LEE L. JOHNSON
TREASURER
SYMBOL HEALTHCARE, INC.

direct line (208) 401-1369
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lee.johnson@pennantservices.com

MANITO HOME HEALTH

OCTOBER 13, 2023

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

RE: Spokane County Hospice Certificate of Need Application for ***Orchard Prairie Healthcare LLC, d/b/a Manito Home Health***

Dear Mr. Eric Hernandez,

Accept the attached as Orchard Prairie Healthcare LLC, d/b/a Manito Home Health Certificate of Need application proposing a service area expansion to provide services to Medicare and Medicaid eligible patients in **Spokane** County.

Please note that payment was made by check (# 0143927) mailed via USPS Priority Mail for 2-Day Delivery.

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

Sincerely,

Lee Johnson
Treasurer

Home Health Agency Certificate of Need Application Packet

Contents:

Application submission must include:

- One electronic copy of your application, including any applicable addendum – no paper copy is required.
- A check or money order for the review fee of **$24,666** payable to **Department of Health.**

Include copy of the signed cover sheet with the fee if you submit the application and fee separately. This allows us to connect your application to your fee. We also strongly encourage sending payment with a tracking number.

- Mail or deliver the application and review fee to:

Mailing Address:

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

Contact Us:

Certificate of Need Program Office 360-236-2955 or FSLCON@doh.wa.gov.

Application Instructions

The Certificate of Need Program will use the information in your application to determine if your project meets the applicable review criteria. These criteria are included in state law and rules. Revised Code of Washington (RCW) 70.38 and Washington Administrative Code (WAC) 246-310.

General Instructions:

- Include a table of contents for application sections and appendices/exhibits
- Number **all** pages consecutively
- Make the narrative information complete and to the point.
- Cite all data sources.
- Provide copies of articles, studies, etc. cited in the application.
- Place extensive supporting data in an appendix.
- **Provide a detailed listing of the assumptions you used for all of your utilization and financial projections, as well as the bases for these assumptions.**
- Under no circumstance should your application contain any patient identifying information.
- Use **non-inflated** dollars for **all** cost projections
- **Do not** include a general inflation rate for these dollar amounts.
- **Do** include current contract cost increases such as union contract staff salary increases. You must identify each contractual increase in the description of assumptions included in the application.
- **Do not** include a capital expenditure contingency.
- If any of the documents provided in the application are in draft form, a draft is only acceptable if it includes the following elements:
  a. identifies all entities associated with the agreement,
  b. outlines all roles and responsibilities of all entities,
  c. identifies all costs associated with the agreement,
  d. includes all exhibits that are referenced in the agreement, and
  e. any agreements in draft form must include a document signed by both entities committing to execute the agreement as submitted following CN approval.

Do not skip any questions in this application. If you believe a question is not applicable to your project, explain why it is not applicable.

Answer the following questions sensibly for your project. In some cases, a table may make more sense than a narrative. The department will follow up in screening if there are questions.

Program staff members are available to provide technical assistance (TA) at no cost to you before submitting your application. While TA isn't required, it's highly recommended and can make any required review easier. To request a TA meeting, call 360-236-2955 or email us at FSLCON@doh.wa.gov.

Washington State Department of Health

Certificate of Need Application
Home Health 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 lee.johnson@pennantservices.com	Telephone Number 208-401-1369
Legal Name of Applicant The Pennant Group Inc Address of Applicant 1675 E Riverside Dr, Suite 150. Eagle, Idaho 83616	Provide a brief project description X New Agency ☐ Expansion of Existing Agency ☐ Other: _____ Estimated capital expenditure: $_____5,000_____
Identify the county proposed to be served for this project. Note: Each Home Health 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. Spokane County	

ORCHARD PRAIRIE HEALTHCARE LLC.,
d/b/a Manito Home Health
Certificate of Need Application
Establish a Medicare/Medicaid Certified Home Health Agency
in
Spokane County

October 2023

Contents

Introduction

With this application, Orchard Prairie Healthcare LLC, d/b/a Manito Home Health, is seeking a new home health agency in Spokane County. Manito Home Health will be Medicare and Medicaid certified. Spokane County will join our established presence in Washington State with affiliate Home Health and Hospice agencies in several counties, including King, Pierce, Snohomish, San Juan, Aston, Garfield, Benton, Thurston, Grays Harbor, Mason and Franklin counties.

Manito Home Health will operate under the philosophy and model of all affiliates of its ultimate parent company, the Pennant Group ("Pennant"), and Pennant's Home Health and Home Health company, Cornerstone Healthcare, Inc.[1] Specifically, that to provide the best outcomes to our patients' health care must be a community-driven service—we must be able to adapt to the specific needs of the communities in which we operate, while simultaneously providing world-class care. This application sets forth in detail how Manito Home Health's unique operating structure sets it apart as the applicant best situated to meet the Home Health care needs of the residents of Spokane County. Three facets of our structure are worth noting at the outset.

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

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

Lastly, as a long-standing home health provider within the State of Washington, Pennant owned home health and hospice's have become trusted community partners that provide diverse and unique care for thousands of patients that has resulted in clinical outcomes that rank among the best in the country. Our locally led care teams understand the home health needs of Spokane County, and they will make uncompromising strides to provide

[1] As referenced below, Cornerstone Healthcare, Inc. is a subsidiary of the Pennant Group, Inc., and wholly owns Orchard Prairie Healthcare LLC

comprehensive patient care and exceptional clinical quality outcomes for the patients in Spokane County. The Washington state average for home health skilled care is 3.5 stars. Our agencies have averaged 4.0 stars or above for clinical outcomes and patient survey results during the last several years, we are proud to know that our patients receive some of the best hands-on care in the state.[2]

With the addition of providing home health care in Spokane County, Orchard will be able to provide more care along the spectrum of post-acute care as we build relationships with community partners in hospitals, physician networks, skilled nursing facilities, assisted living facilities, or home settings. This will allow us to provide patients with the right care, in the right place, at the right time. Orchard 's proposal set out in this application will demonstrate that Manito Home Health is uniquely situated to provide exceptional home health care in Spokane County.

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

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).

The Pennant Group Inc.
1675 E Riverside Dr, Suite 150. Eagle, Idaho 83616

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

The Pennant Group, Inc. (the applicant) is a Delaware Corporation, the UBI number is 604 504 017. Orchard Prairie Healthcare LLC's (the licensee) UBI number is 604 833 090.

[2] Washington state average is 3.5 stars. https://data.cms.gov/provider-data/dataset/tee5-ixt5

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

Lee Johnson, Treasurer of Orchard Prairie Healthcare LLC
1675 E. Riverside Drive, Suite 150, Eagle, ID 83616
208-401-1369
Lee.Johnson@pennantservices.com

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).

There are no consultants authorized to speak on our behalf.

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

The organizational chart is shown at **Exhibit 1.** Please note that the chart shows the five counties in which we are applying for home health certificates of need. The chart also shows Pinnacle Senior Living LLC, which owns assisted living, independent living, and memory care businesses. Pinnacle does not own home health or hospice agencies.

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, Home Health, other)

The list of all healthcare facilities and agencies owned, operated by, or managed by the applicant are shown at **Exhibit 2**. Please note that Pinnacle is owned by Pennant, and it has three lines of service: assisted living, independent living, and memory care. Pinnacle does not own home health or hospice agencies.

Project Description

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

This is a new agency.

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

   This is a new agency.

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.

   Manito Home Health

   104 S. Freya Street, Suite 109, Spokane, WA 99202

4. Provide a detailed description of the proposed project.

Manito Home Health will be a state licensed and Medicare/Medicaid home health agency in Spokane County. If awarded the certificate of need, we look forward to supporting the residents of Spokane County and their long-term healthcare needs.

Regardless of whether our patients' medical needs are complex or simple, our experienced, skilled professionals create a carefully crafted treatment plan with a focus on achieving the very best patient outcomes. We will work with community providers in Spokane County to ensure the care each home health patient needs is brought to them, wherever they reside. The delivery of care will be provided by an interdisciplinary team of experienced and specially trained home health professionals.

Manito Home Health's interdisciplinary staff will work in coordination with the patient, his or her family, and the patient's attending physician to establish personalized home health care goals. We will provide each patient with all necessary home health services and supplies, including skilled nursing care, physical therapy, home health aide services, speech therapy, occupational therapy, respiratory therapy, and nutritional services.

As with all Pennant-affiliated home health agencies, Manito Home Health will approach home health care with the foundational belief that to produce the best patient outcomes, health care must be tailored to the unique needs of the residents of the community in which we provide care. All Pennant-affiliated agencies accomplish this by adopting a model where local leaders are provided the opportunity and challenge to operate a community-centered agency. Pennant does not dictate mandatory practices that may or may not address specific community needs from a corporate headquarters. This project will operate no differently, and because of this, we are uniquely situated to be able to provide the residents of Spokane County with the best possible home health care.

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

Manito Home Health will be available and accessible to the entire geography of Spokane County.

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

Event	Anticipated Month/Year
CN Approval	April 2024
Design Complete (if applicable)	N/A
Construction Commenced* (if applicable)	N/A
Construction Completed* (if applicable)	N/A
Agency Prepared for Survey	July 2024
Agency Providing Medicare and Medicaid home health services in the proposed county.	January 2025

The period between the department's decision and commencing and completing the project is a conservative timeline that includes applying for the state license, hiring, onboarding, and training staff, as well as nurturing and establishing relationships in the Spokane community prior to serving our first patients. In addition, the timeline includes the time it takes to receive accreditation from ACHC (Accreditation Commission for Healthcare), the time it takes to get Medicare approval with the CCN#, and finally, the time it takes to get Medicaid approval.

If no construction is required, commencement of the project is project completion, commencement of the project is defined in WAC 246-310-010(13) and project completion is defined in WAC 246-310-010(47).

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

X Skilled Nursing	X Occupational Therapy
X Home Health Aide	X Nutritional Counseling
☐Durable Medical Equipment	☐Bereavement Counseling
X Speech Therapy	X Physical Therapy
X Respiratory Therapy	☐IV Services
☐ Medical Social Services	☐Applied Behavioral Analysis
☐ Other (please describe)	

Respiratory therapy is provided by speech therapists, it is one of their specialties. Basic nutritional services are provided by RN's, who are trained in nutrition. While it is unusual, should the need arise to provide certified level nutritional services, we will elicit the support of one of our RN's who are certified in nutrition in one of our other Pennant agencies.

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

Manito Home Health will be a new agency, not a service area expansion.

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

Manito Home Health will be a new agency, not a service area expansion.

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

Manito Home Health will serve patients of all ages and diagnosis and is committed to serving all patients regardless of race, color, religion (creed), gender, gender expression, age, national origin, disability, marital status, sexual orientation, English proficiency, or military status, and will ensure that all populations have access to services through its charity care policy. Furthermore, Manito Home Health 's admission, charity care, and non-discrimination policies reflect our commitment to caring for Medicare, Medicaid, and any patients who may be unable to pay for care.

11. Provide a copy of the applicable letter of intent that was submitted according to WAC 246-310-080.

The letter of intent is shown at **Exhibit 5.** Please note that the capital expenses are now $5,000.

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.

Manito Home Health will be a new agency, not a service area expansion. It will be state licensed and certified by Medicare and Medicaid.

a. IHS.FS._____

   Medicare #:_____

   Medicaid #:_____

Certificate of Need Review Criteria

A. Need (WAC 246-310-210)

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

1. List all Home Health providers currently operating in the planning area.

The following list of all home health providers was given by the Department of Health public records department. We listed the home health agencies that are state licensed and active, and we noted those that: 1. are Medicare and Medicaid certified, 2. completed the most recent annual utilization survey, 3. appear to have the appropriate FTE's to cover the county, and 4. show the appropriate service area and required services offered on the website. These are the agencies that appear to qualify to be counted, according to our understanding of the qualifications. We found that there are **eleven** agencies that are state licensed and Medicare/Medicaid certified, and these appear to have an appropriate number of FTE's to cover the county. Of these eleven, three completed the 2022 survey, and all eleven websites confirm the service area and home health services. We concluded that these eleven agencies should be counted against the need in Spokane County. These agencies are highlighted in green in the chart below.

SPOKANE HOME HEALTH AGENCIES						
# FTE's	MEDICARE & MEDICAID CERTIFIED	2022 SURVEY Y OR N	LEGAL ENTITY	DBA	WEBSITE CONFIRMS SERVICE AREA & SERVICES	AGENCY SHOULD BE COUNTED
7	N	N	Lincare Inc.	Lincare	N	N
14	N	N	Lincare Inc.	Lincare	N	N
8	Y	N	Touchmark on South Hill, a Limited	Touchmark Home Health	Y	Y
59.21	N	N	Seattle Childrens Hospital	Seattle Childrens Hospital Home Care	N	N
1	N	N	Alternative Nursing Services	A.N.S.	N	N
25	N	N	Apria Healthcare LLC	Apria Healthcare LLC	N	N
76	N	N	The Ashley House	Ashley House	N	N
76	N	N	The Ashley House	Ashley House	N	N

112	N	N	Avail Home Health Inc	Avail Home Health	N	N
30	N	N	Gentiva Certified Healthcare Corp	CenterWell Home Health	N	N
26	N	N	Pediatric Home Care, Inc	Aveanna Healthcare	N	N
17.71	Y	N	Intrepid of Washington Inc	Intrepid USA Healthcare Services	Y	Y
17.71	N	N	Intrepid of Washington Inc	Intrepid USA Healthcare Services	N	N
43	N	N	Maxim Healthcare Services Inc	Maxim Healthcare Services Inc	N	N
29	N	N	Maxim Healthcare Services Inc	Maxim Healthcare Services	N	N
9.67	N	N	Northwest Home Medical INC	Rotech	N	N
18	N	N	Providence Health and Services -	Providence Elder Place	N	N
17.75	N	N	S and S Health Care Inc	S and S Health Care	N	N
30.05	N	N	Total Care Inc	Aveanna Healthcare	N	N
105	Y	Y	Providence Health and Services -	Providence VNA Home Health	Y	Y
105	N	N	Providence Health and Services -	Providence VNA Home Health	N	N
17	N	N	Accredo Health Group Inc	Accredo Health Group	N	N
39	N	N	Optum Women's and Children's	Optum Women's and Children's	N	N
25	N	N	Popes Kids Place	Popes Kids Place	N	N
27	Y	Y	Northeast Washington Home	Assured Home Health	Y	Y
48	Y	N	Sunshine Home Health Care LLC	Sunshine Home Health Care	Y	Y
48	N	N	Sunshine Home Health Care LLC	Sunshine Home Health Care	Is this a duplicate?	Is this a duplicate?
4.38	N	N	Stepping Stones Pediatric Therapy	Stepping Stones Pediatric Therapy	N	N
26	Y	Y	Spokane Home Care Services LLC	Assured Home Health	Y	Y
26	N	N	Spokane Home Care Services LLC	Assured Home Health	Is this a duplicate?	Is this a duplicate?
10.35	N	N	Option Care Enterprises Inc	Option Care	N	N

