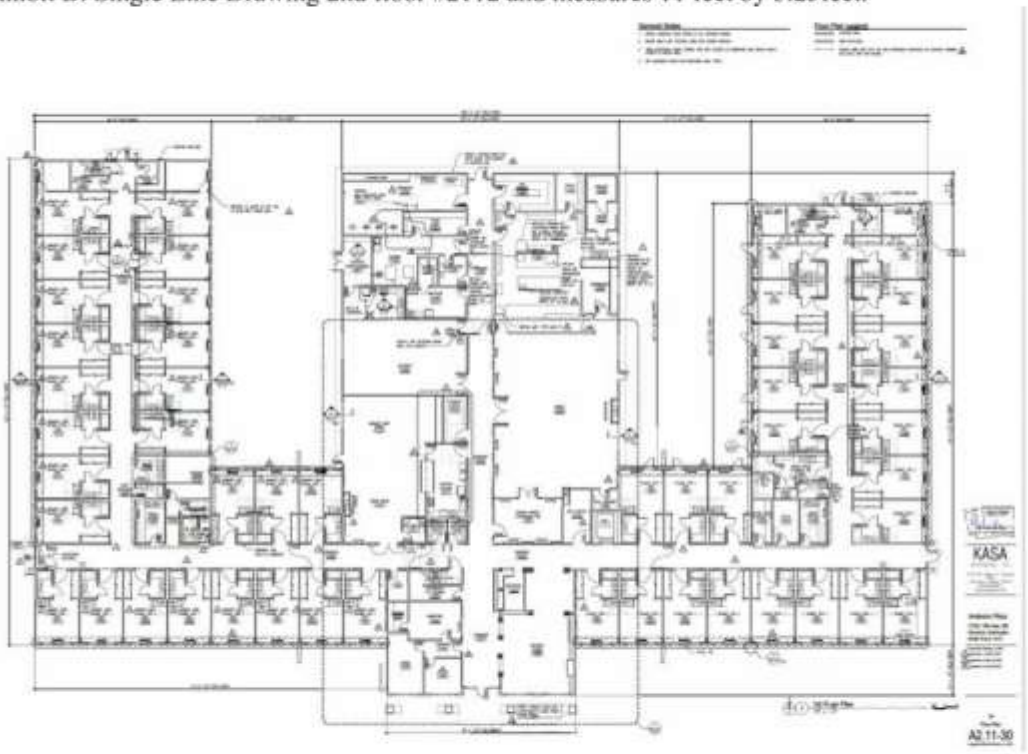
EXHIBIT A
LEGAL DESCRIPTION

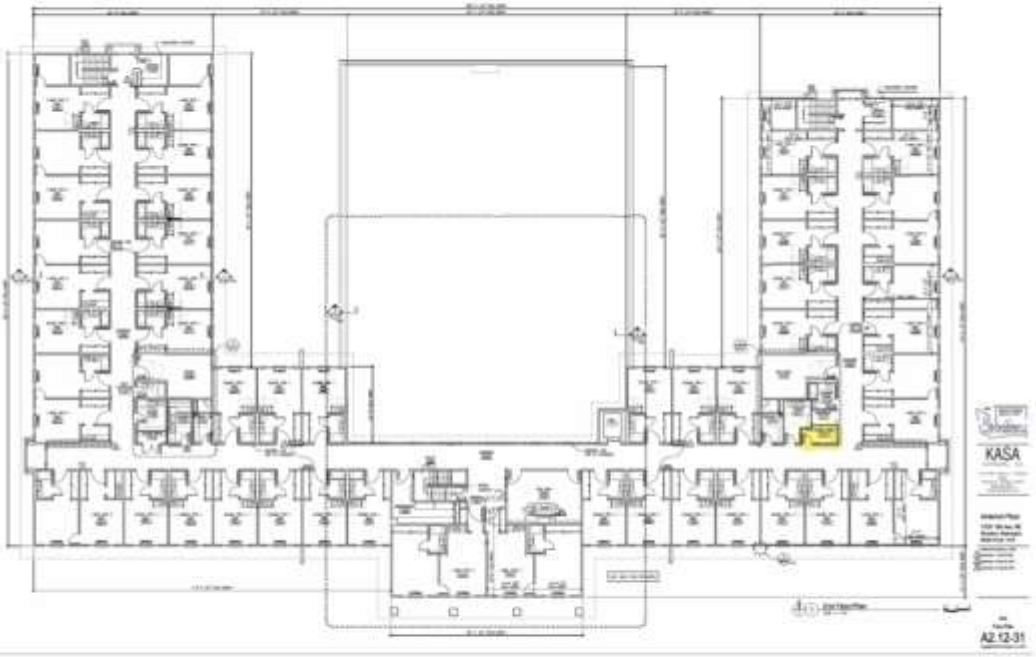
A PART OF THE SOUTHWEST QUARTER OF THE NORTHEAST QUARTER OF SECTION 9, TOWNSHIP 25 NORTH, RANGE 1 EAST, W.M., IN KITSAP COUNTY, WASHINGTON, DESCRIBED AS FOLLOWS:

BEGINNING 30 FEET EAST AND 458.2 FEET SOUTH 00°02' WEST FROM THE NORTHWEST CORNER OF SAID SOUTHWEST QUARTER OF THE NORTHEAST QUARTER; THENCE NORTH 89°37' EAST PARALLEL TO THE NORTH LINE OF SAID SOUTHWEST QUARTER OF THE NORTHEAST QUARTER A DISTANCE OF 400 FEET; THENCE SOUTH 157.5 FEET; THENCE SOUTH 89°37' WEST 400 FEET; THENCE NORTH 00°02' EAST 157.5 FEET TO THE POINT OF BEGINNING;

EXCEPT THAT PORTION WITHIN THE RIGHT-OF-WAY FOR NORTHWEST SCHOLD ROAD.

Exhibit B: Single Line Drawing 2nd floor #2112 and measures 11 feet by 5.25feet.




KASA
A2.12-31

Appendix 26: Assumptions

King County restated Need for assumption projections	2023		35 adc * 365 days per year = 12,775 default pt days 12,775 default pt days / 62.12 ALOS = 205.7 default admissions
Unmet Need ADC	85		
Agencies Need	2		
	365		
Unmet need pt days		30,889.00	2023 is a partial year (May - December)
Numeric Need	2		
Unmet pt days per numeric need		15,444.50	
ALOS	62.66		

VistaRiver Assumptions	2023	2024	2025	2026
Pt Days	3,744	9,608	12,649	19,250
% of unmet pt days per numeric need	24%	62%	82%	125%
VistaRiver	62.66	62.66	62.66	62.66
Monthly Admits	7.5	12.8	16.8	25.6
Annual Admits	59.7	153.3	201.9	307.2
ADC	15.3	26.3	34.7	52.7
VistaRiver Admits	60	153	202	307
	15.3	26.3	34.7	52.7

Community Referral by Setting*	2023	2024	2025	2026	
Hospital	6.0	15.3	20.2	30.7	10%
SNF	9.0	23.0	30.3	46.1	15%
Physican	20.9	53.7	70.7	107.5	35%
Clinic	22.4	57.5	75.7	115.2	38%
HH & Others	1.5	3.8	5.0	7.7	3%
Total	59.7	153.3	201.9	307.2	

**Based on applicants experience*

Routine	98.00%
Continuous Care	1.00%
Respite	0.60%
GIP	0.50%
Total	100.00%

Routine	98.00%
Continuous Care	1.00%
Respite	0.60%
GIP	0.50%
Total	100.00%

Care Level Utilization	2023	2024	2025	2026
Routine	3669	9416	12396	18865
Continuous Care	37	96	126	193
Respite	22	58	76	116
GIP	19	48	63	96
Total	3744	9608	12649	19250

Medicare	Blended Rate	Day 1-60	Days 61+	Day 1-60 %	Day 61+	Blended Rate
Routine (daily) (REV 0651)	$211.96	$223.69	$176.77	75.00%	25.00%	$211.96
Continous Care* (hourly rate) (REV 0652)	$544.24	$68.03	<- *Continuous Care Rate assumed per day rate to be 8 hours x hourly rate = daily reimburseable rate)			
Respite (daily) (REV 0655)	$326.70					
GIP (daily) (REV 0656)	$1,169.36					

WA HCA Medicaid	Blended Rate	Day 1-60	Days 61+	Day 1-60 %	Day 61+	Blended Rate
Routine (REV 651)	$216.28	$228.25	$180.38	75.00%	25.00%	$216.28
Continous Care (REV 652) (Hourly)	$555.36	$69.42	<- *Continuous Care Rate assumed per day rate to be 8 hours x hourly rate = daily reimburseable rate)			
Respite (REV 655)	$327.04					
GIP (REV 656)	$1,193.84					

Revenue by care level				
Routine	$ 777,640.20	$ 1,995,856.23	$ 2,627,535.18	$ 3,998,633.71
Continuous Care	$ 20,374.60	$ 52,292.54	$ 68,842.88	$ 104,766.42
Respite	$ 11,606.16	$ 29,787.84	$ 39,215.55	$ 59,678.97
GIP	$ 21,899.78	$ 56,206.98	$ 73,996.23	$ 112,608.88
Total	$ 831,520.74	$ 2,134,143.59	$ 2,809,589.83	$ 4,275,687.98

Payor Mix by Patient Day	
Medicare	89.00%
Medicaid	6.00%
PP, 3rd Party, VA	5.00%
Total	100.00%

Staff Count Per Position		ADC / Caseld	2023	2024	2025	2026
Administrator		100	0.0	0.0	0.0	0.0
ED / Director of Patient Care Svcs		100	1.0	1.0	1.0	1.0
Assistant Director of Clinical Svcs		75	0.0	0.0	0.0	0.0
Clinical Supervisor		30	0.0	0.4	1.4	1.9
Intake/Scheduling		50	1.0	1.0	1.0	1.1
Community Patient Coordinator		30	1.0	1.1	1.4	1.8
Hospice Aides		12	1.6	2.4	3.4	4.6
SW		30	1.0	1.1	1.4	1.9
Spiritual Care		65	0.3	0.4	0.6	0.8
Physician		150	0.1	0.2	0.3	0.4
Admissions Dedicated RN (Quick Response)		20	1.0	1.5	2.0	2.7
Bereavement		50	0.4	0.6	0.8	1.1
Volunteer		50	0.4	0.6	0.8	1.1
RN		12	1.6	2.4	3.4	4.6
LPN		25	0.8	1.2	1.6	2.2
Total Personnel			**10.1**	**13.8**	**19.2**	**25.1**