8	N	N	RWW Home and Community Rehab	RWW Home and Community Rehab	N	N
1	N	N	Guardian Angel Home Care LLC	Angel Senior Care	N	N
20	N	N	Coram Alternate Site Services Inc	Coram CVS/Specialty	N	N
50	Y	N	Gentiva Certified Healthcare Corp	CenterWell Home Health	Y	Y
50	N	N	Gentiva Certified Healthcare Corp	CenterWell Home Health	Is this a duplicate?	Is this a duplicate?
16.2	N	N	Providence Health and Services -	Providence Infusion and Pharmacy	N	N
19	N	N	Chinook Home Health Care LLC	Chinook Home Health Care	N	N
95.26	N	N	Act for Health Inc.	Professional Case Management of	N	N
13.93	N	N	Ro Health LLC	Ro Health	N	N
2	N	N	Serengeti Care Partners LLC	Serengeti Care	N	N
37.52	N	N	Nuclear Care Partners LLC	Nuclear Care Partners LLC	N	N
21.5	N	N	Energy Employee Home Health	Energy Employee Home Health	N	N
39	N	N	Critical Nurse Staffing LLC	Critical Nurse Staffing LLC a/k/a	N	N
50	N	N	Geras LLC	Family Resource Home Care	N	N
26	N	N	Harbor Health Solutions LLC	Harbor Health Solutions LLC	N	N
34.8	N	N	Atomic Home Health, LLC	Atomic Home Health	N	N
43	Y	N	Eden Home Health of Spokane County,	Eden Home Health	Y	Y
43	N	N	Eden Home Health of Spokane County,	Eden Home Health	Is this a duplicate?	Is this a duplicate?
53	N	N	Fedelta Home Care LLC	Fedelta Home Care	N	N
3.4	Y	N	Aaron and Hur Healthcare, P.C.	Inland Home Healthcare	Y	Y
3.4	Y	N	Aaron and Hur Healthcare, P.C.	Inland Home Healthcare	Is this a duplicate?	Is this a duplicate?
3.4	N	N	Aaron and Hur Healthcare, P.C.	Inland Home Healthcare	Is this a duplicate?	Is this a duplicate?
3.4	N	N	Aaron and Hur Healthcare, P.C.	Inland Home Healthcare	Is this a duplicate?	Is this a duplicate?

8.73	N	N	Healthcare Harmony LLC	Bogden House Wa	N	N
7	N	N	Providence Health and Services -	Providence at Home	N	N
22	N	N	B and M Home Care Services LLC	Caring Hearts Agency	N	N
3	N	N	Malaika Home Care, LLC	Malaika Home Care, LLC	N	N
6	N	N	Positive Nature Homecare LLC	Positive Nature Homecare LLC	N	N
2	N	N	Riverview Lutheran Care Center	RiverCare	N	N
2	N	N	Amazing Touch Home Health	Amazing Touch Home Health	N	N

2. Complete the numeric methodology.

The Spokane County numeric need methodology, including the age cohort chart, is below. Considering the eleven home health agencies that we concluded should be counted, the methodology shows a need of **five** new home health agencies in Spokane County. The final chart includes 2026 and 2027 estimates, using the formula: 2025+(2025-2024) = 2026.

Step one: Project the population of the planning area, broken down by age cohort

COUNTY	AGE COHORT	2023 POP	2024 POP	2025 POP
SPOKANE	0-64	429,326	430,619	431,912
	65-79	78,444	80,868	83,292
	80+	22,844	23,729	24,614

Step two: Project the number of home health patients: This is done by multiplying each projected population age cohort by its corresponding use rate identified in the SHP.

AGE COHORT	USE RATE	2023 # HH PT.	2024 # HH PT.	2025 # HH PT.
0-64	0.005	2146.63	2153.10	2159.56
65-79	0.044	3451.55	3558.20	3664.85
80+	0.183	4180.38	4342.37	4504.36

Step three: Project number of patient visits: This is done by multiplying each age cohorts' projected number of home health patients (calculated in the previous step) by its corresponding number of visits identified in the SHP.

AGE COHORT	USE RATE	VISITS	2023 # HH VISITS	2024 # HH VISITS	2025 # HH VISITS
0-64	0.005	10	21466.30	21530.95	21595.60
65-79	0.044	14	48321.75	49814.81	51307.87
80+	0.183	21	87787.95	91189.78	94591.60

Step four: Determine the projected home health agencies needed: This is done by dividing the total projected number of visits by **10,000, which is the amount the SHP considers the "target minimum operating volume for a home health agency.**" The resulting number represents the maximum projected number of agencies needed in a planning area. The SHP specifies that fractions are rounded down to the nearest whole number.

AGE COHORT	USE RATE	VISITS	2023	2024	2025
0-64	0.005	10	21466.30	21530.95	21595.60
65-79	0.044	14	48321.75	49814.81	51307.87
80+	0.183	21	87787.95	91189.78	94591.60
TOTALS			**157576.01**	**162535.54**	**167495.07**
Target Minimum Operating Volume			10000.00	10000.00	10000.00
Number of Agencies			15.76	16.25	16.75
Number of Agencies Needed (round down)			15	16	16

Step five: Subtract the existing number of home health agencies in a planning area: The fifth and final step in the numeric methodology is to subtract the existing number of home health agencies providing services to a planning area from the projected number of agencies needed. This results in the net number of agencies needed for the planning area. Following is a brief description of how the department determines what agencies should be included or excluded from the numeric need methodology's supply. It is important to note is that the department adheres to the definition in the 1987 Washington State Health Plan (SHP) for a home health agency which states, "Home health agency means an entity coordinating or providing the organized delivery of home health services. Home health services means the provision of nursing services along with at least one other therapeutic service or with a supervised home health aide service to ill or disabled persons in their residences on a part-time or intermittent basis, as approved by a physician." [source: SHP, pB-34]

AGE COHORT	USE RATE	VISITS	2023	2024	2025	2026	2027
0-64	0.005	10	21466.30	21530.95	21595.60	21660.25	21724.90
65-79	0.044	14	48321.75	49814.81	51307.87	52800.93	54293.99
80+	0.183	21	87787.95	91189.78	94591.60	97993.43	101395.25
TOTALS			**157576.01**	**162535.54**	**167495.07**	**172454.61**	**177414.14**
Target Minimum Operating Volume			10000.00	10000.00	10000.00	10000.00	10000.00
Number of Agencies Needed			15.76	16.25	16.75	17.25	17.74
Number of Agencies Needed (round down)			15	16	16	17	17
Number of Existing Medicare & Medicaid Agencies			11	11	11	11	11
Net Agencies Needed			**4**	**5**	**5**	**6**	**6**

Below is the table we used to calculate the unmet visits and the number of visits available to our one new agency, using the formula *Total annual visits / number of agencies needed * net agencies needed.* The updated financials at **Exhibit 10** use this formula.

	2023	2024	2025	2026	2027
# visits per agency	**10505.1**	**10158.5**	**10468.4**	**10144.4**	**10436.1**
unmet visits	**42020.3**	**50792.4**	**52342.2**	**60866.3**	**62616.8**
net agencies needed	**4**	**5**	**5**	**6**	**6**
% of visits per 1 agency	**0%**	**80%**	**95%**	**100%**	**100%**
# visits per our agency	**0**	**4063**	**9945**	**10144**	**10436**

***Visits for Jul-Dec 2024**

SPOKANE			
AGE	**2015**	**2020**	**2025**
0-4	29,915	31,770	32,005
5-9	31,128	32,465	33,789
10-14	30,515	33,664	34,187
15-19	35,373	33,598	36,223
20-24	39,195	34,881	35,258
25-29	32,518	35,440	33,304
30-34	30,408	34,685	34,204
35-39	28,304	33,619	36,263
40-44	28,534	30,718	34,486
45-49	30,234	29,208	31,125
50-54	33,239	29,722	29,320
55-59	33,966	33,148	29,584
60-64	31,163	32,529	32,164
65-69	25,858	30,621	31,780
70-74	17,757	24,870	29,230
75-79	11,853	15,682	22,282
80-84	8,511	9,595	12,866
85+	9,839	10,593	11,748
Total	488,310	516,808	539,818

3. If applicable, provide a discussion identifying which agencies identified in response to Question 1 should be excluded from the numeric need methodology and why. Examples for exclusion could include but are not limited to: not serving the entire geography of the planning area, being exclusively dedicated to DME, infusion, or respiratory care, or only serving limited groups.

Please see our response to question 1 above. We noted all the agencies that should be included in the numeric need, as well as those that should be excluded.

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.

The Department's need methodology shows a need for **five** new Medicare and Medicaid certified agencies in Spokane County. While there are eleven existing Medicare and Medicaid

agencies in the county, these agencies are not able to meet all the need. For example, the *Trella Health* report at **Exhibit 11** shows that the CMS 48-hour requirement for initiating home health care is being met only 66% of the time.[3] Stated another way, at admission, approximately 44% of the time, the existing agencies in Spokane County fail to provide necessary home health care for multiple days. This trend is especially troubling given that many of these patients are returning home directly after being discharged from acute settings like emergency rooms and skilled nursing facilities where transitioning smoothly between care settings is crucial to producing positive care outcomes for the patient. Delays in providing skilled home health care after discharge from acute care settings threaten the health of these already vulnerable patients.

The addition of Manito Home Health will not result in a duplication of services, rather, it will strengthen Spokane County with more home health capacity that will allow patients to be able to better access timely home health care, which in turn will translate to better care transitions and a better experience for the home health patients of Spokane County.

Below are the strategies Manito Home Health will use to ensure it is progressively reaching more of the patient population outside the 44% with timely admissions, while not duplicating services:

- With the use of advanced technologies and continuous improvement methods that have been developed at our other Washington State home health agencies, Manito Home Health's intake team will streamline their processes and consistently admit patients within 48 hours. While we anticipate this consistency to be lower at first in Spokane County, as we learn the referral patterns and behaviors, we expect to increase the consistency over time.
- We work with our referral sources to streamline the entire referral process, and our community liaisons'(aka marketers') are trained to help move referrals to the intake team within the 48 hour timeline.
- We calculated a need for five new agencies in Spokane County. Our projections for five new agencies include us serving 20% (or 1/5) of the available patient visits, which leaves 80% of the available visits for existing agencies. This will prevent duplication of service.

5. For existing agencies, using the table below, provide the Home Health agency's historical utilization broken down by county for the last three full calendar years.

   Manito Home Health will be a new agency, not a service area expansion.

County	2020	2021	2022
Total number of admissions	N/A	N/A	N/A
Total number of visits	N/A	N/A	N/A
Average number of visits/patient	N/A	N/A	N/A

[3] Please see Exhibit 11, which shows the Trella Health home health start of care percentage is 66% in Spokane County. See also https://app.trellahealth.com/hha/dashboard/rep/homehealth.

6. 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.

County	2024	2025	2026	2027
Total number of admissions	214	523	534	549
Total number of visits	4063	9945	10144	10436
Projected number of visits/patient	19	19	19	19

7. Identify any factors in the planning area that could restrict patient access to home health services.

Below are many of the home health factors that can restrict patient access to care in Spokane County, according to the Spokane County Community Health Needs Assessment, 2021[4]:

- Transportation: Lack of transportation can make it difficult for patients to get to and from medical appointments. This is especially a problem for people who live in rural areas or who do not have access to reliable public transportation. 20% of Spokane County residents do not have access to a vehicle.
- Financial resources: The cost of home health care can be a barrier for many patients. This is especially true for people who do not have health insurance or who have limited financial resources. 14% of Spokane County residents are uninsured.
- Language barriers: Language barriers can make it difficult for patients to communicate with their healthcare providers. This can lead to misunderstandings and can make it difficult for patients to get the care they need. 16% of Spokane County residents speak a language other than English at home.
- Cultural barriers: Cultural barriers can also make it difficult for patients to access home health care. This is especially true for people who come from different cultures or who have different beliefs about healthcare. Spokane County is home to a diverse population, including many people from Hispanic, Asian, and Native American backgrounds.
- Lack of caregiver support: Many people who need home health care also need help from family members or friends. However, not everyone has access to this type of support. This can make it difficult for people to get the care they need. 20% of Spokane County residents are age 65 or older.
- Disability: People with disabilities may face challenges accessing home health care due to physical limitations or transportation barriers. Additionally, people with disabilities may have difficulty communicating with healthcare providers, which can make it difficult for them to get the care they need. 15% of Spokane County residents have a disability.

4 https://static1.squarespace.com/static/55ba9fe5e4b09e80d21790f7/t/622685f94e323365beb48a09/1646691840194/SRHD+CHNA+2021.pdf

- Age: Older adults are more likely to need home health care, but they may also face challenges accessing care due to financial barriers, transportation barriers, or caregiver support. Additionally, older adults may have difficulty communicating with healthcare providers, which can make it difficult for them to get the care they need. 17% of Spokane County residents are age 85 or older.

These are just some of the home health factors that can restrict patient access to care. Manito Home Health, with the support of our other Washington State home health agencies, will minimize these barriers in Spokane County.

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

Please see our response to question 4. above, which appears to be a duplicate question.

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

Manito Home Health will be available and accessible to the entire planning area.

10. Identify how this project will be available and accessible to underserved groups.

Spokane County will be served in its entirety by Manito Home Health. Manito Home Health's clinical staff will be available 24 hours a day, seven days a week to meet all patient and family needs. We plan to provide the full range of services for all residents of Spokane County, including the underserved groups, which are described below.