Line Item	Assumption
Revenue	
Routine Care Revenue	Days of Care x Daily Rate*
Inpatient Respite Revenue	Days of Care x Daily Rate*
Continuous Home Care	Days of Care x Hourly Rate*
General Iinpatient Revenue	Days of Care x Daily Rate*
Payor Mix by Patient Day	
Medicare	89.00%
Medicaid	6.00%
PP, 3rd Party, VA	5.00%
Total	100.00%
Care Level Utilization	
Routine	98.00%
Continuous Care	0.50%
Respite	1.00%
GIP	0.50%
Total	100.00%
Contractual adjustments	
Medicare Managed Care, Medicaid Manged Care, Private Pay, 3rd Party	Assumed 2% based on experience averages + source information
Charity Care	Assumed 2% based on
Provisions for Bad Debt	Assumed 1% based on
Contracted Patient Care	
Medical Director	MD Rates of $150 per hour per contract. Assumption of
Physical Therapist	$xx.xx/hr 1.5 hours per 20 ADC per month, based on CON Applications and Experience
Occupational Therapist	$xx.xx/hr 1.5 hours per 20 ADC per month, based on CON Applications and Experience
Speech Language Pathologist	$xx.xx/hr 1.5 hours per 20 ADC per month, based on CON Applications and Experience
Dietician	$xx.xx/hr 1.5 hours per 20 ADC per month, based on CON Applications and Experience
Direct Patient Care	
DME	$6.00 per patient day based on experience, Washington Averages, Industtry Averages
Pharmacy	$7.00 per patient day based on experience, Washington Averages, Industtry Averages
General Inpatient Costs	$1,196.70 per GIP days of care
Medical Supplies	$3.00 per patient day based on experience, , Washington Averages, Industtry Averages
Inmpatient Respite	$527.43 per inpatient respite days of care
Room & Board	$0.5 per patient day based on experience, Washington Averages, Industtry Averages
Mileage	Estimate 10 miles per day of care reimbursed at $0.51 per mile based on experience

Administrative Staff by	
Administrator	FTE x Annual Compensation
Director of Patient Care Svcs	FTE x Annual Compensation
Assistant Director of Clinical	FTE x Annual Compensation
Business Office Manager	FTE x Annual Compensation
Clinical Supervisor	FTE x Annual Compensation
Intake/Scheduling	FTE x Annual Compensation
Administrative	FTE x Annual Compensation
Non-Clinical Case Manager	FTE x Annual Compensation
Area Director	FTE x Annual Compensation
Payroll Taxes & Benefits	22% of Compensation
Annual Compensation	Growth Rate of 2% assumed
Clinical Staffing Costs	FTE x Annual Compensation
Clinical Staffing Payroll Taxes & Benefits	22% x Base Compensation

Appendix 27: ProForma

PRO FORMA PROFIT & LOSS

	2023	2024	2025	2026
Total Revenue	**$794,102**	**$2,038,107**	**$2,683,158**	**$4,083,282**
Total Direct Labor Cost	**$479,973**	**$1,184,228**	**$1,552,330**	**$2,356,787**
Gross Margin	$314,129	$853,879	$1,130,828	$1,726,495
Gross Margin/Revenue	40%	42%	42%	42%
Expenses				
Audit / Accounting Fees	$2,250	$2,250	$2,250	$2,250
Bad Debt	$7,941	$20,381	$26,832	$40,833
B&O Taxes	$11,912	$30,572	$40,247	$61,249
MyCancerJourney	$1,800	$1,800	$1,800	$1,800
EMR (MatrixCare)	$66,255	$50,255	$50,255	$50,255
Education (Quarterly Staff Mee	$1,000	$1,000	$1,500	$1,500
Facilities - Insurance (Commer	$600	$600	$600	$600
Facilities - Licensing (Joint Co	$8,000	$1,200	$1,200	$1,200
Depreciation	$655	$655	$655	$655
Aministrative/Office Payroll Ta	$66,650	$76,229	$103,130	$122,184
Total Admininstrative/Office P.	$266,600	$304,918	$412,519	$488,736
Total Op. Expenses	**$469,909**	**$526,106**	**$679,112**	**$811,387**
Op. Expenses/Revenue	59%	26%	25%	20%
Profit Before Int. & Tax	($155,780)	$327,772	$451,716	$915,108
EBITDA	($155,125)	$328,428	$452,371	$915,763
Interest Expense	$0	$0	$0	$0
Taxes Incurred	$26,856	$88,227	$136,278	$206,806
Net Profit	**($182,636)**	**$239,546**	**$315,438**	**$708,302**
Net Profit %	**-23.0%**	**11.8%**	**11.8%**	**17.3%**

Appendix 28: Balance Sheet

BALANCE SHEET

	2023	2024	2025	2026
Assets				
Current Assets				
Cash	$1,707,835	$2,073,177	$2,662,584	$3,477,847
Accounts Receivable	$0	$0	$0	$0
Inventory	$0	$0	$0	$0
Other Current Assets	$0	$0	$0	$0
Total Current Assets	$1,707,835	$2,073,177	$2,662,584	$3,477,847
Fixed Assets				
Long-term Assets	$9,828	$9,828	$9,828	$9,828
Accum. Depreciation	$655	$1,310	$1,966	$2,621
Land	$0	$0	$0	$0
Total Fixed Assets	$9,173	$8,518	$7,862	$7,207
Total Assets	$1,717,008	$2,081,695	$2,670,446	$3,485,054
Liabilities and Capital				
Current Liabilities				
Accounts Payable	$115,976	$148,763	$224,850	$261,473
Current Borrowing	$0	$0	$0	$0
Other Current Liabilities	$0	$0	$0	$0
Subtotal Current Liabilities	$115,976	$148,763	$224,850	$261,473
Long-term Liabilities	$0	$0	$0	$0
Total Liabilities	$115,976	$148,763	$224,850	$261,473
Paid-in Capital	$1,500,000	$1,500,000	$1,500,000	$1,500,000
Retained Earnings	$0	$101,031	$432,932	$945,596
Earnings	$101,031	$331,901	$512,664	$777,985
Total Capital	$1,601,031	$1,932,932	$2,445,596	$3,223,581
Total Liabilities and Capital	$1,717,008	$2,081,695	$2,670,446	$3,485,054

Appendix 29: VistaRiver of King County, LLC Financial Projections

Please see Excel file for complete projections

Appendix 30: VistaRiver Available Funds

BANK OF AMERICA

BANK OF AMERICA, N.A. (THE "BANK")

Transaction History

VISTARIVER OF KING COUNTY, LLC

BUSINESS ADVANTAGE SAV

**** **** 3736

Last Posting Date 12/28/2021

Date/Time Printed 12/29/2021 5:43 PM EST

Since Last Statement Summary

Last Statement Date:
Balance Last Statement ($)
Deposits/Credits (+) #
Withdrawals/Debits (-) #
Holds (-)
Pending Credits (+)

Available Balance ($) $3,001,000.00

#Counts include posted items only-Intraday items are not included in the counts
Balance Last Statement, Deposits/Credits, Withdrawals/Debits may not total to Available Balance

Date	Description		Type	Amount	Available Balance
12/21/2021	Online Banking transfer from CHK 1380	Confirmation# 5512179500	Transfer	$3,000,000.00	$3,001,000.00
12/01/2021	Online Banking transfer from CHK 1364	Confirmation# 2439763805	Transfer	$1,000.00	$1,000.00

No More Activity For This Account

For additional information or service, please contact the Customer Service Center at: 1-800-432-1000

**** **** 3736

* = Item(s) included in Previous Statement(s).

Appendix 31: Letter of Financial Commitment

VISTARIVER
HOSPICE

Eric Hernandez, Program Manager

Certificate of Need

Department of Health

PO Box 47852

Olympia, WA 98504-7852

RE: Letter of financial commitment on behalf of VistaRiver of King County, LLC

Dear Mr. Hernandez,

The principal owners of the applicant, VistaRiver of King County, LLC, write to convey the financial commitment to establish a Medicare and Medicaid certified hospice agency in King County. The application has been reviewed and approved. We are confident that our cash reserves will sufficiently cover all the necessary expenses associated with establishing, operating, and maintaining a Hospice agency in King County.

Financial statements have been included in the application that support the underlying project along with a letter from the respective banking representatives that confirm the cash reserves are sufficient support this project.

The undersigned write to fully support VistaRiver of King County, LLC's CN application

Sincerely,

VistaRiver King County HoldCo,LLC

Geoff Schackmann, Managing Member

Jonathan Bliss, Managing Member

Jeff Baumgarner, Managing Member

Sante Holdings, LLC

Mark Hansen, CEO

Jacob Schaefer, CFO

Appendix 32: MyCancerJourney Market Research

African American Breast Cancer Care Disparities

Well documented **differences** in **access** and **quality** of care **for minorities**

50% less likely to receive appropriate treatment

33% higher death rate than Caucasians

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3037129/
http://action.acscan.org/site/DocServer/cancer-disparities-chartbook.pdf
http://www.medscape.com/viewarticle/803155
JAMA. 1997;277(18):1485-1492. doi:10.1001/jama.1997.03540420081039

1

We Believe Patients Should Be

Supported & encouraged to participate in their health care decisions

Fully informed with accurate, unbiased & understandable information

Respected by having their goals & concerns honored

Market Research & SDM Evidence

PotentiaMetrics

WHAT MYCANCERJOURNEY DOES:

- Compares **benefits** and **harms**
- Provides information to **clarify** treatment options
- Focuses on **outcomes that matter** to people

WHAT MYCANCERJOURNEY DOES NOT DO:

- Tell health providers how to practice medicine
- Substitute clinical judgement tailored to individual patients
- Replace clinical practice guidelines or provide clinical recommendations

BASIS OF VALUE BASED DECISIONS

Loftus, P. (2018, June 3). Doctors Suggest Less Chemo, Surgery for Some Cancer Treatments. *Wall Street Journal*.

THE WALL STREET JOURNAL.

Doctors Suggest Less Chemo, Surgery for Some Cancer Treatments

Researchers explore leaner approaches aimed at sparing patients tough side effects—and costs

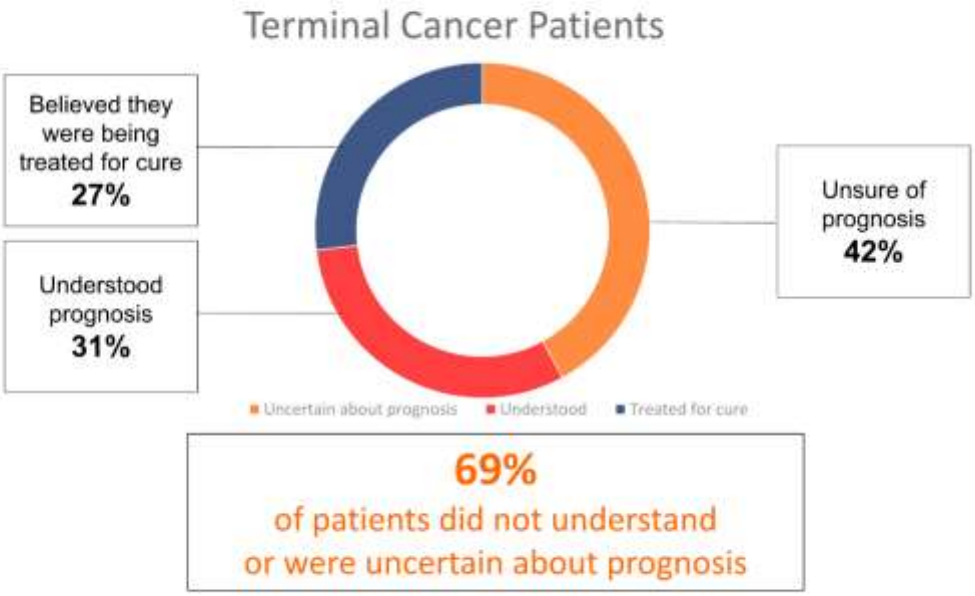
36 year-old stage 1 breast cancer

Option	Treatment	*Avg 1-year Direct Cost	**5-year survival
1	Surgery	$25,419	97.7%
2	Surgery & Chemo	$91,901	98.0%
3	Surgery, Radiation & Chemo	$111,454	97.6%

"Tens of thousands of women were overtreated, they got surgery they didn't need, they got radiation they didn't need, and they got chemotherapy they didn't need," Steven Katz, M.D., Professor of Medicine at the University of Michigan

*Multiple peer reviewed sources used to estimate the first year reimbursements. Summary of model design available upon request.
**Survival analyses are driven by MyInsights, using Cox proportional hazards models derived from National Cancer Data Base (NCDB) cancer registry data of over 150,000 patients, and thus incorporate the actual outcomes of patients with the same diagnosis and similar clinical characteristics, demographic factors and comorbidities.

MANY DO NOT UNDERSTAND THEIR PROGNOSIS



Br J Cancer. 2004 Jul 19;91(2):254-7.

EVIDENCE FOR USING DECISION AIDS

Joosten E. A. G, DeFuentes-Merillas L, de Weert G. H, Sensky T, van der Staak C. P. F, de Jong C. A. J. Systematic Review of the Effects of Shared Decision-Making on Patient Satisfaction, Treatment Adherence and Health Status. Psychother Psychosom 2008;77:219-226

86 RCTs	• Increased patient knowledge • Increased patient involvement in decision making • Increased proportion of patients with accurate risk perceptions
7 RCTs	• Lower surgery rates • No evidence of harm from not having surgery
2 Group Health Studies	• Higher patient knowledge and & Satisfaction • Lower surgery rates with similar outcomes

MCJ MARKET RESEARCH

PCP 80% likely or very likely to reference

Oncologist 80% likely or very likely to reference

Patient 50% likely or very likely to reference

Caregivers 57% likely or very likely to reference

Patients 35% would forgo treatment based on information provided

MCJ MARKET RESEARCH

Patients < 65 with college education 80% likely or very likely to reference

Patients > 65 without college education 50% likely or very likely to reference

Patients > 65 without college education 80% likely or very likely to reference through their doctor

Minority & non-English speaking patients 80% likely or very likely to reference

- Suspect about the care they receive
- View this information as empowering

85% of cancer patients wished to be involved in treatment decisions. However, patients' preferences for involvement in decision making are variable and are affected by factors such as age, sex, and education.

An introduction to patient decision aids
BMJ 2013; 347 doi: https://doi.org/10.1136/bmj.f4147 (Published 23 July 2013)Cite this as: *BMJ* 2013;347:f4147

Appendix 33: Operating Agreement

VISTARIVER KING COUNTY HOLDCO, LLC
OPERATING AGREEMENT

This Operating Agreement (this "Agreement") is effective this **SANTE PARTNERS, LLC** (the "Effective Date"). This Agreement is entered into by and between **Geoff Schackmann, Jonathan Bliss and Jeff Baumgarner.** ("VistaRiver") and **Sante Partners, LLC** . ("Sante ") with respect to the ownership, management and operation of **VistaRiver of King County, LLC**. ("VistaRiver") an Washington limited liability company (the "Company").
Geoff Schackmann ("Schackmann") and Mark Hansen ("Hansen"), owners of VistaRiver King County HoldCo, LLC and Sante Partners, LLC. respectively are collectively referred to herein as "Members"and for the purposes of this agreement are also referred to as "Managers" and individually as a"Member" and "Manager". The Members hereby agree as follows:

AGREEMENT

NOW, THEREFORE, in consideration of the following terms and conditions, the receipt and sufficiency of which is hereby acknowledged, the Members do hereby agree as follows:

ARTICLE I - THE COMPANY

1.1 **Prior Formation. Company Name and Notifications.** The Company is already formed pursuant to the provisions of the Act (hereinafter defined). The name of the Company is **VistaRiver King County HoldCo, LLC.** – Employer Identification Number: **87-4023391.**

1.2 **Sole Permitted Business.** Subject to any limitations contained in the Articles of Organization, the Company shall carry on the sole and exclusive business of acquiring, developing, and operating hospice businesses (the "Business"). The Company may engage in all activities incidental to the Business.

1.3 **Powers and Privileges.** The Company shall possess and may exercise all the powers and privileges granted by the Act, by any other law, and by this Agreement, together with any powers incidental thereto. Without limiting the generality of the foregoing, subject to the limitations and consents specified herein, the Company is hereby authorized to:

(a) Enter into formal and informal contracts with any Person in furtherance of the Business;

(b) Incur and assume indebtedness and grant security interests pertaining to any of its property to secure repayment of any such indebtedness; and

(c) Enter into any kind of activity for, necessary to, in connection with, or incidental to the accomplishment of the Business, so long as the activities are lawfully carried on or performed by the Company under the laws of the State of Washington or any other jurisdiction in which the activities are entered into or performed.

1.4 **Place of Business.** The principal place of business and specified office of the Company shall

be located at Laurel Cove Community Shoreline, WA, or such other place or places as the Managers may from time to time designate in writing. Geoff Schackmann is hereby designated as agent for service of process for the Company in Washington. The agent may resign or be replaced by the Managers at any time.

1.5 Term. The term of the Company commenced on the filing of the Articles of Organization and shall continue in perpetuity or until dissolved as provided in Article VII.

1.6 Fiscal Year. The fiscal year of the Company shall be the calendar year.

ARTICLE II - DEFINITIONS

2.1 "Act" shall mean the Washington Limited Liability Company Act of the Washington Corporations Code and may be amended and/or supplemented, and all successors thereto.

2.2 "Capital Account" shall mean the account maintained with regard to each Member pursuant to Article III.

2.3 "Capital Contributions" shall mean the amounts contributed by each Member to the Company under Article III hereof.

2.4 "Code" shall mean the Internal Revenue Code of 1986, as amended, and all successors thereto.

2.5 "Event of Insolvency" means when the Company or a Member: (i) petitions for, obtains, or becomes subject to an order for relief under the federal Bankruptcy Code; (ii) petitions for, obtains, or becomes subject to an order, judgment or decree of insolvency under state law; (iii) makes an assignment for the benefit of creditors; (iv) consents to or suffers the appointment of a receiver or trustee to any substantial part of its assets that is not vacated within 30 days; (v) consents to or suffers an attachment or execution on any substantial part of its assets that is not released within 30 days; or (vi) consents to or suffers a charging order against its Percentage Interest that is not released or satisfied within 30 days.

2.6 "Managers" shall mean Geoff Schackmann and Mark Hansen and their authorized successors.

2.7 "Members" shall mean represented by Geoff Schackmann; and VistaRiver Holdco LLC represented by Mark Hansen and any person who becomes a Memberthereafter in accordance with the terms of this Agreement

2.8 "Percentage Interests" of the Members shall be as follows: VistaRiver (50%) and SANTE PARTNERS, LLC (50%). Percentage Interests shall also include all rights to capital, voting rights, profits, and distributions associated therewith and shall be subject to the potential allocation of losses andfurther contribution requirements that are provided herein with respect thereto.

2.8 "Person" shall mean any natural person, the Company, joint venture, corporation, trust, association or other legal entity.

2.9 "Prime Rate" shall mean the prime rate of interest published from time to time by the Wall Street Journal.

2.10 "Profits or Losses" shall mean all items of income, gain, loss, expense and deduction, as determined under the Company's method of accounting in accordance with the Code.

2.11 "Regulations" shall mean the regulations currently in force as final or temporary that have been issued by the U.S. Department of Treasury pursuant to its authority under the Internal Revenue Code, and shall include proposed regulations so issued except as the Members may otherwise determine.

2.12 "Vote" shall mean one vote for each percent of the Percentage Interest of each Member. For example, as of the execution of this Agreement, VistaRiver has a 50% Percentage Interest; therefore, SANTE PARTNERS, LLC has 50 votes out of 100. A "Prevailing Vote"shall consist of approval by any combination of Members who, cumulatively, cast votes totaling a simple majority of the total Percentage Interests in the Company.

ARTICLE III - CAPITAL

3.1 Capital Accounts. The Company shall maintain an account (a "Capital Account") for each Member in accordance with the following provisions:

(a) Each Member's Capital Account shall be increased by: the amount of money contributed by the Member to the capital of the Company; the net fair market value of property contributed by the Member to the capital of the Company; and allocations of Company Profits and any items of income or gain that are specially allocated to the Member pursuant to Section 4.4 hereof.

(b) Each Member's Capital Account shall be decreased by: the amount of money distributed to the Member by the Company; the fair market value of property distributed to the Member by the Company (net of liabilities secured by such distributed property that the Member is considered to assume or take subject to); allocations of Company Losses; and any items of expense or loss that are specially allocated pursuant to Section 4.4 hereof.