Below are some of the home health underserved groups in Spokane County as found in the Spokane County Community Health Needs Assessment 2021[5]:

- People who do not have access to a vehicle: 20% of Spokane County residents do not have access to a vehicle. This can make it difficult for them to get to and from medical appointments, which can make it difficult for them to access home health care.
- People who are uninsured: 14% of Spokane County residents are uninsured. This means that they may not be able to afford home health care, which can make it difficult for them to access the care they need.
- People who speak a language other than English at home: 16% of Spokane County residents speak a language other than English at home. This can make it difficult for them to communicate with their healthcare provider, which can make it difficult for them to access home health care.
- People who are from a different culture: Spokane County is home to a diverse population, including many people from Hispanic, Asian, and Native American

[5] https://static1.squarespace.com/static/55ba9fe5e4b09e80d21790f7/t/622685f94e323365beb48a09/1646691840194/SRHD+CHNA+2021.pdf

backgrounds. These cultures may have different beliefs about healthcare than the dominant culture, which can make it difficult for them to access home health care.

- People who are age 65 or older: 20% of Spokane County residents are age 65 or older. This means that they are more likely to need home health care, but they may also face challenges accessing care due to financial barriers, transportation barriers, or caregiver support
- People with a disability: 15% of Spokane County residents have a disability. This can make it difficult for them to access home health care due to physical limitations or transportation barriers. Additionally, people with disabilities may have difficulty communicating with healthcare providers, which can make it difficult for them to get the care they need.

These are just some of the home health underserved groups in Spokane County. It is important to be aware of these groups so that we can work to overcome the barriers they face and ensure that everyone has access to the care they need.

The data is clear that disparities in health stem from the lack of access to timely healthcare for people in certain demographics, and community members in Spokane County identified timely access to health care as a health priority. We believe we can help fix this problem. As mentioned above, we have a robust non-discrimination policy where demographic characteristics like race and income are not considered when making the decision to admit a patient. Manito Home Health will be able to provide increased access to home health care to this underserved population as its non-discrimination policies do not consider these demographic statuses. In addition, Manito Home Health will partner with community providers to meet the care needs of those underserved in Spokane County.

To meet the home health needs of indigent patients and underserved communities, Pennant home health agencies partner with community organizations, such as religious organizations, LGBTQ groups and homeless shelters. These organizations help identify eligible patients and promote our services. We will do the same in Spokane County. Some of the principles we practice include:

- Being culturally sensitive. When working with indigent patients and underserved communities, it is important to be sensitive to their cultural beliefs and practices. We are respectful of their language, customs, and traditions.
- Building trust. It is important to build trust with indigent patients and underserved communities. We do this by being reliable, honest, and transparent.
- Being flexible. We stay flexible to meet the needs of indigent patients and underserved communities.
- Being patient. It takes time to build relationships with indigent patients and underserved communities. We are patient and persistent in our efforts to reach these populations.

Provide a copy of the following policies:

- Admissions policy
- Charity care or financial assistance policy
- Patient Rights and Responsibilities policy
- Non-discrimination policy
- Any other policies directly related with patient access (involuntary discharge)

All the above policies are shown at **Exhibit 6**. Similar versions of these policies are in use at all Cornerstone home health agencies.

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

Financial feasibility of a Home Health 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.**
- For existing agencies proposing addition of another county, provide historical revenue and expense statements, including the current year.

	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/Pagers
Travel (patient care, other)
Other, detail what is included

All the above documents and items are shown at **Exhibit 10**. We are applying for home health certificates of need in multiple counties, the submitted financials include the income statement and balance sheet for Cornerstone + all the counties. The Cornerstone + all other counties financials will vary slightly in each county's applications due to lease terms that have not been finalized for applications that are being submitted later. As an example, the Kitsap county application will be submitted first, and the Cornerstone + all other counties financials lease amount will not be exact, because we are waiting for two of the other counties lease terms to be finalized. The financials for Kitsap include estimated lease rates for these two counties. We do not anticipate a significant difference between the estimates and the actual lease rates.

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

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

The above applicable agreements/contracts are shown at **Exhibit 8 (**operating agreements). There is no medical director, joint venture or management agreement.

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 Home Health 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, addenda, or substitute agreements to be created as a result of this project to demonstrate site control.

   If this is a **new** Home Health agency 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.

The lease agreement is shown at **Exhibit 3.** Please note that there is not an Exhibit 4 in this application.

4. Complete the table below 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 below, include the definition of the line item. Include all assumptions used to create the capital expenditure estimate.

a. Land purchase	$ NA
b. Utilities to lot line	$ NA
c. Land Improvements	$ NA
d. Building Purchase	$ NA
e. Residual Value of Replaced Facility	$ NA
f. Building Construction	$ NA
g. Fixed Equipment (not already included in the construction contract)	$ NA
h. Movable Equipment	$ NA
i. Architect and Engineering Fees	$ NA
j. Consulting Fees	$ NA
k. Site Preparation	$ NA
l. Supervision and Inspection of Site	$ NA
m. Any Costs Associated with Securing the Sources of Financing (include interim interest during construction)	$NA
1. Land	$ NA
2. Building	$ NA
3. Equipment	$ 5,000
4. Other	$ NA
n. Washington Sales Tax	$ NA
Total Estimated Capital Expenditure	**$ 5,000**

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 Pennant Group Inc. is responsible for the capital costs.

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.

We expect the following start-up costs to total $15,500.

Recruitment - $5,000 estimated based on Pennant's experience with starting new home health operations. Includes external postings on job boards that include; LinkedIn, Indeed, Career Builder, and Glassdoor. We will also identify and attend any applicable and timely job fairs. We will also contact the local colleges and local healthcare professional associations.

Marketing/Advertising - $4,000 estimated based on Pennant's experience with starting new operations. Advertisements in local media including print, notifying of our grand opening, including holding a meet and greet for local healthcare administrators and other community partners. We will also develop marketing brochures and patient packets.

Travel - $6,500 estimated based on Pennant's past experience with starting new operations. This accounts for essential Resources traveling to and from the Pennant Service Center to provide necessary support, including HR, IT, and Clinical Resources. This will continue for a period of 60-90 days.

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

The Pennant Group Inc. is responsible for the estimated capital costs identified above. Pennant's 10Q is shown at **Exhibit 9.**

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

This project will positively impact the costs and charges of health services in the planning area. Home health care has been shown to be cost-effective and is documented to reduce healthcare costs. This project proposes to address the home health agency shortage in the county and will improve access to care. Over time, this will reduce the cost of healthcare and benefit patients and their families.

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 healthcare services in the planning area.

The office equipment and start-up costs of this project are minimal, estimated at $20,500 ($5,000 office equipment, $15,500 start-up). These costs will not have an unreasonable impact on the costs and charges of health services in the planning area. Home health care has been shown to be cost-effective and is documented to reduce healthcare costs. This project proposes to address the home health agency shortage in the county and will improve access to care. Over time, this will reduce the cost of healthcare and benefit patients and their families.

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."

When reviewing demographic data from the Spokane County Community Health Needs Assessment to inform the projected payer mix, we compare age, sex, ethnicity, and median income demographics to other Washington Counties in which we serve home health patients.[6] While this data is helpful, it can only lead to assumptions. We estimate conservatively, as the patient percentages and payer rates are not certain. The payer rates are negotiated with the insurance companies, and we will not know the exact rates until they are determined. Please note that the below percentages apply to 2025-2027. The percentages are different for July-December 2024. Please see the Jul-Dec '24 percentages at **Exhibit 10**, in the assumptions and calculations section, near the top.

Payer Mix	Percentage of Gross Revenue	Percentage by Patient
Medicare	84.1%	81%
Medicaid	1.4%	3%
Commercial	13.5%	15%
Self-pay	1%	1%
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.

[6] https://static1.squarespace.com/static/55ba9fe5e4b09e80d21790f7/t/622685f94e323365beb48a09/1646691840194/SRHD+CHNA+2021.pdf

This is a new agency.

Payer Mix	Percentage of Gross Revenue	Percentage by Patient
Medicare		
Medicaid		
Commercial		
Self-pay		
Total	100	100

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.

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

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 Pennant Group Inc. is the source of financing. The commitment of funds letter is shown at **Exhibit 12.**

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

This project will not be debt financed through a financial institution.

15. Provide the most recent audited financial statements for:

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

The most recent audited financial statement for Cornerstone Healthcare Inc., is shown at **Exhibit 10**. The 10Q of the applicant, The Pennant Group Inc., is shown at **Exhibit 9.**

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.

SPOKANE COUNTY

Clinical Staff by FTE	Jul-Dec '24	2025	2026	2027
Registered Nurse	1.3	3.1	3.2	3.3
Home Health Aid	1.8	4.3	4.4	4.5
Physical Therapist	0.6	1.4	1.5	1.5
Physical Therapist Aid	0.3	0.7	0.7	0.8
Speech Therapist	0.3	0.7	0.7	0.7
Occupational Therapist	0.3	0.7	0.7	0.7
Director of Clinical Services	0.6	1.4	1.5	1.5
Total	**5.0**	**12.3**	**12.6**	**12.9**
Administrative Staff by FTE				
Administrator	0.5	1.0	1.0	1.0
Medical Records, Insurance	0.5	1.3	1.4	1.4
Intake, Scheduling	0.6	1.6	1.6	1.6
Community Liaison	0.5	1.3	1.4	1.4
Total	**2.2**	**5.2**	**5.3**	**5.4**

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.

This is a new agency.

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

The assumptions used to project the number and types of FTE's identified for this project are based upon the average numbers and types used across all Pennant-affiliated home health agencies, which include four Washington state home health agencies. The Washington state home health numbers are consistent with these averages.

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

Manito Home Health is confident that our proposed staff to patient ratio is appropriate. First, Pennant-affiliated home health agencies, including our four Washington State home health agencies, have found that operating at these ratios is optimal to produce quality outcomes. Second, our staffing ratios are consistent with industry standards, which tend to be conservative.

5. If you intend to have a medical director, 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.

We do not intend to have a medical director, instead, we plan on working directly with each patient's attending physician.

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

We do not intend to have a medical director, instead, we plan on working directly with each patient's attending physician.

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.)

This is a new agency. Anticipating the evaluation decision in April 2024, we will begin recruiting in April of 2024 to be fully staffed in July 2024.

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

This is a new agency.

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.

   In the event of being short-staffed, Orchard Prairie Healthcare LLC, dba: Manito Home Health, will have several options to ensure our patients receive the proper care throughout their time on services with us.

   - Our first option would be to reach out to our affiliate partners in neighboring counties to float needed staff. We have home health agencies and staff in Benton, Asotin, Pierce, and King Counties that can help us if there is a staffing shortage.

   - Second, we use incentives and floating days off to help ensure that patients are seen, and proper care is given when needed. We have the flexibility to offer this to our staff and have been successful in the past with using this method at many of our other agencies locally.

- Our third action would be to reach out to our contracting agencies. We have great working relationships with several local and national staff contracting agencies that have staff in the area that we can deploy to meet patient needs.

- Finally, we will build strong relationships with partner facilities in Spokane County that we would collaborate with to transfer patients to other agencies if the previously listed methods were unsuccessful.

Pennant, owns 134 healthcare organizations across 14 states, including a senior living home in Redmond, Washington, and home health agencies that operate in King, Pierce, Snohomish, San Juan, Aston, Garfield, Benton, and Franklin counties. Additionally, Pennant owns Washington-based hospice agencies that service Snohomish, Aston, Garfield, Thurston, Grays Harbor, Mason, King and Pierce counties. In the experience of Pennant-owned health care agencies, health care employees are drawn to the Pacific Northwest Region for its outdoor experiences, culture and vitality, making recruiting to locations like Spokane County generally easier than other parts of the country. Additionally, if Pennant-owned health care agencies have qualified and experienced staff in good standing that want to move to Spokane County, or to transition from long-term care or hospice to home health, we are able and willing to support that relocation or transition.

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

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

The following provides additional details as to Manito Home Health 's approach to recruiting and retention.

<u>Recruiting</u>
Manito Home Health leaders will continually perform the following recruiting activities.

- Identify any opportunity to recruit at local job fairs and State and National associations websites and conferences.
- Maintain a liaison with career/placement staff at regional colleges, universities, and clinical certification organizations to actively recruit its students, including offering clinical shadowing and volunteer opportunities.
- Join applicable healthcare professional associations.
- Utilize national talent search companies.
- Meet community market wages, recruiting and sign on bonuses.
- Provide leadership and advancement opportunities for staff to elevate within Cornerstone.
- Post positions within Pennant's multistate organizations.

Manito Home Health ’s Administrator and DCS will continually identify open positions. They will create open positions based on staffing needs driven by caseloads and ADC growth. This will be continuously assessed to ensure staff to patient ratios remain appropriate to maintain consistent delivery of quality patient care and ensure the IDT team/staff are not overburdened.

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

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

Once a candidate has been identified the agency will follow its standard screening process:
Step 1. Conduct phone interview of candidate, screening for relevant experience, positive attitude, and discuss compensation.
Step 2. DCS in-person or video conference interview with clinical candidate; Administrator or DCS in-person or video conference interview with administrative candidate.
Step 3. Ride-along with clinical staff (only clinical candidates with little or no home health experience)
Step 4. Candidates interviewed by 2-4 agency staff.

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

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

information.

Retention

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

We provide ongoing professional training based on needs identified in our QAPI program, annual compliance and profession-specific training, and regular in-service training.

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

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

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

All Pennant home health agencies (and hospice agencies) have a method for assessing customer satisfaction and quality improvement. Each of these agencies has a robust process to ensure Federal, State, and local guidelines for customer satisfaction and quality improvement are met.

Customer Satisfaction is a critical element for our quality program and reflects the patient and family experience. We partner with Strategic Healthcare Programs (SHP) for this process. SHP mails the Consumer Assessment of Healthcare Providers and System (CAHPS) survey to the appropriate designee identified by our electronic medical record (EMR) system vendor, Home Care Home Base (HCHB), and collects the data from the responses. Those responses are then summarized into useable data for use in

interdisciplinary meetings (IDG) and quality assurance/performance improvement (QAPI) programs to address customer perceptions and improve community relationships.

To help drive our quality improvement, we have partnered with SHP. Through SHP we can view our quality metrics in real time. We also utilize partnership with HCHB to provide data and reporting based on direct patient contact and the patient record. These partners combined with our processes related to IDG meetings and QAPI programs drive patient satisfaction and quality improvement and help build a reputation within our communities of being a home health provider of choice.

Accurate documentation is a critical necessity supported by our internal compliance department and agency leadership with regular review intervals. HCHB helps ensure we have all required documentation at the initiation of service and subsequent visits in areas such as Symptom Management, and Service Intensity. HCHB is integrated with SHP to help us develop trends related to Home Health Quality Reporting Program elements. HCHB also provides an avenue to document opportunities for improving on avoidable events in areas like infection control, patient complaints, falls, and medication errors. We can then use this information to help focus the discussion in our IDG meetings and to drive areas of improvement in our QAPI programs.