(c) In the event of (i) the contribution of money or other property (other than a de minimus amount) to the Company by a new or existing Member as consideration for an interest or an adjustment to an interest (in the case of an existing Member) in the Company, (ii) the distribution of money or other property (other than a de minimus amount) by the Company to a Member as consideration for an interest in the Company, or (iii) the liquidation of the Company, and if the Managers reasonably determine that an adjustment is necessary or appropriate to reflect the Members' relative economic interests in the Company, the Company's assets shall be revalued on the Company's books at their respective fair market values and the Members' Capital Accounts

shall be increased or decreased in accordance with applicable law to reflect the manner in which unrealized income, gain, loss or deduction inherent in Company assets would be allocated among the Members if there were a taxable disposition of such assets for fair market value as of the date of the event described above.

(d) Additional adjustments shall be made to the Members' Capital Accounts in accordance with applicable law, as determined by the Managers upon consultation with the Company's accountants, to the extent necessary to comply therewith. The provisions of this Agreement relating to the maintenance of Capital Accounts are intended to comply with applicable law and shall be interpreted and applied in a manner consistent therewith.

3.2 Capital Contributions. The Members shall make capital contributions to the Company in the amounts set forth in Exhibit "A" attached hereto and made a part hereof.

3.3 Additional Capital Contributions. The Managers may call for additional capital contributions or other assessments (collectively "Additional Capital Contributions" and individually an "Additional Capital Contribution") from the Members at such times and in such amounts as determined by the Managers in the exercise of their discretion in the best interests of the Company. The Members shall make such Additional Capital Contributions in proportion to their respective Percentage Interests. The Managers shall give notice of Additional Capital Contributions in writing and shall state in the notice the date that the contribution is due (but not more than 60 days from the date of the notice), the amount of each Member's contribution, and the business purpose of the contribution.

3.4 Member Call for Additional Capital Contributions. Any Member may request the Managers to call for an Additional Capital Contribution pursuant to Section 3.3 by delivering to the Managers a written request and proposal for the Additional Capital Contribution, including therein a description of the purpose, need, and amount of the proposed Additional Capital Contribution. If, within 20 days of receipt of the request for the Additional Capital Contribution, the Managers fail or refuse to call for the Additional Capital Contribution as requested by the Member, the Managers shall, at the written request of the Member, call a meeting of the Members pursuant to Section 6.3 to have a Vote on the proposed Additional Capital Contribution. If, at the meeting, a Prevailing Vote supports the proposed Additional Capital Contribution, the Managers shall call for the Additional Capital Contribution pursuant to Section 3.3. If 50 percent of the Percentage Interests, but not a Prevailing Vote, vote in favor of the proposed Additional Capital Contribution, the issue shall be resolved by the decision of a third-party certified public accountant, or someone similarly licensed or experienced, selected by the Managers. The cost of the third-party review shall be paid by the Company. Within 30 days of his or her appointment, the third-party shall decide, in writing, whether the proposed Additional Capital Contribution is necessary and appropriate under the circumstances of the Company. If the third-party decides in favor of the proposed Additional Capital Contribution, the Managers shall call for the Additional Capital Contribution pursuant to Section 3.3.

3.5 Contributing Members and Delinquent Members. A Member who contributes timely all of an Additional Capital Contribution shall be considered a contributing Member (a

"Contributing Member"). A Member who fails to contribute timely all or any portion of an Additional Capital Contribution shall be considered a delinquent Member (a "Delinquent Member").

3.6 Remedies in the Event of a Delinquent Member. Upon the failure of a Delinquent Member to contribute timely all or any portion of an Additional Capital Contribution, one of three events shall occur:

(a) The Contributing Members elect to make a Contribution Loan (as defined in and pursuant to the terms of section 3.7) in the full amount of the Additional Capital Contribution not contributed by the Delinquent Member. In such case, the Contribution Loan, and its consequences, shall be governed by this Article III, except for section 3.11.

(b) No Contributing Member elects to make a Contribution Loan. In such case, the failure of the Delinquent Member to contribute the Additional Capital Contribution shall be governed by this Article III, except for sections 3.7, 3.8, 3.9, and 3.10.

(c) The Contributing Members elect to make a Contribution Loan (as defined in and pursuant to the terms of section 3.7) in the amount of some, but not all, of the Additional Capital Contribution not contributed by the Delinquent Member. In such case, the Contribution Loan, and its consequences, shall be governed by this Article III, except for section 3.11, and the Delinquent Member's unpaid portion of the Additional Capital Contribution for which there is no Contribution Loan shall be governed by this Article III, except for sections 3.7, 3.8, 3.9, and 3.10.

3.7 Contribution Loan. A Contributing Member may, at the election and discretion of the Managers, advance to the Company, in cash, the Additional Capital Contribution, in whole or in part, owed by a Delinquent Member, and such advance shall be treated as a nonrecourse loan from the Contributing Member to the Delinquent Member (a "Contribution Loan"). If more than one Contributing Member wants to participate in a Contribution Loan, they may do so only in proportion to their respective Percentage Interests. (For example, if two Contributing Members, one with a 50% Percentage Interest and one with a 25% Percentage Interest, want to make a Contribution Loan, the Contribution Loan shall be divided 50/75 to the Contributing Member with the 50% Percentage Interest and 25/75 to the Contributing Member with the 25% Percentage Interest.) A Contribution Loan shall bear interest at the lesser of (a) the Prime Rate plus three percentage points, or (b) the maximum, nonusurious rate then permitted by law for such loans. Repayment of a Contribution Loan shall be due and payable at the earlier of: (a) six months after the money is advanced to the Company, or (b) upon the sale or dissolution of the Company. The six-month term of the Contribution Loan may be extended at the election of the Contributing Members making the Contribution Loan. Repayment of a Contribution Loan shall be secured by the Delinquent Member's interest in the Company. The Delinquent Member hereby grants a security interest in his membership interest in the Company, including all rights to receive distributions of cash or property from the Company, to the Contributing Member or Members making the Contribution Loan and hereby irrevocably appoints the Contributing Member or Members making the Contribution Loan as his attorney-in-fact with full power to prepare and execute any reasonable documents, instruments and agreements, including, but not limited to,

reasonable Uniform Commercial Code Financing and Continuation Statements, and other reasonable security instruments as may be appropriate to perfect and continue such security interest in favor of the Contributing Member or Members making the Contribution Loan. Copies of all such documents shall be mailed to the Delinquent Member.

3.8 Capital Treatment of Contribution Loan. In the event of a Contribution Loan, the Delinquent Member shall be deemed to have contributed an amount equal to the principal amount of the Contribution Loan to the capital of the Company, which amount shall be credited to the Capital Account of the Delinquent Member. Notwithstanding anything herein to the contrary, until the Contribution Loan is repaid in full by the Delinquent Member (a) no return shall accrue with respect to any amounts deemed to be contributed to the capital of the Company by the Delinquent Member pursuant to this paragraph, (b) the Delinquent Member shall receive no further distributions from the Company, and (c) all cash or property otherwise distributable to the Delinquent Member shall be distributed to the Contributing Members who made the Contribution Loan (in proportion to their participation in the Contribution Loan) as a reduction of the outstanding amount, including all unpaid interest, of the Contribution Loan, with the distributions being applied first to the accrued interest and then to the principal balance of the Contribution Loan. Any distributions so applied shall be treated, for all purposes under this Agreement, as having actually been distributed to the Delinquent Member and applied by the Delinquent Member to repay the Contribution Loan.

3.9 Failure to Repay Contribution Loan. If a Delinquent Member fails to repay timely a Contribution Loan in full, the Contributing Members making the Contribution Loan may (a) extend the term of the Contribution Loan (or portion thereof) pursuant to the terms of section 3.7, or (b) contribute all or any portion of the outstanding principal balance, and any accrued interest, of the Contribution Loan (or portion thereof) to the capital of the Company and dilute the Percentage Interest of the Delinquent Member pursuant to the provisions of section 3.10. Upon making an election pursuant to this paragraph, the Contributing Member making the election shall give notice of the election to the Delinquent Member. Failure of the Contributing Member to give notice of the election within 30 days of the due date of the Contributing Loan shall be deemed to be an election to extend the term of the Contribution Loan for an additional six months.

3.10 Dilution of Percentage interest of Delinquent Member in the Event of a Contribution Loan. If a Contributing Member making a Contribution Loan elects to contribute the amount of the Contribution Loan (in whole or in part) to the capital of the Company pursuant to section 3.9, the Capital Account of the Contributing Member shall increase in the amount of the contribution and the Capital Account of the Delinquent Member shall decrease in the amount of the contribution. In addition to the changes in Capital Accounts as set forth in this paragraph, the Percentage Interest of the Contributing Members making the contribution shall increase and the Percentage Interest of the Delinquent Member shall decrease in an amount calculated as follows: the amount contributed by the Contributing Members pursuant to this paragraph divided by the Delinquent Member's Percentage Interest of the appraised value of the Company, multiplied by the Delinquent Member's Percentage Interest. Any and all adjustments to the Members' respective Percentage Interests pursuant to this section shall be rounded to the nearest one one-hundredth of one percentage point (0.01%) and the Contributing Members shall not succeed to all or any portion

of the Capital Account of the Delinquent Member as the result of any such adjustment. Notwithstanding anything herein to the contrary, the Delinquent Member's Percentage Interest shall in no event be reduced below one-hundredth of one percent (.01%) by operation of this section. Upon the dilution of the Delinquent Member's Percentage Interest pursuant to this section, the Delinquent Member shall be fully and finally released from all obligations or liability with respect to the relevant Contribution Loan.

The following is an example of the calculation of the dilution in the Percentage Interest of a Delinquent Member pursuant to this section 3.10:

> The appraised value of the Company is $500,000. The Additional Capital Contribution is $100,000. Member A's Member Percentage Interest is 25%, making Member A responsible for $25,000 of the Additional Capital Contribution. Upon Member A's failure to make the Additional Capital Contribution, the Contributing Members make a Contribution Loan to Member A in the amount of $25,000. Member A defaults on the Contribution Loan. The Contribution Loan of $25,000 (inclusive of all costs and interest for purposes of this example) is contributed to the capital of the Company by the Contributing Members.
>
> To determine the dilution of Member A's Percentage Interest, the amount contributed ($25,000) is divided by $125,000 (which is 25% of the appraised value of the Company), resulting in a figure of 20%, which is multiplied by 25% (Member A's Percentage Interest). The result is five percent.
>
> Thus, Member A's Percentage Interest is reduced from 25% to 20%. If there were only one Contributing Member, his or her Percentage Interest would increase by five percent. If there were multiple Contributing Members, their Percentage Interests would increase in a total of five percent, divided among them in proportion to their participation in the amount contributed to the capital of the Company.

3.11 Dilution of Percentage Interest of Delinquent Member in the Event of No Contribution Loan. In the event that Contributing Members elect not to make a Contribution Loan for any or all of the unpaid Additional Capital Contribution of a Delinquent Member, the Percentage Interest of the Contributing Members shall increase and the Percentage Interest of the Delinquent Member shall decrease in an amount calculated as follows: the amount not contributed by the Delinquent Member (reduced by the amount of any partial Contribution Loan) divided by the Delinquent Member's Percentage Interest of the appraised value of the Company, multiplied by the Delinquent Member's Percentage Interest, multiplied by the result of the Additional Capital Contributions contributed by the Contributing Members divided by the total Additional Capital Contribution. Except as expressly stated herein, the provisions of section 3.10 apply to this section.

The following is an example of the calculation of the dilution in the Percentage Interest of a Delinquent Member pursuant to this section 3.11:

> The appraised value of the Company is $500,000. The Additional Capital Contribution is $100,000. Member A's Member Percentage Interest is 25%, making

Member A responsible for $25,000 of the Additional Capital Contribution. Upon Member A's failure to make the Additional Capital Contribution, the Contributing Members make no Contribution Loan for Member A's unpaid $25,000.

To determine the dilution of Member A's Percentage Interest, the amount not contributed ($25,000) is divided by $125,000 (which is 25% of the appraised value of the Company), resulting in a figure of 20%, which is multiplied by 25% (Member A's Percentage Interest), resulting in five percent, which is multiplied by 75% (the result of $75,000 (the Contributing Members' contributed portion of the Additional Capital Contribution) divided by $100,000 (the total Additional Capital Contribution). The result is 3.75%.

Thus, Member A's Percentage Interest is reduced from 25% to 21.25%. If there were only one Contributing Member, his or her Percentage Interest would increase by 3.75%. If there were multiple Contributing Members, their Percentage Interests would increase in a total of 3.75%, divided among them in proportion to their participation in Additional Capital Contribution.

3.12 Determination of Appraised Value. For purposes of sections 3.10 and 3.11, the appraised value of the Company shall be determined by an independent, qualified appraiser appointed by the Managers. If, for any reason, the Managers cannot or will not agree on the appointment of an appraiser, the appraiser shall be appointed by the Superior Court of Multnomah County, State of Washington, upon petition by any Manager. The appraiser shall promptly determine the appraised value of the Company as the cash available for distribution to the Members based on the greater of (a) the price at which the Company would sell as an ongoing business enterprise, excluding the entire amount of the relevant contribution, but including the assumption of the debts and obligations of the Company, or (b) the sale of the assets of the Company, excluding the entire amount of the relevant contribution, at the assets' fair market value if such assets were sold in the open market allowing a reasonable time to find a purchaser who purchases with knowledge of the business of the Company as of the date of the relevant contribution, less debts and obligations of the Company and less a reasonable reserve for any contingent, conditional or unmatured liabilities or obligations of the Company.

3.13 No interest No Member shall be paid, receive, or accrue any annual or other monetary interest on contributions to Company capital.

3.14 Withdrawal of Capital; Limitation on Distributions. No Member shall have the right or power to: (i) withdraw or reduce all or any part of his Capital Account or his contribution to the capital of the Company, except as a result of the dissolution of the Company or as otherwise provided by law, (ii) demand or receive any distributions from the Company, except as expressly provided herein, (iii) bring an action for partition against the Company, (iv) cause the termination and dissolution of the Company by court decree or otherwise, except as set forth in this Agreement, (v) demand or receive property other than cash from the Company, or (vi) have priority over any other Member either as to the return of contributions of capital or as to allocations

of the profits, losses or distributions of the Company. Other than upon the termination and dissolution of the Company, as provided by this Agreement, there has been no time agreed upon when the Capital Account or capital contribution of each Member is to be returned.

3.15 Enforceability of Provisions. THE MEMBERS ACKNOWLEDGE AND AGREE THAT, UNDER THE CIRCUMSTANCES EXISTING AS OF THE DATE HEREOF, THE REMEDIES PROVIDED FOR IN THIS ARTICLE ill ARE FAIR AND REASONABLE AND DO NOT CONSTITUTE A FORFEITURE OR PENALTY. THE MEMBERS FURTHER ACKNOWLEDGE AND AGREE THAT THEY HAVE BEEN PROVIDED WITH THE OPPORTUNITY TO CONSULT WITH INDEPENDENT COUNSEL WITH RESPECT TO THE PROVISIONS OF THIS ARTICLE III AND AGREE AND COVENANT NOT TO CONTEST THE VALIDITY OR ENFORCEABILITY OF ANY SUCH REMEDY AS A PENALTY, FORFEITURE, OR OTHERWISE IN ANY COURT OF LAW OR EQUITY AND/OR ARBITRATION (OR OTHERWISE).

ARTICLE IV - DISTRIBUTIONS AND ALLOCATIONS

4.1 Distributions. From time to time, the Managers shall determine the amount, if any, by which Company funds then on hand exceed the reasonable working capital needs of the Company, including reasonable reserves for future Company obligations, liabilities and expenses. The Managers, in their sole discretion, may retain property or funds for any purpose or may distribute and pay excess funds to the Members. If distributions are made, the distributions shall be made in proportion to the Percentage Interests of the Members.

4.2 Allocation of Net Profits. Subject to the prior application of Special Allocations (as defined in Section 4.4), net profits for any taxable year (or shorter period as may be required in order to comply with applicable law) shall be allocated to the Members in proportion to their respective Percentage Interests.

4.3 Allocation of Net Losses. Subject to the prior application of Special Allocations, net losses for any taxable year (or shorter period as may be required in order to comply with applicable law) shall be allocated to the Members in proportion to their respective Percentage Interests.

4.4 Special Allocations. Special allocations ("Special Allocations") shall mean allocations of items of income, gain, loss, deduction or credit that are specially allocated pursuant to this Agreement other than by allocation as part of net profits or net losses as such, and may be made by the Managers if determined necessary and consistent with the Code and Regulations.

4.5 Part Year Membership. If any Member is not a Member for any fiscal year, or if his Percentage Interest changed during such year, the share of profits, losses and distributions allocable to such Member shall be determined consistent with the portion of the year during which he was a Member and by taking into account his varying Percentage Interest.

ARTICLE V - MANAGEMENT AND BUSINESS POLICIES

5.1 Management of the Company. Subject to the provisions of Section 5.3 hereof, the Managers shall have full and complete authority and discretion in the management and control of the business of the Company for the purposes herein stated, and shall jointly make all decisions affecting the business of the Company. Included in the Managers' duties, without limitation, and except as may otherwise be set forth herein, shall be the right and responsibility of operating the business of the Company and making all decisions related thereto including decisions regarding financing, accounting, sales, contractual format, and compliance with all federal, state and local regulatory and statutory requirements and procedures. The Managers shall manage and control the affairs of the Company to the best of their ability and shall use their best efforts to carry out the business of the Company. In connection therewith, the Managers shall have the specific rights and powers set forth in Section 5.2 below and elsewhere in the Agreement, subject to the limitations of Section 5.3 hereof. The initial number of Managers shall be two, subject to change by the unanimous Vote of the Members. The initial Managers shall be Schackmann and Bliss subject to change by the unanimous Vote of the Members. In the event of the resignation or incapacity of Schackmann, the successor to Schackmann shall be selected solely by Schackmann, or Schackmann's legal representative. In the event of the resignation or incapacity of Bliss, the successor to Bliss shall be selected solely by Bliss, or Bliss' legal representative. For purposes of this Section 5.1 only, the term "incapacity" shall mean the inability of a Manager, for any reason whatsoever, to conduct the affairs of the Company in the ordinary course of business for a period of 60 consecutive days.

5.2 Specific Rights and Powers. In addition to any other rights and powers which they may possess, but subject to the limitations of Section 5.3 and the remaining provisions of this Agreement, the Managers shall have all specific rights and powers required for or appropriate to their management of the Company's business, which, by way of illustration and not limitation, shall include the rights and powers to do the following:

(a) Make or have made for the Company such research reports, economic and statistical data, evaluations, analyses, opinions and recommendations as it may deem necessary or desirable with respect to the financing, operation or management of the Company's business;

(b) Investigate and make determinations with respect to the selection and employment of, and relations with, attorneys, accountants, consultants, borrowers, lenders, agents, employees, and other persons acting in any other capacity, in connection with the Company's business, and to pay fees, expenses, salaries, bonuses, wages, distributions, and other compensation to such persons;

(c) Expend the capital and revenues of the Company in furtherance of the Company's business;

(d) Enter into and execute all agreements, leases, documents, certificates, and other instruments deemed by the Managers to be necessary or appropriate to the proper operation of the Company's business, and necessary or appropriate to perform effectively and properly their duties

or exercise their powers hereunder;

(e) To borrow money on such terms and conditions as the Managers may determine from banks, other lending institutions, and other lenders for any Company purposes, and pledge the assets of the Company to secure repayment of the borrowed sums, executing in connection therewith on behalf of the Company any notes, deeds of trust or other loan documents required by any lender in connection therewith; and, as between this Company and the lender, it shall be conclusively presumed that the proceeds of such loan are to be and will be used for the purposes authorized under this Agreement;

(f) Invest Company assets in bank savings accounts, savings and loan associations, commercial paper, government securities, certificates of deposit, bankers' acceptances, and other short-term interest-bearing obligations and deposit; withdraw, pay, retain and distribute the Company funds in any manner consistent with the provisions of this Agreement; and loan Company funds on such terms and conditions as the Managers may deem desirable in connection with the conduct of the Company business;

(g) Replace or obtain replacement of encumbrances related in any way to the Company business, and prepay in whole or in part, refinance, recast, increase, modify, consolidate, or extend any loans or encumbrances affecting the Company and/or the Company's business;

(h) Enter into agreements and contracts with third parties and give receipts, releases and discharges with respect thereto and any matters incident thereto as the Managers may deem advisable or appropriate; modify, adjust, submit to arbitration, prosecute, defend or compromise, upon such terms as the Managers may deem advisable or appropriate, any obligation, suit, liability, cause of action or claim, in law or equity, including taxes, either in favor of or against the Company;

(i) Purchase, at the expense of the Company, liability and other insurance to protect the property and the business of the Company or the Members;

(j) Delegate all or any of the powers, rights and obligations of the Managers under this Agreement, and appoint (as attorney-in-fact or otherwise), employ, contract or otherwise deal with any person for the transaction of the business of the Company, which person may, under the supervision of the Managers, perform any acts or services for the Company as the Managers may approve;

(k) Perform any and all other acts or activities customary or incident to the acquisition, ownership, construction, management, improvement, and disposition of real and personal property and the Company's business;

(l) Make such elections under the tax laws of the United States, the State of Washington, and other relevant jurisdictions as to the treatment of items of Company income, profit, loss, deduction and credit, fiscal year, accounting method, and as to all other matters

arising under such tax laws as the Managers believe necessary or desirable.