Quality improvement is driven by our IDG. Our IDG meeting's main purpose is to bring together key home health professionals to review and discuss the needs for each patient and their family. We mentioned above, individualized care plans help drive the best patient outcomes. The IDG also establishes policies governing the day-to-day provision of services, which include agency programs to ensure our clinicians are skilled in providing home health care.

Lastly, our QAPI program is designed to drive great patient outcomes. Our QAPI program will be regularly reviewed by our leadership team and our governing body. More frequency reviews of performance improvement projects (PIP) developed through our QAPI program occur in the IDG meeting. One of the main purposes of our QAPI program is to measure, analyze and track quality indicators to drive the best quality outcomes and patient satisfaction possible.

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

This is a new agency.

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

This is a new agency.

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

The below list includes the standard ancillary and support services used by all our home health agencies.

Strategic Healthcare Programs (SHP)[7]

Home Care Home Base (HCHB)

Pharmacy Vendor

Medical Supply Vendor

eSolutions – accounting interface

Workday – HR interface

Lippincott – electronic educational/procedural tool for clinicians

Forcura – Leading document management and HIPPA compliant communication for clinicians

Provider Link – for community physicians

Relias Learning – clinician focused learning tool

Tiger Connect—HIPAA compliant communication for clinicians

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

This is a new agency

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

This is a new agency.

[7] Note, the Applicant has contracts with many of these vendors as part of Pennant- or Cornerstone-wide enterprise contracts, which helps with cost containment.

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

The list below includes the healthcare facilities we anticipate establishing working relationships with in Spokane County:

- Rehabilitation:
  - Providence Sacred Heart Rehabilitation Hospital
  - Encompass Health Rehabilitation Hospital
  - Touchmark Rehabilitation
  - Regency at Northpointe
  - Providence St. Joseph Care Center
- Senior Living:
  - The Gardens on University
  - Sunshine Terrace
  - Arbor Crest
  - Atria at the Park
  - Parkview at the Park
- Assisted Living:
  - Sunshine Terrace Assisted Living
  - Regency at Northpointe
  - ManorCare Health Services-Spokane
  - Alderwood Manor
  - Royal Park Health and Rehabilitation
- Orthopedic:
  - Providence Sacred Heart Medical Center
  - MultiCare Rockwood
  - Northwest Orthopedic Hospital
  - Valley Medical Center
  - PeaceHealth Sacred Heart Medical Center
- Memory Care:
  - The Gardens on University
  - Sunshine Terrace Memory Care
  - Regency at Northpointe
  - Royal Park Health and Rehabilitation
  - Arbor Crest
- Hospital:
  - Providence Sacred Heart Medical Center
  - MultiCare Rockwood
  - Northwest Orthopedic Hospital
  - Valley Medical Center
  - PeaceHealth Sacred Heart Medical Center

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 health care facility; or
    b. A revocation of a license to operate a healthcare facility; or
    c. A revocation of a license to practice as 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.

Neither Orchard Prairie Healthcare LLC, Cornerstone, nor Pennant has any history of criminal convictions, denial or revocation of license to operate a health care facility, revocation of license to practice a health profession, or decertification as a provider of services in the Medicare or Medicaid program. Further, they have never been adjudged insolvent or bankrupt in any state or federal court. And none have been involved in court proceedings to make judgment of insolvency or bankruptcy with respect to the applicants.

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

Much like Community Health Assessment group, we are committed to collaboration through community engagement and data observation. Like our other Washington State home health agencies, Manito Home Health will establish continuity in local health care by aligning with hospitals, health systems, and the post-acute care community to improve access to care for Spokane County residents. With these relationships, we believe we can improve the continuity and quality of care in Spokane County.

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.

Continuing with our approach in Washington State, Manito Home Health will develop strong relationships with existing healthcare systems in Spokane County and surrounding counties. Manito Home Health will work closely with community partners, local hospital systems, private duty providers, physicians, and in-home care physician groups. In fact, as mentioned above, Pennant's operational model is for each agency to engage in and seek market-specific care and opportunities within each county services are available. This is best accomplished through partnerships with other health care providers. This partnership takes many forms, including sharing of coordination of care, assisting and coordinating

appropriate admissions, mutually driven quality outcomes, preventing hospital readmissions, and patient satisfaction.

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 facilities current compliance status.

We are proud to share that none of Pennant's 63 home health and hospice agencies have exhibited a pattern of conditional level findings.

22. If information provided in response to the question above show 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.

This question is inapplicable based on the answer to the question immediately preceding this one.

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.

Please see our response to question 2 below for the discussion.

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.

Alternative A: Take no Action	
Criteria	**Results**
Access to Health Care Services	There is no advantage to taking no action in terms of improving access. The disadvantage is that taking no action does nothing to address the need for additional agencies. Therefore, this option does not address the access to care problem that exists.
Quality of Care	There is no advantage to taking no action regarding quality of care. The disadvantage of taking no action is driven by shortages in access to services. With time, access would tighten and there would be adverse impacts on quality of care.
Cost and Operating Efficiency	With this option, there would be no impact on costs. The disadvantage is that there would be no improvements to cost efficiencies.
Staffing Impacts	The advantage is not hiring/employing additional staff. There are no disadvantages from a staffing perspective.
Legal Considerations	No Legal considerations.
Decision	This alternative was not chosen; it does not improve access to health care services and could negatively impact the quality of care.
Alternative B: Apply for and Receive CN	
Criteria	
Access to Health Care Services	This project meets current and future access issues. It will increase access to care. With this project, there are no disadvantages to access to health care services.
Quality of Care	This project meets and promotes quality of care. There are no disadvantages.
Cost and Operating Efficiency	Cost and operational efficiency will be affected by minimal operating expenses during the initial startup period before it achieves volume that covers fixed and variable costs.
Staffing Impacts	This project will create new jobs that benefit the county. These new jobs also provide paths for staff dedicated to efficient delivery of services. There are no disadvantages; Cornerstone Healthcare Inc. has a proven track record of hiring and retaining quality staff.
Legal Considerations	The advantage: Our staff will be able to provide services to the county's residents. This will improve access, quality, and continuation of care. The disadvantage: CN approval is required; this requires time and expense.
Decision	This alternative was selected because it will improve access to health care services, enhance quality and continuation of care, it leverages existing fixed costs and has no negative impacts on staffing. Finally, this project will quickly be executed, and it does not require undue legal or regulatory requirements.
Alternative C: Purchase Existing Home	

Health	
Criteria	
Access to Health Care Services	The disadvantage is that an acquisition may not add additional capacity for services in the county when compared to alternative A and alternative B. Also, at present, we do not know of an agency for sale.
Quality of Care	The advantage: This option could enhance quality and continuation of care. There are no apparent disadvantages to this option.
Cost and Operating Efficiency	The disadvantage: The acquisition of an existing agency requires considerable up-front cost and time to purchase and complete due diligence.
Staffing Impacts	The advantage of staffing is that the staff from the existing agency already exist. This option potentially creates no new jobs, which does not benefit the county.
Legal Considerations	There are no advantages. The disadvantage is that an acquisition takes considerable time and resources to conduct due diligence.
Decision	This alternative was not chosen; it does not improve access to health care services, it may add additional costs and effort related to acquiring an existing agency, and it requires considerable time and resources related to legal and due diligence requirements. Finally, we are not aware of any agencies for sale.

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.

This 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.

The following are some examples of the ways we use innovations in the delivery of care, effectively increasing efficiency in the delivery of care, promoting quality assurance, and fostering cost effectiveness.

- *HomeCare HomeBase (HCHB).* This platform is the leading electronic medical records system in the nation specific to home health and hospice agencies. HCHB was designed by home health and hospice industry leaders and integrates compliance measures and tools to ensure the requirements of pertinent regulations are met. We are also able to customize HCHB to meet any other specific needs we may have (compliance with state specific regulations, meeting the needs of patient populations, addressing a certain payer mix, etc.).

- *HCHB Analytics*. Analytics is the tableau (visualization of data software) reporting platform that is built by HCHB and integrates all the HCHB data into tableau. HCHB supplies a stock

set of reports that can be used for preparation for upcoming regulation changes, productivity management/regulation and quality reporting management. The reports can be built and customized by a certain tableau report builder for all our specific reporting needs.

- *Forcura*. Forcura is a totally HIPAA compliant document management, referral management, order tracking, and wound measurement/management solution that integrates directly with HCHB to allow the transmission of patient data between the two platforms. Forcura is available to office workers via a dashboard and field workers via mobile application for each use. This application provides our users with a more seamless referral acceptance for quicker processing, more accurate wound measurement tracking tools for more accurate documentation between multiple caregivers, order tracking, and automatic processing of orders out and back in with auto populated details for quicker, more seamless order processing.

  In Addition to these innovative tools, we believe we are a partner of choice to payors, providers, patients, and employees in the healthcare communities we serve. As a partner, we focus on improving care outcomes and the quality of life of our patients in home or home-like settings. Our local leadership approach facilitates strong professional relationships, allowing us to better understand and meet our partners' needs. We believe our emphasis on working closely with other providers, payors and patients yields unique, customized solutions and programs that meet local market needs and improve clinical outcomes, which in turn accelerates revenue growth and profitability.

  We are a trusted partner to, and work closely with, payors and other acute and post-acute providers to deliver innovative healthcare solutions in lower cost settings. In the markets we serve, we have developed formal and informal preferred provider relationships with key referral sources and transitional care programs that result in better coordination within the care continuum. These partnerships have resulted in significant benefits to payors, patients and other providers including reduced hospital readmission rates, appropriate transitions within the care continuum, overall cost savings, increased patient satisfaction and improved quality outcomes. Positive, repeated interactions and data-sharing result in strong local relationships and encourage referrals from our acute and post-acute care partners. As we continue to strengthen these formal and informal relationships and expand our referral base, we believe we will continue to drive cost effectiveness and quality outcomes.

Home Health Agency Tie Breakers (1987 State Health Plan, Volume II, pages B35-36)
If two or more applicants meet all applicable review criteria and there is not enough need projected for all applications to be approved, the department will approve the agency that better improves patient care, reduces costs, and improves population health through increased access to services in the planning area. Ensure that sufficient documentation and discussion of these items is included throughout the application under the relevant sections.

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 Home Health 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

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 Home Health Agencies Program Web Page

EXHIBIT 10

ORCHARD PRAIRIE HEALTHCARE LLC 2023

HOME HEALTH CN APP FINANCIALS

Home health assumptions and calculations	New Agency			Estimated	Estimated	
SPOKANE COUNTY	**2024**	**2025**	**2026**	**2027**	**2028**	
UNMET VISITS	**50792**	**52342**	**60866**	**62617**	**64367**	**Total annual visits / number of agencies needed * net agencies needed**
NUMERIC NEED FOR AGENCIES	**5**	**5**	**6**	**6**	**6**	
TOTAL VISITS PER AGENCY	10158	10468	10144	10436	10728	

Assumptions and Projections

Assumes 7/1/24 start date	**Jul-Dec '24**	**2025**	**2026**	**2027**
number of visits	**4063**	**9945**	**10144**	**10436**
Average length of stay 60 days	**60**	**60**	**60**	**60**
Annual Unduplicated Patient admissions	**214**	**523**	**534**	**549**
Average Daily Census (ADC)	**35**	**86**	**88**	**90**

% of visits for 1 agency

Jul-Dec '24	**2025**	**2026**	**2027**
80%	95%	100%	100%

% of patients payer mix	**payer mix %**
Medicare (PDGM)	**81.0%**
Medicaid	**3.0%**
Managed Care	**15.0%**
Self Pay	**1.0%**
	100.0%

# visits per payer type	**Jul-Dec '24**	**2025**	**2026**	**2027**	
Medicare (PDGM)	3,291	8,055	8,217	8,453	payer mix percentage x number of visits
Medicaid	122	298	304	313	payer mix percentage x number of visits
Managed Care	610	1,492	1,522	1,565	payer mix percentage x number of visits
Self Pay	41	99	101	104	payer mix percentage x number of visits
Total Visits	4,063	9,945	10,144	10,436	

PAYER RATES-2023 per wage index	**PERIOD 1**	**PERIOD 2+**	**BLENDED**
Medicare (PDGM)	**$2,179.95**	**$1,852.96**	**$1,976.12**
Medicaid	**$89.00**	Per Visit	
Managed Care	**$178.00**	Per Visit	
Self Pay	**$197.00**	Per Visit	

*PDGM blended rate period 1 @ 100%, period 2 @ 85%, includes 2% sequestration

REVENUE

Gross revenue by payer mix	Jul-Dec '24	2025	2026	2027	
Medicare (PDGM)	$337,632	$1,652,688	$1,685,819	$1,734,303	Medicare (PDGM) blended rate x ADC
Medicaid	$10,849	$26,553	$27,086	$27,864	Medicaid rate x annual number of visits
Managed Care	$108,493	$265,532	$270,855	$278,645	Managed care rate x annual number of visits
Self Pay	$8,005	$19,592	$19,984	$20,559	Self pay rate x annual number of visits
Gross revenue subtotal	$464,979	$1,964,365	$2,003,744	$2,061,371	

% of revenue by payer mix					
Medicare (PDGM)	72.6%	84.1%	84.1%	84.1%	Based on Cornerstone averages & county estimates
Medicaid	2.3%	1.4%	1.4%	1.4%	Based on Cornerstone averages & county estimates
Managed Care	23.3%	13.5%	13.5%	13.5%	Based on Cornerstone averages & county estimates
Self Pay	1.7%	1.0%	1.0%	1.0%	Based on Cornerstone averages & county estimates
Subtotal	100%	100%	100%	100%	

Adjustments to revenue	Jul-Dec '24	2025	2026	2027	
Contractual adjustments Medicare Managed Care, Medicaid Managed Care, Private Pay, Third Party Ins	(9,300)	(39,287)	(40,075)	(41,227)	Assumed 2%
Charity Care	(13,949)	(58,931)	(60,112)	(61,841)	Assumed 3%
Provisions for Bad Debt	(4,650)	(19,644)	(20,037)	(20,614)	Assumed 1%
Total Adjustments to Revenue	(27,899)	(117,862)	(120,225)	(123,682)	