(m) Call for Additional Capital Contributions as provided in Section 3.3 hereof.

(n) Give, negotiate, contract, and approve options for ownership interests in the Company to employees, investors, and other third parties providing goods, services, and/or benefits to the Company.

5.3 Limitations on Managers' Authority. The Managers shall have no authority to do any act prohibited by law, nor shall the Managers have any authority, without the written unanimous approval of the Members, to:

(a) Enter into contracts on behalf of the Company after the occurrence of an Event of Insolvency with regard to the Company or an event of dissolution as set forth in Section 7.1 herein, except as may be necessary to wind up the affairs of the Company;

(b) Alter the Business of the Company as set forth in Section 1.2 of this Agreement;

(c) Receive from the Company a rebate or give-up, or participate in any reciprocal business arrangements which would enable a Manager, or any person or entity controlled by a Manager, to do so;

(d) Purchase property from the Company;

(e) Cause the Company to loan Company assets to a Manager;

(f) Commingle the Company funds with those of any other person or entity;

(g) Cause the Company to enter into any transaction with any other company or venture in which a Manager has any interest, except as provided for in this Agreement;

(h) Take any action that changes the Percentage Interests, other than pursuant to Section 5.2(n);

(i) Enter into a bulk sale of the assets of the Company;

(j) Terminate or dissolve the Company;

(k) Amend this Agreement; or

(l) Enter into a contract on behalf of the Company with a total annual cost to the Company exceeding $50,000.

5.4 Salaries, Overhead, Fees and Commissions: Reimbursements. All salaries, fees, compensation, bonuses, commissions, and options associated with or paid to Company employees, consultants, Members, contractors, representatives, and Managers shall be

determined by, and in the discretion of, the Managers. Subject to the review and approval of the Managers, the Managers and employees shall be entitled to reimbursement for any and all out-of-pocket and third party expenses reasonably incurred in the operation and business of the Company including, but not limited to, mileage, travel expenses, including airfare and ground transportation, and food.

5.5 Vote of Managers. Any decision to be made by the Managers must be by unanimous consent. In the event the Managers cannot agree upon a decision, the matter shall be determined by a simple majority vote of the Managers.

5.6 Manager or Affiliate Dealing With the Company: Member Loans. Any Manager, Member, person related to a Manager or Member, or a company controlled by a Manager or Member may contract or otherwise deal with the Company for the sale of goods or services to the Company if compensation paid or promised for the goods and services is reasonable (i.e., the fees, terms and conditions of the transactions are at least as favorable to the Company as would be obtainable in an arm's-length transaction), and is paid only for goods and services actually furnished to the Company. If the Company has insufficient cash to pay its obligations when due, any Member, with the approval of the Managers, may loan money to the Company for payment of the obligations on such terms and conditions as the lending Member and Managers may determine. Each such loan shall constitute a loan from the Member to the Company and shall not constitute a capital contribution.

5.7 Indemnification: Reimbursement of Expenses; Insurance. To the fullest extent permitted by applicable law:

(a) The Company shall indemnify each Manager or officer who was or is threatened to be made a party to any threatened, pending or completed action, suit or proceeding, whether civil or criminal, and any appeal therein, or any inquiry or investigation preliminary thereto (hereinafter a "Proceeding"), solely by reason of the fact that he is or was a Manager and was acting within the scope of his duties or under the authority of the Members. If the Proceeding is criminal, the Company's obligation to indemnify shall exist only if the Manager or officer had no reasonable cause to believe the conduct was unlawful.

(b) The Company shall pay or reimburse a Manager for expenses incurred by the Manager (1) in advance of the final disposition of a Proceeding to which the Manager was, is or is threatened to be made a party, and (2) in connection with his appearance as a witness or other participation in any Proceeding. The Company, by a Prevailing Vote, may indemnify and advance expenses to any officer, employee or agent of Company to the same extent and subject to the same conditions under which it may indemnify and advance expenses to Managers herein. The provisions of this Section 5.7 shall not be exclusive of any other right under any law, provision of this Agreement, or otherwise.

(c) Notwithstanding the foregoing, this indemnity shall not apply to actions constituting gross negligence, willful misconduct or bad faith, but shall apply to actions constituting simple negligence. The Company may purchase and maintain insurance to protect

itself and any Manager, officer, employee or agent of the Company, whether or not the Company would have the power to indemnify such person under this Section 5.7. This indemnification obligation shall be limited to the assets of the Company and no Member shall be required to make an Additional Capital Contribution in respect thereof.

5.8 Managers Not to be Liable. A Manager shall have no liability based upon any action taken or failure to act as a Manager if the Manager acts or fails to act in good faith and if the Manager believes the action taken or failure to act is in the best interests of the Company and its Members. In taking action or failing to act, a Manager shall be entitled to rely in good faith on information, opinions, reports, and statements, including financial statements and other financial data, in each case prepared or presented by any of the following: (1) one or more officers or employees of the Company whom the Manager in good faith believes to be reliable and competent in the matters presented; and (2) counsel, independent accountants, or other persons as to matters that the Manager in good faith believes to be within the person's professional or expert competence. In addition, the Manager may delegate his obligations under this Agreement to employees or independent contractors whom the Manager in good faith believes to be reliable and competent to discharge the obligations, whose services and compensation shall be at the expense of the Company. A Manager is not obligated to devote all of the time or business efforts of the Manager to the affairs of the Company.

5.9 Books and Records. The Managers shall cause to be maintained, at the Company's expense, complete and accurate books of the Company at the Company's principal place of business, showing all receipts and expenditures, assets and liabilities, income and loss, and all other records necessary for recording the Company's business and affairs, so that it is possible to determine, among other things, the amount of capital actually contributed by each Member, the amount of cash distributed to each Member, and all Company items of income, gain, loss, deduction or credit. The books of the Company shall be kept on a cash basis of accounting and shall be open to inspection, examination, and copying by any Member upon notice and at reasonable times.

5.10 Bank Accounts. The Managers shall open and maintain in the Company's name a Company bank account or accounts, in which shall be deposited all Company funds and only Company funds. The funds in the Company bank account(s) shall be used solely for the business of the Company. Withdrawals from any Company bank account may be made by checks or other withdrawal forms signed by persons designated by the Managers.

5.11 Reports. The Managers shall cause the Company's accountants, at the Company's expense, to prepare and deliver to each Member as promptly as practicable and in any event within 90 days after the end of each fiscal year, a statement of the Member's Capital Account and a statement of profit and loss for the preceding year, all in reasonable detail, together with a statement showing the amount of income, loss, gain and other items allocable to each Member for federal income tax purposes.

5.12 Tax Matters.

(a) Returns. The Managers shall cause, at Company expense, to be prepared and filed all income tax returns for the Company.

(b) Tax Matters Member. Bliss shall serve as the "tax matters partner" under the Code and is hereby vested with all powers and duties as stated in the Code, including but not limited to the right and authority to represent the Company before any office of the Internal Revenue Service with respect to income tax matters regarding the Company, and to appoint an attorney-in-fact to represent the Company before any office of the Internal Revenue Service.

ARTICLE VI - CERTAIN LIABILITIES AND RIGHTS OF MEMBERS

6.1 Limitation of Members' Liabilities. Except as otherwise specified herein, no Member shall be personally liable for any of the debts of the Company or any of the losses thereof beyond the amount of such Member's positive Capital Account.

6.2 No Control of Business or Right to Act for Company. The Members, other than Managers, shall take no part in nor interfere in any manner with the control of the Company's business, and shall have no right or authority to act for or bind the Company.

6.3 Right to Vote. Wherever in this Agreement a right to vote is provided to the Members, the procedure shall be conducted as a Vote, and the issue shall be determined based upon a Prevailing Vote. Members who are also Managers may vote on any and all Company issues. Any Member may call for a Vote of any issue or matter that is subject to a Vote of the Members by the terms of this Agreement by giving notice to the Managers of the Member's call for a Vote, but not more than three times per calendar year, including therein a description of the issue or matter of the requested Vote. Upon receipt of the notice of the call for a Vote, the Managers shall, within 30 days after receipt of the notice, give notice of a meeting of Members to conduct the Vote. If there are no Managers, any Member may call for a Vote to replace the Managers by giving notice of not less than 20 days to all of the Members for a meeting and the Vote.

6.4 No Competing Activity; Business Opportunities.

(a) Except as set forth in this Section 6.4, no Member shall directly or indirectly, own, manage, operate, join, advise, control or otherwise engage or participate in or be connected as an owner, shareholder, partner, investor, employee, consultant, advisor, officer, director, independent contractor, creditor, guarantor, or agent of any person, company, business, partnership, firm, entity or other organization that provides, markets or otherwise sells services or goods competitive with the services or goods provided by the Company, other than for, through, or on behalf of the Company in the market established in the Portland, Washington surrounding area.

(b) Except as set forth in this Section 6.4, no Member shall market, recruit, solicit, hire, encourage, or assist any other person or entity to market, recruit, or solicit, any of the Company's customers or prospective customers, other than for, through, or on behalf of the Company. For purposes of this subparagraph, a customer is any person or entity that has purchased services or

goods from the Company at any time within 12 months before the Member ceases to be a Member. For purposes of this subparagraph, a prospective customer is any person or entity with whom the Company has engaged in written or oral communication regarding the Company's services or goods at any time within the 12 months before the Member ceases to be a Member.

(c) No member shall, either on his/her own account or for any person, firm or company, solicit, interfere with, or endeavor to cause any employee of the Company to leave his or her employment or induce or attempt to induce any such employee to terminate or breach his or her employment agreement, if any.

(d) The prohibitions of this Section 6.4(a) shall be effective so long as the Member is a Member and for 12 months after the Member ceases to be a Member, provided that in the latter situation, either the Company or the other Members, purchase the Member's interest in the Company in accordance with Article VIII hereof or otherwise. In the event that any court finds 12 months to be overbroad or unenforceable, then the prohibitions shall be effective for nine months after the Member ceases to be a Member. In the event that any court finds nine months to be overbroad or unenforceable, then for six months after the Member ceases to be a Member. In the event that any court finds six months to be overbroad or unenforceable, then for three months after the Member ceases to be a Member.