Total Net Revenue	**437,080**	**1,846,503**	**1,883,519**	**1,937,689**

EXPENSES

PATIENT CARE COSTS

Clinical Staff by FTE	Jul-Dec '24	2025	2026	2027	Annual Comp/FTE	Note
Registered Nurse	1.3	3.1	3.2	3.3	80,000	1 RN/50 ADC and .8 RN/50 ADC for weekend/night/call rotation
Home Health Aid	1.8	4.3	4.4	4.5	40,000	1 HHA/20 ADC
Physical Therapist	0.6	1.4	1.5	1.5	83,000	1 PT/60 ADC
Physical Therapist Aid	0.3	0.7	0.7	0.8	58,000	1 PTA/120 ADC
Speech Therapist	0.3	0.7	0.7	0.7	84,000	1 ST/130 ADC
Occupational Therapist	0.3	0.7	0.7	0.7	85,000	1 OT/130 ADC
Director of Clinical Services	0.6	1.4	1.5	1.5	110,000	1/DCS/60 ADC includes QAPI
Total	**5.0**	**12.3**	**12.6**	**12.9**		

Clinical Staffing	Jul-Dec '24	2025	2026	2027	Note
Compensation and Benefits					
Registered Nurse	50,624	247,801	252,768	260,038	FTE x Annual Compensation

Home Health Aid	35,156	172,084	175,534	180,582	FTE x Annual Compensation
Physical Therapist	24,316	119,025	121,411	124,903	FTE x Annual Compensation
Physical Therapist Aid	8,496	41,587	42,421	43,641	FTE x Annual Compensation
Speech Therapist	11,358	55,596	56,711	58,342	FTE x Annual Compensation
Occupational Therapist	11,493	56,258	57,386	59,036	FTE x Annual Compensation
Director of Clinical Services	32,226	157,744	160,906	165,533	FTE x Annual Compensation
Payroll Taxes	52,100	255,028	260,141	267,622	30% Base Compensation
Total	**225,769**	**1,105,123**	**1,127,277**	**1,159,697**	

Contracted Patient Care	**Jul-Dec '24**	**2025**	**2026**	**2027**	**Note**
Physical Therapist	0	0	0	0	None
Occupational Therapist	0	0	0	0	None
Speech Therapist	0	0	0	0	None
Dietitian	0	0	0	0	None
Total	**0**	**0**	**0**	**0**	

Direct Patient Care Costs	**Jul-Dec '24**	**2025**	**2026**	**2027**	**Note**
Medical Supplies	11,743	28,741	29,317	30,160	$2.59/per visit based on Cornerstone averages
Mileage	18,854	46,145	47,070	48,424	Estimate 8 miles/DOC reimbursed at $.58/mile based on averages
Subtotal	**30,597**	**74,886**	**76,387**	**78,584**	
Total Direct Patient Care Costs	**256,366**	**1,180,009**	**1,203,664**	**1,238,282**	

ADMINISTRATIVE COSTS

Administrative Staff by FTE	**Jul-Dec '24**	**2025**	**2026**	**2027**	**Annual Comp/FTE**	**Note**
Administrator	0.5	1.0	1.0	1.0	80,000	
Medical Records, Insurance Auth	0.5	1.3	1.4	1.4	45,000	1/65 ADC
Intake, Scheduling	0.6	1.6	1.6	1.6	46,000	1/55 ADC
Community Liaison	0.5	1.3	1.4	1.4	63,000	1/65 ADC
Total	**2.2**	**5.2**	**5.3**	**5.4**		

Administrative Compensation and Benefits	**Jul-Dec '24**	**2025**	**2026**	**2027**	**Note**
Administrator	40,000	80,000	80,000	80,000	FTE x Annual Compensation
Medical Records, Insurance Auth	12,169	59,568	60,762	62,509	FTE x Annual Compensation
Intake, Scheduling	14,701	71,962	73,405	75,516	FTE x Annual Compensation
Community Liaison	17,037	83,395	85,066	87,513	FTE x Annual Compensation
Payroll Taxes & Benefits	25,172	88,477	89,770	91,661	30% of Base Compensation
Total	**109,080**	**383,402**	**389,003**	**397,199**	

Administration Costs	**Jul-Dec '24**	**2025**	**2026**	**2027**	**Note**

Advertising	8,371	18,465	18,835	19,377	$4,000 launch plus 1% of revenue
Allocated Costs	23,249	98,218	100,187	103,069	5% Allocation to Cornerstone Service Center for support; Legal, HR, Accounting, IT, and Clinical
B & O Taxes	6,975	29,465	30,056	30,921	1.5% of Gross Revenue
Dues & Subscriptions	2,250	4,500	4,500	4,500	$375/month, primarily Medbridge
Education and trainings	5,000	10,000	10,000	10,000	$10,000/year, Continuing education including Clinical education and compliance
Information Technology/Computer/Software Maintenance	7,500	15,000	15,000	15,000	$1250/month
Insurance	600	1,200	1,200	1,200	Liability and property
Legal and professional	0	0	0	0	Included in Allocated Costs to Cornerstone Service Center
Licenses and Fees	4,618		5,256		bi-annual state lic based on FTE
Postage	3,000	6,000	6,000	6,000	$500/month
Purchased services	6,000	12,000	12,000	12,000	$1000/month; bank fees, system access: HCHB, SHP, Workday
Repairs and Maintenance	900	1,800	1,800	1,800	$150/month
Cleaning	1,260	2,520	2,520	2,520	$210/month
Office supplies	1,500	3,000	3,000	3,000	$250/month
Equipment lease & maintenance	3,000	6,000	6,000	6,000	$500/month, copier and postage machines
Building rent or lease	13,300	23,332	22,564	24,019	
Lease NNN or Common Area Maintenance charges	0	0	0	0	No NNN costs
Recruitment	5,000	3,000	3,000	3,000	$5,000 startup and $250/month following
Telephones	6,285	14,563	14,782	15,102	$55/FTE/month + $250/month for landlines
Travel	6,500	1,000	1,000	1,000	First year $6500 support and launch, $1,000 thereafter
Subtotal	**105,307**	**250,064**	**257,701**	**258,507**	
Total Administrative Expense	**214,387**	**633,466**	**646,703**	**655,706**	
TOTAL COSTS	**470,753**	**1,813,475**	**1,850,368**	**1,893,988**	
EBITDA	(33,673)	33,028	33,152	43,701	
EBITDA Margin %	-7.7%	1.8%	1.8%	2.3%	
Depreciation	1,333	1,333	1,334	-	
Amortization	-	-	-	-	
EBIT	(35,006)	31,695	31,818	43,701	
Interest Expense	-	-	-		
Earnings before Taxes	(35,006)	31,695	31,818	43,701	

ORCHARD PRAIRIE HEALTHCARE LLC 2023

PRO FORMA-HOME HEALTH

SPOKANE COUNTY

REVENUE

Gross revenue by payer mix	**Jul-Dec '24**	**2025**	**2026**	**2027**	
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Gross revenue subtotal	464,979	1,964,365	2,003,744	2,061,371	

Adjustments to revenue	**Jul-Dec '24**	**2025**	**2026**	**2027**	
Contractual adjustments					
Medicare Managed Care, Medicaid Managed Care, Private Pay, Third Party Ins	(9,300)	(39,287)	(40,075)	(41,227)	Assumed 2%
Charity Care	(13,949)	(58,931)	(60,112)	(61,841)	Assumed 3%
Provisions for Bad Debt	(4,650)	(19,644)	(20,037)	(20,614)	Assumed 1%
Total Adjustments to Revenue	(27,899)	(117,862)	(120,225)	(123,682)	

Total Net Revenue	**437,080**	**1,846,503**	**1,883,519**	**1,937,689**

EXPENSES

Clinical Staffing	**Jul-Dec '24**	**2025**	**2026**	**2027**	**Note**
Compensation and Benefits					-
Registered Nurse	50,624	247,801	252,768	260,038	FTE x Annual Compensation
Home Health Aid	35,156	172,084	175,534	180,582	FTE x Annual Compensation
Physical Therapist	24,316	119,025	121,411	124,903	FTE x Annual Compensation
Speech Therapist	11,358	55,596	56,711	58,342	FTE x Annual Compensation
Occupational Therapist	11,493	56,258	57,386	59,036	FTE x Annual Compensation
Director of Clinical Services	32,226	157,744	160,906	165,533	FTE x Annual Compensation
Total	**225,769**	**1,105,123**	**1,127,277**	**1,159,697**	

Contracted Patient Care	**Jul-Dec '24**	**2025**	**2026**	**2027**	**Note**	-
Physical Therapist	0	0	0	0	None	-
Occupational Therapist	0	0	0	0	None	-
Speech Therapist	0	0	0	0	None	-
Dietitian	0	0	0	0	None	-
Total	**0**	**0**	**0**	**0**		

Direct Patient Care Costs	Jul-Dec '24	2025	2026	2027	Note
Medical Supplies	11,743	28,741	29,317	30,160	$2.59/per visit based on Cornerstone averages
Mileage	18,854	46,145	47,070	48,424	Estimate 8 miles/DOC reimbursed at $.58/mile based on averages
Subtotal	**30,597**	**74,886**	**76,387**	**78,584**	
Total Direct Patient Care Costs	**256,366**	**1,180,009**	**1,203,664**	**1,238,282**	

ADMINISTRATIVE COSTS

Administrative Compensation and Benefits	Jul-Dec '24	2025	2026	2027	Note
Administrator	40,000	80,000	80,000	80,000	FTE x Annual Compensation
Medical Records, Insurance Auth	12,169	59,568	60,762	62,509	FTE x Annual Compensation
Intake, Scheduling	14,701	71,962	73,405	75,516	FTE x Annual Compensation
Community Liaison	17,037	83,395	85,066	87,513	FTE x Annual Compensation
Payroll Taxes & Benefits	25,172	88,477	89,770	91,661	30% of Base Compensation
Total	**109,080**	**383,402**	**389,003**	**397,199**	

Administration Costs	Jul-Dec '24	2025	2026	2027	Note
Advertising	8,371	18,465	18,835	19,377	$4,000 launch plus 1% of revenue
Allocated Costs	23,249	98,218	100,187	103,069	5% Allocation to Cornerstone Service Center for support; Legal, HR, Accounting, IT, and Clinical
B & O Taxes	6,975	29,465	30,056	30,921	1.5% of Gross Revenue
Dues & Subscriptions	2,250	4,500	4,500	4,500	$375/month, primarily Medbridge
Education and trainings	5,000	10,000	10,000	10,000	$10,000/year, Continuing education including Clinical education and compliance
Information Technology/Computer/Software Maintenance	7,500	15,000	15,000	15,000	$1250/month
Insurance	600	1,200	1,200	1,200	Liability and property
Legal and professional	-	-	-	-	Included in Allocated Costs to Cornerstone Service Center
Licenses and Fees	4,618	-	5,256		bi-annual state lic based on FTE
Postage	3,000	6,000	6,000	6,000	$500/month
Purchased services	6,000	12,000	12,000	12,000	$1000/month; bank fees, system access: HCHB, SHP, Workday
Repairs and Maintenance	900	1,800	1,800	1,800	$150/month
Cleaning	1,260	2,520	2,520	2,520	$210/month
Office supplies	1,500	3,000	3,000	3,000	$250/month
Equipment lease & maintenance	3,000	6,000	6,000	6,000	$500/month, copier and postage machines
Building rent or lease	13300	23332	22564	24019	
Lease NNN or Common Area Maintenance charges	0	0	0	0	No NNN costs
Recruitment	5,000	3,000	3,000	3,000	$5,000 startup and $250/month following
Telephones	6,285	14,563	14,782	15,102	$55/FTE/month + $250/month for landlines
Travel	6,500	1,000	1,000	1,000	First year $6500 support and launch, $1,000 thereafter

Subtotal	**105,307**	**250,064**	**257,701**	**258,507**
Total Administrative Expense	**214,387**	**633,466**	**646,703**	**655,706**
TOTAL COSTS	**470,753**	**1,813,475**	**1,850,368**	**1,893,988**
EBITDA	(33,673)	33,028	33,152	43,701
EBITDA Margin %	-7.7%	1.8%	1.8%	2.3%
Depreciation	1,333	1,333	1,334	-
Amortization	-	-	-	
EBIT	(35,006)	31,695	31,818	43,701
Interest Expense	-	-	-	
Earnings before Taxes	(35,006)	31,695	31,818	43,701

ORCHARD PRAIRIE HEALTHCARE LLC 2023				
BALANCE SHEET	**Jul-Dec '24**	**2025**	**2026**	**2027**
SPOKANE COUNTY				
Assets				
Current Assets				
Cash	(82,013)	(142,757)	(111,397)	(72,255)
Accounts Receivable	49,558	209,366	213,563	219,705
Allowance for Bad Debt	(1,982)	(8,375)	(8,543)	(8,788)
Prepaid Assets	1,108	1,944	1,880	2,002
Total Current Assets	(33,329)	60,179	95,505	140,663
Property and Equipment				
Leasehold Improvements	-	-	-	-
Furniture & Equipment	5,000	5,000	5,000	5000
Accumulated Deprciation/Amortization	(1,333)	(2,666)	(4,000)	(4,000)
Total Property and Equipment	3,667	2,334	1,000	1,000
Other Assets				
Security Deposit	3,325.00	5,833.00	5,641.00	6,004.75
Start Up Costs	15,500	15,500	15,500	15,500
Other Assets	-	-	-	-
Total Other Assets	18,825	21,333	21,141	21,505
Total Assets	**(10,837)**	**83,846**	**117,646**	**163,168**
Liabilities				
Current Liabilities				
Accounts Payable/Credit Card Payable	10,217	25,135	25,960	26,089
Payroll Liabilities	13,952	62,022	63,178	64,871
Total Current Liabilities	24,169	87,157	89,139	90,960
Long Term Liabilities				
Other Liabilities				
Hospice CAP				
Total Long Term Liabilities	-	-	-	-
Total Liabilities	**24,169**	**87,157**	**89,139**	**90,960**
Equity				
Retained Earnings	-	(35,006)	(3,311)	28,507
Net Income	(35,006)	31,695	31,818	43,701
Total Equity	(35,006)	(3,311)	28,507	72,208
Total Liabilities and Equity	**(10,837)**	**83,846**	**117,646**	**163,168**