(e) The other prohibitions of this Section 6.4 shall be effective so long as the Member is a Member and for 12 months after the Member ceases to be a Member.

(f) If a Member violates the prohibitions of this Section 6.4, commits fraud, willful misconduct, gross negligence, habitual negligence, or misappropriation of funds, or is convicted of a crime involving moral turpitude (a "Violating Member"), then, at the election and discretion of the Managers, and without further notice, demand or advertisement to the Violating Member (all of which are hereby expressly waived by the Violating Member), the Violating Member shall be immediately expelled from the Company and shall be treated as an expelled Member ("Expelled Member"). An Expelled Member shall have no right to participate in the affairs of the Company. All adjustments to the Capital Account of an Expelled Member pursuant to Section 3.1 shall be deemed to have ceased as of the day upon which the Violating Member is expelled, and the Capital Account of the Expelled Member shall thereafter be subordinate to the Capital Accounts of all other Members, and shall be repaid to the Expelled Member under the terms hereof only after the Company's obligations to all other Members have been satisfied in full. The Expelled Member's Percentage Interest shall be proportionately divided among the remaining non-expelled Members based on their respective Percentage Interests. The expulsion of a Member shall not dissolve or terminate the Company. In lieu of, but not in addition to, the rights and remedies provided for in this Section 6.4, the Managers may elect, in their discretion, to evoke and pursue any and all other remedies against the Expelled Member, whether provided at law or in equity, including, but not limited to, bringing suit for damages, specific performances, or the appointment of a receiver or specific master.

(g) Each Member acknowledges that the covenants of this Section 6.4 are necessary to

protect the legitimate business interests of the Company and do not prevent the Member from earning a livelihood. Each Member agrees that, if the scope or breadth of the enforceability of any or all of the restrictive covenants set forth herein are disputed as overbroad or unenforceable, a court may modify and enforce the covenants to the extent it believes them to be reasonable under the circumstances existing at that time and consistent with applicable law.

(h) Notwithstanding anything in this Section 6.4 to the contrary, Members may directly compete with the Company as follows: (i) by and through any business, hospice or other healthcare related entity, as long as it is not in the same geographical coverage area as Heritage Hospice LLC.

6.5 Confidential Information. Each Member acknowledges that during the term of this Agreement, the Member will have access to and will learn confidential, proprietary, and trade secret information ("Confidential Information") of the Company. The Confidential Information includes, but is not limited to, designs, plans, and information regarding the sales, policies, pricing, practices, and financial matters of the Company, all of which shall be considered the exclusive property of the Company. Each Member acknowledges and agrees that all Confidential Information is of great value to the Company and that the Member is receiving the Confidential Information for the sole purpose of enabling the Company and the Member to comply with the terms of this Agreement and to perform work in connection with the Business of the Company. Each Member agrees that the Member will not, at any time or in any manner, disclose to any person or entity or use, in any manner, the Confidential Information except(a) as expressly authorized, in writing, by the Managers; (b) if such Confidential Information is, or becomes generally available to the public other than as a result of a disclosure by the Member; or (c) in the case a Member is legally compelled to disclose such Confidential Information whether by law or by or to a judicial, administrative, or regulatory authority; provided, however that the Member shall provide the Company and/or the other Members with prompt written notice of such legal compulsion so that the Company and/or the other Members may seek a protective order or other available remedy.

ARTICLE VII - DISSOLUTION AND LIQUIDATION

7.1 Dissolution. The Company shall be dissolved upon the happening of any of the following events:

(a) An Event of Insolvency with regard to the Company, or the withdrawal of the last Manager without replacement within 60 days;

(b) The Company becomes insolvent or bankrupt;

(c) The sale, exchange or disposition of all or substantially all of the assets of the Company;

(d) The cancellation of the Certificate of Limited Company, the dissolution of the Limited Company by judicial decree, or all Members cease to be such and no additional Members are admitted; or

(e) Upon a Prevailing Vote.

If any of the events specified in this Section 7.1 shall occur, the Company shall not terminate until its affairs have been wound up and its assets distributed as provided herein.

7.2 Procedure for Winding Up. Upon the occurrence of an event specified in Section 7.1, the Manager shall wind up the affairs of the Company, shall sell all of the Company assets as promptly as is consistent with obtaining, insofar as possible, the fair market value thereof, and, after paying all liabilities, including all costs of dissolution, and subject to the right of the Managers to set up such cash reserves as he or they may deem reasonably necessary for any contingent or unforeseen liabilities or obligations of the Company, shall distribute the remainder, pursuant to the provisions of Article IV of this Agreement.

7.3 No Withdrawal. No Member may withdraw from the Company without a Prevailing Vote. Any violation of this restriction shall result in a default by the withdrawing Member and entitle the Company to exercise all legal rights against the withdrawing Member for a wrongful withdrawal, including the right to seek damages.

ARTICLE VIII - TRANSFERS OF PERCENTAGE INTEREST

8.1 Effect of Non-complying Transfer. Any assignment, sale, gift, exchange, encumbrance, lien, or other transfer of any interest (a "Transfer") of any Percentage Interest shall be of no force or effect, and shall be null, void, and ineffectual, and shall not bind or be recognized by the Company, unless the Transfer is in complete accordance and compliance with the provisions of this Article VIII.

8.2 Compliance with Law. In addition to the other restrictions set forth in this Article VIII, no Transfer shall be made unless and until it appears, to the full satisfaction of the Managers, that the Transfer will not be in violation of, or otherwise render the Company and/or the Managers liable under the Securities Act of 1933, as amended (and the rules and regulations promulgated thereunder) or under any other applicable federal or state laws. The Managers may require additional documents, including appropriate opinions of counsel, in order to meet the foregoing conditions of this Section 8.2.

8.3 Conditions to Assignment of Percentage Interest. Subject to the other provisions of this Article VIII, including but not limited to the rights of first refusal and rights of purchase set forth in Sections 8.4, 8.6, and 8.7, a Member may make a Transfer of all or a portion of his Percentage Interest if the transferring Member first complies in full with the following conditions:

(a) A duly executed and acknowledged written instrument of assignment, in form and content satisfactory to the Managers, shall be delivered to the Company, which instrument shall specify the Percentage Interest being assigned and shall state the intention of the transferring Member that the assignee succeed to the transferring Member's interest as a Member in the Percentage Interest transferred;

(b) The transferring Member and assignee shall deliver to the Managers such other instruments as the Managers deem necessary or desirable to effect the Transfer, including but not limited to a written acceptance by the assignee of all of the provisions of this Agreement, a written assumption of all of the transferring Member's obligations hereunder, and a written acceptance of

the assignment by any affected third-party creditors (i.e., any bank or financial institution to which the assignor had guaranteed an obligation).

(c) The Managers shall obtain a written opinion of legal counsel selected by the Managers, in form and content satisfactory to the Managers, that the Transfer will not violate any federal or state laws, will not jeopardize the Company's federal income tax status, and complies in full with this Agreement.

(d) A transfer fee shall be paid to the Company by the transferring Member and/or the assignee sufficient to cover all reasonable expenses, including all legal fees, connected with the Transfer; and

(e) The Managers shall have consented to the Transfer, which consent may be granted or withheld in the Managers' sole and absolute discretion, which consent shall not be unreasonably withheld.

8.4 Right of First Refusal on Sale. If a Member proposes to enter into a Transfer of any or all of his Percentage Interest (other than a transfer described in Section 8.5 or to another Member), the Member shall, by notice to the Managers, first offer the Percentage Interest to the Company on the same terms and conditions upon which the Member proposes to complete the Transfer. The Company shall have 30 days after receipt of the notice of the proposed Transfer to elect to purchase the Percentage Interest. If the Company elects not to purchase the offered Percentage Interest or otherwise fails to respond within the 30 days, then the Member shall, by notice to the other Members, offer the Percentage Interest to the other Members on the same terms and conditions upon which the Member proposes to complete the Transfer. The Members shall have 30 days after receipt of the notice of the proposed Transfer to elect to purchase such Percentage Interest. If more than one Member elects to purchase the offered Percentage Interest, the electing Members shall purchase the offered Percentage Interest in proportion to their respective Percentage Interests. If the Members elect not to purchase the offered Percentage Interest or otherwise fail to respond within the 30 days, then the selling Member shall thereafter be free, for a period of 90 days to complete the Transfer on terms not less favorable to the selling Member as those offered to the Company and the other Members. If the transferring Member fails to complete the Transfer within the 90 days, the transferring Member shall be offered again to the Company and other Members pursuant to this Section 8.4.

8.5 Right to Assign to Family or Trust. Notwithstanding anything herein to the contrary, a Member shall have the right to assign, by gift or upon his death, by intestacy or by will, his Percentage Interest to a spouse, child, or a family trust, provided that the assignment complies with Section 8.3(a) through (d). Notwithstanding anything herein to the contrary, if a family trust that received an assignment of a Percentage Interest from a former Member distributes the Percentage Interest back to the former Member, the Company shall recognize and accept the former Member as the owner of the Percentage Interest.

8.6 Right to Purchase Upon Divorce, Death, Bankruptcy, Permanent Incapacity or Dissolution.

(a) Upon the death, Event of Insolvency, permanent incapacity dissolution of a Member, or termination of employment of a Member (for any of the following reasons: termination for cause, voluntary termination, or retirement) ("the Withdrawing Member"), the Company and/or the other Members shall purchase all of the Percentage Interest of the Withdrawing Member pursuant to this Section 8.6. For purposes of this Section 8.6 only, the term "permanent incapacity" shall mean the inability of a Member, for any physical, mental, or emotional cause, to be unable to understand or conduct his business affairs for a period of 60 consecutive days, and shall include, immediately upon issuance, any issuance of a judgment or order of a court for a conservator or guardian for the Member, or declaring the Member mentally unstable or handicapped. For purposes of this Section 8.6 only, "termination for cause" means termination due to a willful breach of duty by the Member in the course of employment, or the habitual neglect of duties by the Member in the course of employment, or the Member's continued incapacity to perform the duties of employment. A Member who is subject to a petition or procedure of divorce or marital dissolution shall be a Withdrawing Member, and the Percentage Interest of the Member shall be subject to purchase by the Company and/or the other Members pursuant to this Section 8.6, if he fails to receive, as part of the procedure of divorce or marital dissolution, the full, complete, sole, and separate ownership rights to his Percentage Interest.