PENNANT

Cornerstone + All 5 Counties

For the Twelve Months Ending Saturday, December 31, 2022

	2022 & Static for 2023	2024	2025	2026	2027
Home Health Services - Medicare	91,899,458	91,899,458	91,899,458	91,899,458	91,899,458
Home Health Services- HMO	29,486,092	29,486,092	29,486,092	29,486,092	29,486,092
Home Health Services - VA	916,447	916,447	916,447	916,447	916,447
Home Health Services - Commercial	29,550,565	29,550,565	29,550,565	29,550,565	29,550,565
Home Health Services - Medicaid	10,229,034	10,229,034	10,229,034	10,229,034	10,229,034
Home Health Services - Private	443,547	443,547	443,547	443,547	443,547
Home Health Services - 606 Adj	(2,667,811)	(2,667,811)	(2,667,811)	(2,667,811)	(2,667,811)
TOTAL HOME HEALTH REVENUE ALL 5 COUNTIES		**1,933,280**	**8,782,061**	**9,030,560**	**9,944,964**
Total Home Health INCL ALL 5 COUNTIES	159,857,332	161,790,612	168,639,392	168,887,892	169,802,296
Hospice Services - Medicare	140,715,256	140,715,256	140,715,256	140,715,256	140,715,256
Hospice Services - HMO	705,208	705,208	705,208	705,208	705,208
Hospice Services - VA	396,086	396,086	396,086	396,086	396,086
Hospice Services - Commercial	3,801,659	3,801,659	3,801,659	3,801,659	3,801,659
Hospice Services - Medicaid	15,990,515	15,990,515	15,990,515	15,990,515	15,990,515
Hospice Services - Private	57,068	57,068	57,068	57,068	57,068
Hospice Services - 606 Adj	(1,048,093)	(1,048,093)	(1,048,093)	(1,048,093)	(1,048,093)
Total Hospice	160,617,698	160,617,698	160,617,698	160,617,698	160,617,698
Palliative Care - Medicare Part B	(97,108)	(97,108)	(97,108)	(97,108)	(97,108)
Total Palliative Care	(97,108)	(97,108)	(97,108)	(97,108)	(97,108)
Private Duty - VA	1,244,544	1,244,544	1,244,544	1,244,544	1,244,544
Private Duty - Commercial	1,048,341	1,048,341	1,048,341	1,048,341	1,048,341
Private Duty - Medicaid	14,193,620	14,193,620	14,193,620	14,193,620	14,193,620
Private Duty - Private	2,156,024	2,156,024	2,156,024	2,156,024	2,156,024
Total Private Duty	18,642,530	18,642,530	18,642,530	18,642,530	18,642,530
Facility Services Revenue	256,824	256,824	256,824	256,824	256,824
Part B - Medicare	16,381	16,381	16,381	16,381	16,381
Part B - Private	1,354,321	1,354,321	1,354,321	1,354,321	1,354,321
Part B - Other	6,057	6,057	6,057	6,057	6,057
Total Provider Services	1,633,582	1,633,582	1,633,582	1,633,582	1,633,582
Case Management - Private	1,301,717	1,301,717	1,301,717	1,301,717	1,301,717
Total Case Management	1,301,717	1,301,717	1,301,717	1,301,717	1,301,717

Other Rev - Foot Clinics	68,181	68,181	68,181	68,181	68,181
Other Rev - Misc Rev	1,364,057	1,364,057	1,364,057	1,364,057	1,364,057
Total Other Revenue	1,432,238	1,432,238	1,432,238	1,432,238	1,432,238
TOTAL NET REVENUE	343,387,989	345,321,270	352,170,050	352,418,549	353,332,953
DIRECT COSTS					
HH- Therapy Wages	30,143,011	30,143,011	30,143,011	30,143,011	30,143,011
HH- Therapy Benefits	7,114,811	7,114,811	7,114,811	7,114,811	7,114,811
HH- Therapy Mileage	1,672,328	1,672,328	1,672,328	1,672,328	1,672,328
HH - Therapy Other	3,163,236	3,163,236	3,163,236	3,163,236	3,163,236
Total Home Health Therapy	42,093,385	42,093,385	42,093,385	42,093,385	42,093,385
HH- CNA Wages	2,151,470	2,151,470	2,151,470	2,151,470	2,151,470
HH- CNA Benefits	573,977	573,977	573,977	573,977	573,977
HH- CNA Mileage	431,304	431,304	431,304	431,304	431,304
HH - CNA Other	94	94	94	94	94
Total Home Health CNA	3,156,845	3,156,845	3,156,845	3,156,845	3,156,845
HH- Nursing Wages	28,206,504	28,206,504	28,206,504	28,206,504	28,206,504
HH- Nursing Benefits	7,371,597	7,371,597	7,371,597	7,371,597	7,371,597
HH- Nursing Mileage	1,942,755	1,942,755	1,942,755	1,942,755	1,942,755
HH - Nursing Other	612,337	612,337	612,337	612,337	612,337
Total Home Health Skilled Nursing	38,133,194	38,133,194	38,133,194	38,133,194	38,133,194
HH - SS Wages	1,818,904	1,818,904	1,818,904	1,818,904	1,818,904
HH - SS Benefits	397,790	397,790	397,790	397,790	397,790
HH - SS Mileage	115,288	115,288	115,288	115,288	115,288
HH - SS Other	10,249	10,249	10,249	10,249	10,249
Total Home Health Social Services	2,342,230	2,342,230	2,342,230	2,342,230	2,342,230
HH - Supplies	2,965,567	2,965,567	2,965,567	2,965,567	2,965,567
HH - Other Direct Costs	27,736	27,736	27,736	27,736	27,736
TOTAL DIRECT COSTS - HOME HEALTH	88,718,958	88,718,958	88,718,958	88,718,958	88,718,958
Hospice- CNA Wages	6,114,869	6,114,869	6,114,869	6,114,869	6,114,869
Hospice- CNA Benefits	1,417,506	1,417,506	1,417,506	1,417,506	1,417,506
Hospice- CNA Mileage	924,443	924,443	924,443	924,443	924,443
Hospice - CNA Other	23,304	23,304	23,304	23,304	23,304
Total Hospice CNA	8,480,122	8,480,122	8,480,122	8,480,122	8,480,122
Hospice- Nursing Wages	24,789,926	24,789,926	24,789,926	24,789,926	24,789,926
Hospice- Nursing Benefits	5,549,675	5,549,675	5,549,675	5,549,675	5,549,675
Hospice- Nursing Mileage	1,223,757	1,223,757	1,223,757	1,223,757	1,223,757
Hospice - Nursing Other	268,122	268,122	268,122	268,122	268,122

Total Hospice Skilled Nursing	31,831,480	31,831,480	31,831,480	31,831,480	31,831,480
Hospice - SS Wages	4,739,694	4,739,694	4,739,694	4,739,694	4,739,694
Hospice - SS Benefits	967,778	967,778	967,778	967,778	967,778
Hospice - SS Mileage	245,273	245,273	245,273	245,273	245,273
Hospice - SS Other	11,719	11,719	11,719	11,719	11,719
Total Hospice Social Services	5,964,463	5,964,463	5,964,463	5,964,463	5,964,463
Hospice - Chaplain Wages	3,065,576	3,065,576	3,065,576	3,065,576	3,065,576
Hospice - Chaplain Benefits	590,535	590,535	590,535	590,535	590,535
Hospice - Chaplain Mileage	248,781	248,781	248,781	248,781	248,781
Hospice - Chaplain Other	195	195	195	195	195
Total Hospice Chaplain	3,905,087	3,905,087	3,905,087	3,905,087	3,905,087
Hospice - Volunteer Wages	704,729	704,729	704,729	704,729	704,729
Hospice - Volunteer Benefits	177,354	177,354	177,354	177,354	177,354
Hospice - Volunteer Mileage	25,519	25,519	25,519	25,519	25,519
Hospice - Volunteer Other	6,578	6,578	6,578	6,578	6,578
Total Hospice Volunteer	914,180	914,180	914,180	914,180	914,180
Hospice - Pharmacy	5,594,912	5,594,912	5,594,912	5,594,912	5,594,912
Hospice - Supplies	2,775,165	2,775,165	2,775,165	2,775,165	2,775,165
Hospice - DME	5,164,215	5,164,215	5,164,215	5,164,215	5,164,215
Hospice- Room and Board	11,998,693	11,998,693	11,998,693	11,998,693	11,998,693
Hospice - Respite and GIP	506,409	506,409	506,409	506,409	506,409
Hospice - Other Direct Costs	413,106	413,106	413,106	413,106	413,106
TOTAL DIRECT COSTS - HOSPICE	77,547,832	77,547,832	77,547,832	77,547,832	77,547,832
Palliative - Nursing Wages	110,097	110,097	110,097	110,097	110,097
Palliative - Nursing Benefits	26,522	26,522	26,522	26,522	26,522
Palliative - Supplies	4,401	4,401	4,401	4,401	4,401
Total Palliative Nursing	141,021	141,021	141,021	141,021	141,021
TOTAL DIRECT COSTS - PALLIATIVE	141,021	141,021	141,021	141,021	141,021
PD - Wages	9,021,959	9,021,959	9,021,959	9,021,959	9,021,959
PD - Benefits	1,463,689	1,463,689	1,463,689	1,463,689	1,463,689
PD - Mileage	257,206	257,206	257,206	257,206	257,206
PD - Supplies	24,890	24,890	24,890	24,890	24,890
PD - Other	1,357,363	1,357,363	1,357,363	1,357,363	1,357,363
TOTAL DIRECT COSTS - PRIVATE DUTY	12,125,107	12,125,107	12,125,107	12,125,107	12,125,107
Finding Home - Wages	929,000	929,000	929,000	929,000	929,000

Finding Home - Benefits	148,434	148,434	148,434	148,434	148,434
Finding Home - Mileage	10,981	10,981	10,981	10,981	10,981
Finding Home - Supplies	251	251	251	251	251
Finding Home - Other	54,619	54,619	54,619	54,619	54,619
TOTAL DIRECT COSTS - FINDING HOME	1,143,285	1,143,285	1,143,285	1,143,285	1,143,285
TOTAL DIRECT COSTS	179,676,203	179,676,203	179,676,203	179,676,203	179,676,203
HCHB	2,496,863	2,496,863	2,496,863	2,496,863	2,496,863
Administration-Wages	46,228,560	46,228,560	46,228,560	46,228,560	46,228,560
Administration-Benefits	6,742,523	6,742,523	6,742,523	6,742,523	6,742,523
Administration-Purchased Services	10,639,409	10,639,409	10,639,409	10,639,409	10,639,409
Administration-Insurance	1,886,510	1,886,510	1,886,510	1,886,510	1,886,510
Administration-Other	15,773,640	15,773,640	15,773,640	15,773,640	15,773,640
Total Administration	81,270,642	81,270,642	81,270,642	81,270,642	81,270,642
Marketing - Wages	12,330,525	12,330,525	12,330,525	12,330,525	12,330,525
Marketing - Benefits	2,389,909	2,389,909	2,389,909	2,389,909	2,389,909
Marketing - Mileage	367,663	367,663	367,663	367,663	367,663
Marketing - Activity Programs	4,602	4,602	4,602	4,602	4,602
Marketing - Other	1,854,434	1,854,434	1,854,434	1,854,434	1,854,434
Total Marketing	16,947,133	16,947,133	16,947,133	16,947,133	16,947,133
Occupancy - Utilities	362,384	362,384	362,384	362,384	362,384
Occupancy - Other	1,294	1,294	1,294	1,294	1,294
Total Occupancy	363,677	363,677	363,677	363,677	363,677
TOTAL INDIRECT COSTS	101,078,316	101,078,316	101,078,316	101,078,316	101,078,316
TOTAL COSTS	280,754,520	280,754,520	280,754,520	280,754,520	280,754,520
TOTAL COSTS ALL 5 COUNTIES		**1,885,088**	**8,265,525**	**8,507,120**	**9,315,217**
Other Income/Expenses	(84,940)	(84,940)	(84,940)	(84,940)	(84,940)
TOTAL OPERATING EXPENSES	280,669,580	282,554,667	288,935,105	289,176,700	289,984,797
Service Center Allocation	16,765,831	16,765,831	16,765,831	16,765,831	16,765,831
EBITDAR	45,952,578	46,000,771	46,469,114	46,476,018	46,582,326
EBITDAR Margin	0	0	0	0	0
Occupancy- Rent	5,060,433	5,060,433	5,060,433	5,060,433	5,060,433
Property Taxes	9,740	9,740	9,740	9,740	9,740
Total Property Expenses	5,070,173	5,070,173	5,070,173	5,070,173	5,070,173
EBITDA	40,882,405	40,930,598	41,398,940	41,405,845	41,512,153
EBITDA MARGIN	0	0	0	0	0
Depreciation and Amortization **+ ALL 5 COUNTIES**	1,424,390	1,431,055	1,431,055	1,431,060	1,424,390

Gain or loss on disposal	38,440	38,440	38,440	38,440	38,440
Earnings Before Interest & Tax	39,419,576	39,461,104	39,929,446	39,936,346	40,049,323
Interest	8,311,460	8,311,460	8,311,460	8,311,460	8,311,460
Earnings Before Income Taxes	31,108,116	31,149,644	31,617,987	31,624,886	31,737,864
Income Tax Expense	1,600	1,600	1,600	1,600	1,600
NET INCOME INCL ALL 5 COUNTIES	31,106,516	31,148,044	31,616,387	31,623,286	31,736,264

PENNANT

Cornerstone + All 5 Counties

For the Twelve Months Ending Saturday, December 31, 2022

	2022 & Static for 2023	2024	2025	2026	2027
ASSETS					
CURRENT ASSETS					
CASH					
Petty Cash	2,562	2,562	2,562	2,562	2,562
TOTAL CASH	2,562	2,562	2,562	2,562	2,562
ACCOUNTS RECEIVABLE					
Medicare A	31,641,547	31,641,547	31,641,547	31,641,547	31,641,547
Medicare B	189,841	189,841	189,841	189,841	189,841
A/R 606 Contra - Medicare	(509,981)	(509,981)	(509,981)	(509,981)	(509,981)
A/R 606 Contra - Medicaid	(1,820,694)	(1,820,694)	(1,820,694)	(1,820,694)	(1,820,694)
A/R 606 Contra - Private/Other	(1,380,097)	(1,380,097)	(1,380,097)	(1,380,097)	(1,380,097)
A/R 606 Contra - Managed Care	(3,290,198)	(3,290,198)	(3,290,198)	(3,290,198)	(3,290,198)
Medicaid	8,384,867	8,384,867	8,384,867	8,384,867	8,384,867
Private	579,418	579,418	579,418	579,418	579,418
Managed Care	12,660,346	12,660,346	12,660,346	12,660,346	12,660,346
Veterans	272,950	272,950	272,950	272,950	272,950
Miscellaneous	201,342	201,342	201,342	201,342	201,342
Employee Receivable - Concur	(1,559)	(1,559)	(1,559)	(1,559)	(1,559)
Prebilled A/R	1,630,127	1,630,127	1,630,127	1,630,127	1,630,127
Clearing - Adjustments - Cornerstone	1,011,491	1,011,491	1,011,491	1,011,491	1,011,491
TOTAL ACCOUNTS RECEIVABLE	49,569,399	49,569,399	49,569,399	49,569,399	49,569,399
ALLOWANCE FOR DOUBTFUL ACCOUNTS					
ACCOUNTS RECEIVABLE NET OF ALLOWANCE	49,569,399	49,569,399	49,569,399	49,569,399	49,569,399
PREPAID EXPENSES					
Prepaid Liability Insurance	0	0	0	0	0
Prepaid - Real Property Tax	2,750	2,750	2,750	2,750	2,750
Prepaid - One Time	4,319	4,319	4,319	4,319	4,319
Prepaid Other <$1,000	21,844	21,844	21,844	21,844	21,844
Prepaid Other	355,879	355,879	355,879	355,879	355,879
Prepaid Rent	133,776	133,776	133,776	133,776	133,776
TOTAL PREPAID EXPENSES	518,568	518,568	518,568	518,568	518,568
OTHER CURRENT ASSETS					
SUPPLIES					
INTERCOMPANY BALANCES					

Inter Company - SC due from Facility	664,841	664,841	664,841	664,841	664,841
Spin Interco	(12,910,000)	(12,910,000)	(12,910,000)	(12,910,000)	(12,910,000)
NET INTERCOMPANY BALANCES	(12,245,159)	(12,245,159)	(12,245,159)	(12,245,159)	(12,245,159)
Deposits - Other	5,233	5,233	5,233	5,233	5,233
PREPAID EXPENSES AND OTHER CURRENT ASSETS	(11,721,357)	(11,721,357)	(11,721,357)	(11,721,357)	(11,721,357)
TOTAL CURRENT ASSETS	37,850,604	37,850,604	37,850,604	37,850,604	37,850,604
FIXED ASSETS					
Leasehold improvements	1,384,266	1,384,266	1,384,266	1,384,266	1,384,266
Fixed Equipment	445,567	445,567	445,567	445,567	445,567
Minor Moveable	315,293	315,293	315,293	315,293	315,293
Furniture and Fixtures	922,428	922,428	922,428	922,428	922,428
Computer Equipment	1,208,107	1,208,107	1,208,107	1,208,107	1,208,107
Computer Software	5,791,297	5,791,297	5,791,297	5,791,297	5,791,297
Vehicles	667,879	667,879	667,879	667,879	667,879
Fixed Asset Clearing Account	15,359	15,359	15,359	15,359	15,359
	10,750,197	10,750,197	10,750,197	10,750,197	10,750,197
ACCUMLATED DEPRECIATION					
Leasehold Improvements	(725,530)	(725,530)	(725,530)	(725,530)	(725,530)
Fixed Equipment	(273,549)	(273,549)	(273,549)	(273,549)	(273,549)
Minor Equipment	(278,423)	(278,423)	(278,423)	(278,423)	(278,423)
Furniture & Fixtures	(504,307)	(504,307)	(504,307)	(504,307)	(504,307)
Computer Equipment	(1,032,130)	(1,032,130)	(1,032,130)	(1,032,130)	(1,032,130)
Computer Software	(5,182,080)	(5,182,080)	(5,182,080)	(5,182,080)	(5,182,080)
Vehicles	(358,058)	(358,058)	(358,058)	(358,058)	(358,058)
TOTAL ACCUMLATED DEPRECIATION	(8,354,078)	(8,354,078)	(8,354,078)	(8,354,078)	(8,354,078)
FIXED ASSETS NET	2,396,119	2,396,119	2,396,119	2,396,119	2,396,119
ROU Asset-Op Lease (R/E)	16,222,505	16,222,505	16,222,505	16,222,505	16,222,505
ROU Asset A/D-Op Lease (R/E)	(6,798,251)	(6,798,251)	(6,798,251)	(6,798,251)	(6,798,251)
Op Lease Clearing	396,814	396,814	396,814	396,814	396,814
TOTAL ROU ASSETS	9,821,068	9,821,068	9,821,068	9,821,068	9,821,068
Customer Relationships	9,405	9,405	9,405	9,405	9,405
Goodwill	75,854,486	75,854,486	75,854,486	75,854,486	75,854,486
Tradename	1,385,498	1,385,498	1,385,498	1,385,498	1,385,498
MCare License	57,231,717	57,231,717	57,231,717	57,231,717	57,231,717
INTANGIBLE AND OTHER ASSETS, NET	134,481,106	134,481,106	134,481,106	134,481,106	134,481,106
Investment in PMD	37,637,305	37,637,305	37,637,305	37,637,305	37,637,305
L/T Prepaid	0	0	0	0	0

Deposits Utilities	11,117	11,117	11,117	11,117	11,117
Deposits Rent	377,823	377,823	377,823	377,823	377,823
Escrow Deposits	49,000	49,000	49,000	49,000	49,000
L/T Prepaid	5,105,300	5,105,300	5,105,300	5,105,300	5,105,300
Other Long Term Assets	7,160,907	7,160,907	7,160,907	7,160,907	7,160,907
Restricted & Other Assets	50,341,453	50,341,453	50,341,453	50,341,453	50,341,453
TOTAL OTHER LONG TERM ASSETS	184,822,558	184,822,558	184,822,558	184,822,558	184,822,558
TOTAL ASSETS ALL 5 COUNTIES		**137,005**	**943,461**	**1,472,005**	**2,139,432**
TOTAL ASSETS INCL ALL 5 COUNTIES	234,890,349	235,027,355	235,833,810	236,362,354	237,029,781
LIABILITIES AND STOCKHOLDERS' EQUITY					
CURRENT LIABILITIES					
TRADE ACCOUNTS PAYABLE					
Accounts payable - trade	732,968	732,968	732,968	732,968	732,968
Accrued AP	2,870,854	2,870,854	2,870,854	2,870,854	2,870,854
Patient Refunds	55,075	55,075	55,075	55,075	55,075
Due:Prior Owners	(6,777,907)	(6,777,907)	(6,777,907)	(6,777,907)	(6,777,907)
TOTAL TRADE PAYABLES	(3,119,010)	(3,119,010)	(3,119,010)	(3,119,010)	(3,119,010)
ACCRUED WAGES AND RELATED LIABILITIES					
Accrued Payroll	10,055,757	10,055,757	10,055,757	10,055,757	10,055,757
Payroll Clearing	(1,495)	(1,495)	(1,495)	(1,495)	(1,495)
Garnishments Payable	37,905	37,905	37,905	37,905	37,905
Federal Payroll Taxes Payable	2,165,061	2,165,061	2,165,061	2,165,061	2,165,061
Due:Finding Home Foundation - Payroll Deductions	870	870	870	870	870
Direct Care Worker Funds Cornerstone	121,983	121,983	121,983	121,983	121,983
Accrued Vacation	3,529,671	3,529,671	3,529,671	3,529,671	3,529,671
TOTAL ACCRUED WAGES AND RELATED LIABILITIES	15,909,752	15,909,752	15,909,752	15,909,752	15,909,752
Op Lease Liability ST	3,681,027	3,681,027	3,681,027	3,681,027	3,681,027
TOTAL CURRENT OP LEASE LIABILITIES	3,681,027	3,681,027	3,681,027	3,681,027	3,681,027
OTHER ACCRUED LIABILITIES					
Accrued Other	555,141	555,141	555,141	555,141	555,141
Deferred Revenue	82,431	82,431	82,431	82,431	82,431
WA & WY Workers Comp	74,794	74,794	74,794	74,794	74,794
Sales/Excise/B&O TAXES PAYABLE	59,121	59,121	59,121	59,121	59,121
Hospice CAP Accrued	1,051,099	1,051,099	1,051,099	1,051,099	1,051,099
Real Property Taxes	13,185	13,185	13,185	13,185	13,185
Personal Property Taxes	2,780	2,780	2,780	2,780	2,780
Unprocessed Patient Refunds	1,547,696	1,547,696	1,547,696	1,547,696	1,547,696
Deferred Income Taxes					

Facility Fund	85,338	85,338	85,338	85,338	85,338
TOTAL OTHER ACCRUED LIABILITIES	3,471,585	3,471,585	3,471,585	3,471,585	3,471,585
TOTAL CURRENT LIABILITIES	19,943,354	19,943,354	19,943,354	19,943,354	19,943,354
LONG TERM DEBT					
Op Lease Liability LT	16,788,036	16,788,036	16,788,036	16,788,036	16,788,036
Op Lease Liability A/D	(10,334,005)	(10,334,005)	(10,334,005)	(10,334,005)	(10,334,005)
Total Long Term Op Lease Liabilities	6,454,031	6,454,031	6,454,031	6,454,031	6,454,031
TOTAL LONG TERM LIABILITIES	6,454,031	6,454,031	6,454,031	6,454,031	6,454,031
TOTAL LIABILITIES ALL 5 COUNTIES		**95,478**	**392,062**	**403,837**	**441,516**
TOTAL LIABILITIES INCL ALL 5 COUNTIES	26,397,384	26,492,862	26,789,447	26,801,221	26,838,900
STOCKHOLDERS' EQUITY					
Common Stock	33,155	33,155	33,155	33,155	33,155
Additional Paid-In-Capital JV	12,151,918	12,151,918	12,151,918	12,151,918	12,151,918
Additional Paid-In-Capital	77,299,216	77,299,216	77,299,216	77,299,216	77,299,216
Spin RE Adjust - Adj	33,059,257	33,059,257	33,059,257	33,059,257	33,059,257
	122,543,545	122,543,545	122,543,545	122,543,545	122,543,545
Retained Earnings, Prior Year	54,841,804	54,841,804	54,841,804	54,841,804	54,841,804
Current Year Income	31,107,615	31,107,615	31,107,615	31,107,615	31,107,615
Current Year Income	31,107,615	31,107,615	31,107,615	31,107,615	31,107,615
Total Stockholders' Equity	208,492,965	208,492,965	208,492,965	208,492,965	208,492,965
TOTAL LIABILITIES AND STOCKHOLDERS' EQUITY ALL 5 COUNTIES		**137,005**	**943,461**	**1,472,005**	**2,139,432**
STOCKHOLDERS' EQUITY INCL ALL 5 COUNTIES	234,890,349	235,027,355	235,833,810	236,362,354	237,029,781

KEY:
Green boxes represent the counties we are applying for home health Certificates of Need in-Kitsap, Thurston, Spokane, Whatcom, Walla Walla.