(b) In the case of an Event of Insolvency or dissolution, a Withdrawing Member shall forthwith give notice to the Managers of the applicable Event of Insolvency or, if an entity, its dissolution. In the case of divorce or marital dissolution, a Withdrawing Member shall forthwith give notice to the Managers of any judgment, decree, or order awarding an ownership interest in the Withdrawing Member's Percentage Interest to any other person or entity. In the case of death or permanent incapacity, the Withdrawing Member's representative shall forthwith give notice to the Managers of the Withdrawing Member's death or permanent incapacity. Upon receipt of notice pursuant to this Section 8.6(b), or upon the Managers' independent discovery of facts indicating a Withdrawing Member, the Managers shall forthwith give notice to the other Members of the notice received or facts discovered. In the case of termination of employment of a Member, the Managers shall forthwith give notice to the other Members of such termination.

(c) Upon receipt of the notice given pursuant to Section 8.6(b), the other Members shall have 30 days within which to elect to purchase the Withdrawing Member's Percentage Interest. In the case of termination of employment of a Member, the other Members shall have 30 days from the last day of employment within which to elect to purchase the terminated Member's Percentage Interest. If more than one Member elects to purchase the Withdrawing Member's Percentage Interest, the electing Members shall purchase the offered Percentage Interest in proportion to their respective Percentage interests. If the Members elect not or fail to elect to purchase the Withdrawing Member's Percentage Interest within the 30 days, then the Company shall purchase the Withdrawing Member's Percentage Interest.

(d) The total purchase price for the Withdrawing Member's Percentage Interest in the Company shall be computed by taking the fair market value of the assets of the Company less the total liabilities of the Company as of the valuation date, multiplied by the Percentage Interest of the Withdrawing Member, then less the amount of any obligations owed by the Withdrawing Member to the Company. For purposes of this Section 8.6, the fair market value of the assets of

the Company shall be determined by the agreement of the Withdrawing Member, or the Withdrawing Member's representative in the case of the Transferring Member's death, and the purchasing party or parties. If the parties to the purchase transaction do not agree to the fair market value of the assets of the Company, then the fair market value of the assets of the Company shall be determined by an appraiser appointed by the Company, at the equal expense of the parties to the transaction. The Company's appraiser shall submit his appraisal to the Managers by a written report that shall be distributed forthwith to the purchasing parties. If a party to the transaction disagrees with the Company's appraisal, that party shall have the right to obtain an additional appraisal, at his expense, of the fair market value of the assets of the Company. The additional appraiser(s) shall submit the appraisal(s) by written report(s) to the Managers who shall forward the appraisal(s) to the parties to the transaction. If there is less than 10 percent difference between the highest and lowest appraisals, the fair market value of the Company's assets shall be the average of all of the appraisals. If there is more than 10 percent difference between the highest and lowest appraisals, then the Company's appraiser and the other appraiser(s) shall jointly appoint another appraiser who shall appraise the fair market value of the assets of the Company and submit the appraisal by written report to the Managers who shall forthwith distribute the appraisal to the parties to the transaction. The fair market value of the assets of the Company shall then be determined by disregarding the highest and lowest appraisals and taking the average of all of the other appraisals. The fair market value shall be determined as of the date when the Withdrawing Member became a Withdrawing Member. All appraisers appointed shall have not less than 10 years of experience as certified business appraisers within the State of Washington.

8.7 Right of First Refusal Upon Default of Loan. If any Member proposes to give a security interest in the Member's Percentage Interest to secure a loan or other obligation, the security instrument granting such security interest shall give the Company and other Members the option (in the event the loan or other obligation is in default) to purchase the borrowing or obligated Member's Percentage Interest in the same order and terms as provided in Sections 8.4 and 8.8 for the lesser price of: (a) the outstanding balance of the loan or obligation secured by the Percentage Interest, or (b) the value of the pledged Percentage Interest as of the default. The value of the pledged Percentage Interest shall be determined by the same procedure used in Section 8.6(d).

8.8 Closing Procedure for Purchase of Member's Percentage Interest.

(a) The closing of the purchase of a Withdrawing Member's Percentage Interest pursuant to Sections 8.4, 8.6, and 8.7 shall be held 120 days from the exercise of any election or option to purchase at 10:00 a.m., Washington time, at the principal office of the Company, or at suchother date, time and place as shall be agreed upon by the parties to the transaction.

(b) In the case of a purchase pursuant to Section 8.4 hereof, the purchase price shall be paid in accordance with the terms and conditions of the offer.

(c) In the case of a purchase pursuant to Section 8.6 hereof, the purchase price of the Withdrawing Member's Percentage Interest shall be payable as follows: A down payment of 10% of the purchase price (20% in the case of a deceased or incapacitated Withdrawing Member) shall

be payable at the settlement.

(1) The balance of the purchase price shall be paid in six equal annual principal installments (four years in the case of a deceased or incapacitated Transferring Member), the first installment to be due one year following the closing date, and subsequent annual principal payments shall be due on the same day of each successive year thereafter.

(2) Interest on the deferred balance of the purchase price shall bear interest at the then Prime Rate from the closing date until paid in full (adjusted monthly on the 1st day of each month). Accrued interest shall be payable at the same time as installments of principal.

(3) Notwithstanding the foregoing, the unpaid balance of the purchase price for the selling Member's Percentage Interest shall be immediately due and payable if any of the following events occur:

(i) Any material default in the payment of principal or interest pursuant to the terms of the payment of the purchase price.

(ii) If an Event of Insolvency occurs with regard to the Company or any of the purchasing Members.

(iii) If the Company sells, disposes, or transfers all or most of its assets.

(iv) The winding up of the Company's business affairs.

(4) The unpaid balance of the purchase price, including accrued interest, shall be secured by a security interest in the Transferring Member's Percentage Interest.

ARTICLE IX - MISCELLANEOUS

9.1 Certificates and Filings. The Members shall execute any and all documents to comply with the requirements of the Act.

9.2 Partial Invalidity. The invalidity of a portion of this Agreement shall not affect the validity of the remainder hereof.

9.3 Governing Law: Parties in Interest. This Agreement shall be governed by and construed according to the laws of the State of Washington and, subject to the restrictions on transfer contained herein, shall bind and insure to the benefit of the heirs, successors, assigns, and personal representatives of the Members.

9.4 Amendment. This Agreement may be amended from time to time by a Prevailing Vote. Notwithstanding the foregoing, any amendment that will cause the Members to lose their

limited liability or affect the status of the Company as a limited liability company for federal income tax purposes shall require the written consent of all of the Members.

9.5 Execution in Counterparts. This Agreement or any amendment thereto may be executed in counterparts, all of which taken together shall be deemed an original.

9.6 Titles and Captions. All article, section or paragraph titles or captions contained in this Agreement are for convenience only and are not deemed part hereof.

9.7 Meetings. The Managers may, upon 20 days prior written notice, call a meeting of Members. The Managers shall determine the time and date for the meeting. The meeting shall be held at the principal office of the Company or such other location as the Managers may designate in the notice. The Managers shall cause minutes of the meeting to be kept and shall provide copies of the minutes, including all adopted resolutions, to all Members within five business days after the meeting.

9.8 Notices. All notices hereunder, whether for meetings or otherwise, shall be in writing and may be given by hand delivery, facsimile transmission, e-mail or by regular mail to the last known addresses of the Members. All hand delivered notices, facsimile notices, and e-mail notices shall be effective upon delivery, provided that facsimile notices and e-mail notices shall be additionally mailed to the recipient. All notices given by mail only shall be effective three days after deposit in the mail.

9.9 Pronouns and Plurals. All pronouns and any variations thereof are deemed to refer to the masculine, feminine, neuter, singular or plural as the identity of the Person or Persons may require.

9.10 Consent to Jurisdiction and Venue. Each Member irrevocably and unconditionally consents and submits for himself and his respective Percentage Interest, to the fullest extent permitted by law, to the personal, exclusive jurisdiction and venue of any trial court in the Multnomah County, State of Washington, for purposes of any dispute, claim (whether direct or derivative, in tort, contract, statutory, or otherwise), or disagreement concerning (1) the interpretation or application of this Agreement, (2) the rights, duties, powers, and privilegesof the Managers or Members under this Agreement, (3) the termination, expulsion or removal of a Member or Manager, (4) the termination of a Manager's employment with the Company, and (5) the rights of a Member pursuant to the Act. The Members further agree that for any cause of action in connection with this Agreement, the Company, or the Act, venue is proper inthe County of Multnomah, State of Washington. The Members irrevocably waive to the fullest extentpermitted by applicable law the defense of an inconvenient forum to the maintenance of a judicial proceeding in the jurisdiction identified above, and waive, to the fullest extent permittedby law, the defense of improper venue or right to removal with respect to any claim subject to this Section 9.10.

9.11 Injunctive Relief. The Members recognize and acknowledge that in the event of any breach of any provision of Sections 6.4 or 6.5 of this Agreement, irreparable harm will be suffered by the Company and that any remedy available at law will be inadequate and that in

such event the Company shall be entitled to seek injunctive relief in any court of competent jurisdiction against a Member or former Member and against any other person or entity involved in or connected with the breach, without necessity of posting any bond, cash or security against/for the Member or former Member or any other person or entity involved in or connected with the breach, which right shall be in addition to all rights that the Company may have for damages and in addition to all other remedies that the law or equity may provide. In the event the Company is successful in enforcing the restrictive covenants of this Agreement to any extent, the duration of the restrictive covenant(s) contained in this Agreement that are enforced shall be computed from the date such relief is granted reduced by the time period between termination of a Member's membership, whether voluntarily or involuntarily, with or without cause and with or without notice, and the date of the first violation of the covenant(s) by a Member.

9.12 Attorney's Fees. If any party hereto institutes a lawsuit or other proceeding against any other party in any way connected with this Agreement or its enforcement, or as between a Member and the Company, the prevailing party to any such action shall be entitled to recover from the other party reasonable attorney fees (not to exceed the actual attorney fees incurred), witness fees and expenses, and court costs in connection with the suit or proceeding at both trial and appellate levels, regardless of whether any such action or proceeding is prosecuted to judgment.

9.13 Entire Agreement. This Agreement contains the entire understanding between the Members in their capacity as such, and supersedes any prior understandings and agreements between them with respect to the subject matter hereof.

IN WITNESS WHEREOF, the Members have executed this Agreement to be effective as of the date set forth at the beginning of this Agreement.

COMPANY:

VistaRiver King County HoldCo, LLC

Geoff Schackmann, Managing Member

_____

Mark Hansen, CEO Sante Partners, LLC

MEMBERS:

VistaRiver, INC

Geoff Schackmann, CEO

_____

Mark Hansen, CEO Sante Partners, LLC