EXHIBIT 1

WA. STATE CN's

Isaac Ricketts | August 29, 2023

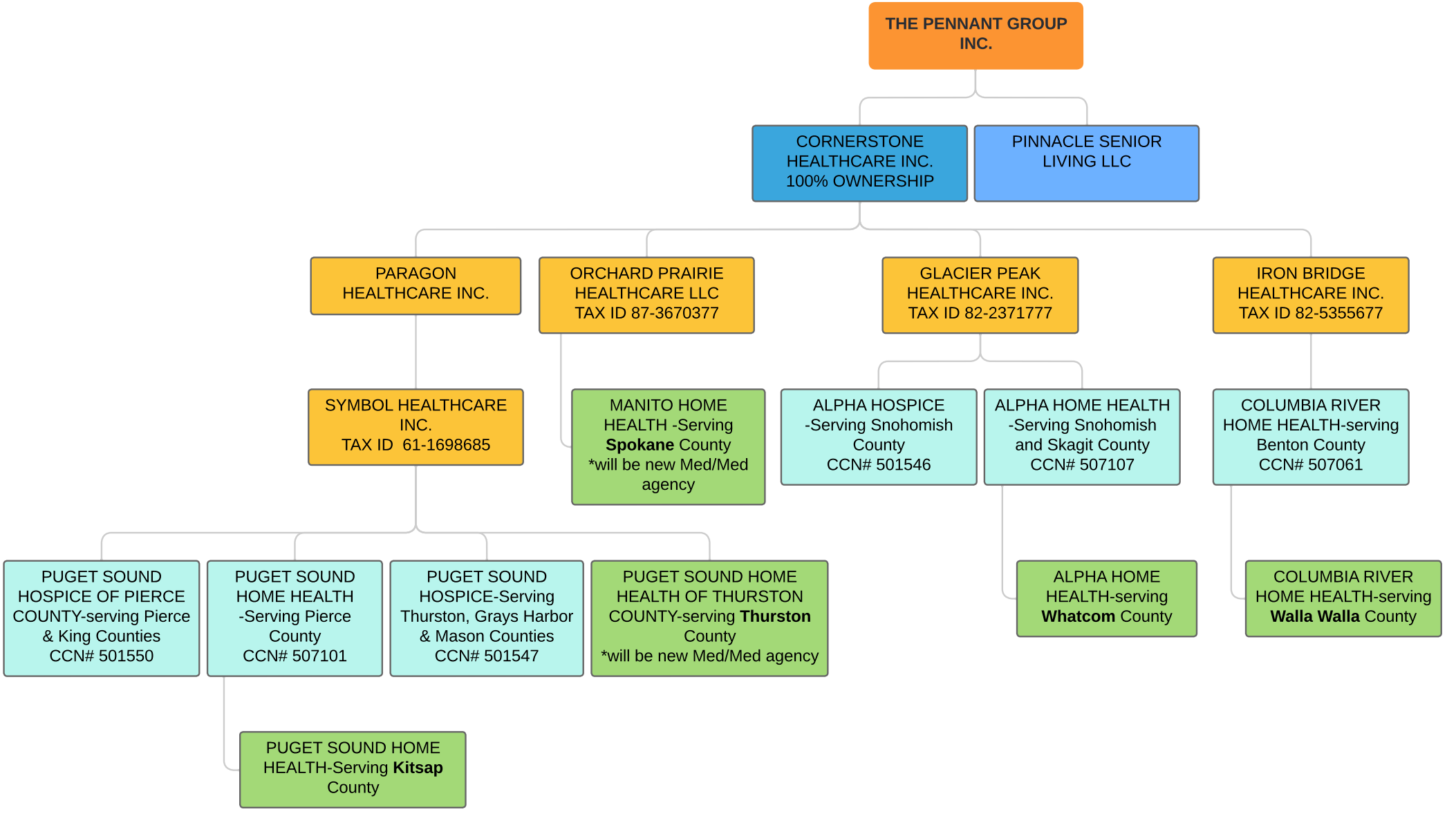


EXHIBIT 2

Subsidiaries of Applicant, **The Pennant Group, Inc.**

Entities Owned by **Cornerstone Healthcare, Inc.**

Agency or Facility Name	Type	Street Address	City	State	ZIP Code	CCN	State Lic. No.	Accrediting Body
A Gentle Touch Home Care	Homecare	1173 South 250 West, Suite 401B	St. George	UT	84770	n/a	PCA-UT000269	Not Accredited
Agape Hospice & Palliative Care	Hospice	4400 East Broadway Blvd., Suite 400	Tucson	AZ	85711	03-1614	HSPC9712	The Joint Commission
Agape Hospice Pinal County	Hospice	520 N Camino Mercado, Suite 11	Casa Grande	AZ	85122-5754	031678	HSPC10844	Not Accredited
All County Home Health	Home Health	7900 Callaghan Road, Suite 115	San Antonio	TX	78229	743120	019469	Not Accredited
All County Hospice	Hospice	7900 Callaghan Road, Suite 115	San Antonio	TX	78229	671756	019469	Not Accredited
Alpha Home	Home Health	10530 19th Ave	Everett	WA	98208	507107	IHS.FS.60793191	Not Accredited
Alpha	Hospice	10530 19th Ave	Everett	WA	98208	501546	IHS.FS.61032013	ACHC
Bella Terra	Home Health	391 N Main	Corona	CA	92878-4001	057252	980000471	Not Accredited
Bella Terra	Hospice	391 N Main	Corona	CA	92878	55-1620	550001417	ACHC
Big Sky Home	Home Health	205 Haggerty	Bozeman	MT	59715	27-7097	000000008	Not Accredited
Big Sky Hospice	Hospice	1900 S. Reserve St.	Missoula	MT	59801-6455	27-1525	13573	Not Accredited
Buena Vista Hospice	Hospice	2545 West Hillcrest Drive, Ste 130	Thousand Oaks	CA	91320	051787	550000060	The Joint Commission
Buena Vista Palliative	Home Health	2545 West Hillcrest Drive,	Thousand Oaks	CA	91320-2296	55-7165	050000273	CHAP

CMS-Kinder Hearts Home Health	Home Health	1102 Early Blvd.	Early	TX	76802	67-7177	020902	Not Accredited
Columbia River Home Health	Home Health	7105 W. Hood Place, Suite B-201	Kennewick	WA	99336-6714	507061	IHS.FS.60875683	Not Accredited
Comfort Home Health	Home Health	6655 West Sahara Ave, Ste D202	Las Vegas	NV	89146-0867	297149	9994-HHA-0	CHAP
Comfort Hospice	Hospice	6655 West Sahara Ave, Ste D202	Las Vegas	NV	89146-0867	291520	8955	The Joint Commission
Connected Home Health	Home Health	7515 NE Ambassador Pl., Ste C	Portland	OR	97220-1379	387146	13-1509	Not Accredited
Connected Hospice	Hospice	7515 NE Ambassador Pl., Ste C	Portland	OR	97220-1379	381563	16-1065	ACHC
Custom Care Home Health	Home Health	4811 Merlot Avenue, Suite 110	Grapevine	TX	76051	679672	015646	Not Accredited
Custom Care Home Health - Ft. Worth	Home Health	6410 Southwest Blvd, Suite 127	Benbrook	TX	76109	45-8125	021109	Not Accredited
Custom Care Hospice	Hospice	4811 Merlot Avenue, Suite 110	Grapevine	TX	76051	451635	013152	Not Accredited
Elevate Home Care	Homecare	6000 E. Evans Ave., Suite 2-020	Denver	CO	80222-5411	N/A	10Z779	Not Accredited
Elevate Home	Homecare	310 Lashley St.,	Longmont	CO	80504-6057	N/A	04Z850	Not Accredited
Elite Home Health	Home Health	1370 Bridge Street / PO Box 736	Clarkston	WA	99403-0736	507111	IHS.FS.60384078	Not Accredited
Elite Hospice	Hospice	1370 Bridge Street	Clarkston	WA	99403	501533	IHS.FS.60384078	Not Accredited
Emblem Home Care	Homecare	4801 S. Lakeshore Drive, Ste 206	Tempe	AZ	85282	N/A	N/A	Not Accredited

Emblem Home Health	Home Health	1400 E. Southern Avenue, Ste. 1010	Tempe	AZ	85282	037253	HHA6969	Not Accredited
Emblem Home Health	Home Health	301 East Bethany Home	Phoenix	AZ	85012	03-7438	HHA10676	Not Accredited
Emblem Hospice	Hospice	1400 E. Southern Avenue, Ste. 1010-B	Tempe	AZ	85282	031595	HSPC5656	Not Accredited
Emblem Hospice	Hospice	301 East Bethany Home	Phoenix	AZ	85051	03-1579	HSPC10253	Not Accredited
Emblem	Hospice	7225 N. Oracle	Tucson	AZ	85704	031624	HSPC11452	Not Accredited
Emblem Hospice West	Hospice	10320 West McDowell Road,	Avondale	AZ	85392	03-1661	HSPC12174	Not Accredited
Excell Home	Home Health	1200 SW 104th	Oklahoma City	OK	73139	377534	HC7462	Not Accredited
Excell	Hospice	1200 SW 104th	Oklahoma City	OK	73139	371610	HO4151	Not Accredited
Excell Private Care Services	Homecare	4631 N. May Ave	Oklahoma City	OK	73112	n/a	HC7932	Not Accredited
Finding Home Medical Services	Physician Group	47 6th Avenue	Page	AZ	86040	Z244229	n/a	Not Accredited
Finding Home Medical Services	Physician Group	1675 E. Riverside Drive, Ste 200	Eagle	ID	83616	20010640	n/a	Not Accredited
Gateway	Home Health	210 1st St. SW,	Clarion	IA	50525	167405	n/a	Not Accredited
Gateway	Hospice	210 1st St. SW,	Clarion	IA	50525	161556	n/a	Not Accredited
Harmony Hospice	Hospice	5550 South Jones Blvd.	Las Vegas	NV	89118	29-1514	10256-HPC-1	Not Accredited
Horizon Home Health	Home Health	63 W Willowbrook Drive	Meridian	ID	83646-1656	137065	HH-139	ACHC

Horizon Home Health Magic Valley	Home Health	1411 Falls Ave East, Suite 615	Twin Falls	ID	83301-3458	137114	HH-237	Not Accredited
Horizon Hospice	Hospice	63 W Willowbrook Drive	Meridian	ID	83646-1656	131520	16-1064 (OR)	ACHC
Horizon Hospice Magic Valley	Hospice	1411 Falls Ave East, Suite 615	Twin Falls	ID	83301-3458	131516	16-1064 (OR)	Not Accredited
Hospice of the South Plains	Hospice	4413 82nd Street, Ste 135	Lubbock	TX	79424	671667	016805	Not Accredited
Kenosha Visiting Nurse Association	Home Health	600 52nd St., Suite 300	Kenosha	WI	53140	527024	TBD	Not Accredited
Kinder Hearts Home Health	Home Health	842 N. Mockingbird Lane	Abilene	TX	79603-5729	679193	017913	Not Accredited
Kinder Hearts	Hospice	842 N.	Abilene	TX	79603-5729	671790	017766	CHAP
Kinder Hearts Hospice of Amarillo	Hospice	1901 Medi Park Dr., Suite 1030	Amarillo	TX	79106	67-1768	021188	Not Accredited
Namaste Home Health	Home Health	6000 E. Evans Ave., Suite 2-400	Denver	CO	80222-5411	067471	04K559	Not Accredited
Namaste Hospice	Hospice	6000 E. Evans Ave., Suite 2-400	Denver	CO	80222-5411	061545	1704DM	Not Accredited
Pasco/SW	Home Health	2208 E. Main St	Cortez	CO	81321-4222	067339	04R277	Not Accredited
Pasco/SW Home Health -	Home Health	2764 Compass Dr., Ste 244	Grand Junction	CO	81506-8722	067535	04H560	Not Accredited
Physician	Physician	1916 N 700 W,	Layton	UT	84041	U000102236	n/a	Not Accredited
PPM California	Physician Group	6929 Sunrise Boulevard, Ste 180	Citrus Heights	CA	95610		n/a	Not Accredited

PPM Oregon	Physician Group	7515 NE Ambassador Pl., Ste C	Portland	OR	97220-1379	R238811	n/a	Not Accredited
PPM Washington	Physician Group	1370 Bridge Street	Clarkston	WA	99403	G9042146	n/a	Not Accredited
PPM Wisconsin	Physician Group	W175N11117 Stonewood Dr.,	Germantown	WI	53022		n/a	Not Accredited
Preceptor Home Health	Home Health	W175N11117 Stonewood Dr.,	Germantown	WI	53022	52-7313	1171	CHAP
Preceptor Hospice	Hospice	W175N11117 Stonewood Dr.,	Germantown	WI	53022	52-1593	2033	CHAP
Preceptor Therapy	Therapy Group	W175N11117 Stonewood Dr.,	Germantown	WI	53022	K100579730	n/a	Not Accredited
Puget Sound Home Health	Home Health	4002 Tacoma Mall Blvd Ste 204	Tacoma	WA	98409-7702	507101	IHS.FS.60332035	Not Accredited
Puget Sound Home Health of King County	Home Health	4002 Tacoma Mall Blvd Ste 204A	Tacoma	WA	98409	507122	IHS.FS.60751653	Not Accredited
Puget Sound Hospice	Hospice	111 Tumwater Blvd SE, Suite A302	Tumwater	WA	98501	501547	IHS.FS.61032138	ACHC
Puget Sound Hospice of Pierce County	Hospice	4002 Tacoma Mall Blvd Ste 204	Tacoma	WA	98409	501550	IHS.FS.61369722	ACHC
Resolutions Hospice	Hospice	363 N Sam Houston Parkway E, Suite 545	Houston	TX	77060	74-1720	020685	Not Accredited
Resolutions Hospice Austin	Hospice	1101 Arrow Point Drive Ste 301	Cedar Park	TX	78613	67-1631	019485	Not Accredited
Resolutions Hospice Houston	Hospice	17040 El Camino Real, Suite 200	Houston	TX	77058	67-1722	019607	CHAP

River Valley	Home Health	149350 Ukiah	Big River	CA	92242	059373	550001658	Not Accredited
River Valley Home Health	Home Health	1990 N McCulloch Blvd, Ste. 109	Lake Havasu	AZ	86403-3606	037402	HHA7444	Not Accredited
River Valley	Home Health	1317 S. Joshua	Parker	AZ	85344	037297	HHA7419	Not Accredited
River Valley	Hospice	149350 Ukiah	Big River	CA	92242	751698	550003021	Not Accredited
River Valley Hospice	Hospice	2649 Hwy 95, Unit H	Bullhead City	AZ	86442	031636	HSPC7364	Not Accredited
River Valley	Hospice	1317 S. Joshua	Parker	AZ	85344	031639	HSPC7545	Not Accredited
Riverside Home Health Care	Home Health	402 SE G Street	Grants Pass	OR	97526-3066	38-7143	13-1542	Not Accredited
Sacred Heart Home Health Care-Tucson	Home Health	4400 East Broadway Blvd., Suite 405	Tucson	AZ	85711-3517	03-7144	HHA10800	Not Accredited
Safe Harbor Home Care	Homecare	3750 Convoy Street, Suite 220	San Diego	CA	92111-3741	n/a	374700005	Not Accredited
Seaport Home Health	Home Health	5411 Avenida Encinas, Suite 270	Carlsbad	CA	92008-4380	05-9303	550001427	Not Accredited
Seaport Hospice	Hospice	3750 Convoy Street, Suite 220B	San Diego	CA	92111-3741	55-1745	550002260	Not Accredited
Seaport Scripps Home Health	Home Health	3750 Convoy Street, Suite 220	San Diego	CA	92111-3741	05-7602	080000215	Not Accredited
Sequoia Home Health	Home Health	830 Hillview Ct., Suite 225	Milpitas	CA	95035-4550	058496	550000575	The Joint Commission
Sequoia	Hospice	830 Hillview Ct.,	Milpitas	CA	95035-4563	921794	550003611	ACHC
Stonebridge Home Care North	Homecare	308 E. 4500 South, Suite 100-A	Murray	UT	84107	n/a	PCA-UT000903	Not Accredited
Stonebridge Home Care Solutions	Homecare	1173 South 250 West, Suite 401B	St. George	UT	84770	n/a	n/a	Not Accredited

Horizon Homecare	Homecare	55 W. Willowbrook Drive, Suite 101	Meridian	ID	83646	n/a	n/a	Not Accredited
Stonebridge Home Care Solutions	Homecare	308 E. 4500 South, Suite 100-C	Murray	UT	84107	n/a	PCA-UT000767	Not Accredited
Stonebridge Home Care South	Homecare	961 W Center Street	Orem	UT	84057	n/a	PCA-UT000904	Not Accredited
Symbii Home	Home Health	1916 N 700 W,	Layton	UT	84041	467231	HHA-77779	Not Accredited
Symbii Home	Home Health	240 W Burnside	Chubbuck	ID	83202	13-7110	HH-233	Not Accredited
Symbii Home	Home Health	625 S	Afton	WY	83110	537073	15291	Not Accredited
Symbii Home Health and Hospice	Therapy Group	1385 West 2200 South, Suite 201	West Valley City	UT	84119	U000098514	n/a	Not Accredited
Symbii Home Health Bear River	Home Health	1153 North Main, Suite B 100/110	Logan	UT	84341-2573	467219	HHA-UT000158	Not Accredited
Symbii Home Health South	Home Health	308 East 4500 South, Suite 100	Murray	UT	84107	46-7342	HHA-UT000618	Not Accredited
Symbii	Hospice	1916 N 700 W,	Layton	UT	84041	461567	HOSPICE-102378	Not Accredited
Symbii	Hospice	240 W Burnside	Chubbuck	ID	83202	13-1552	n/a	Not Accredited
Symbii	Hospice	625 S	Afton	WY	83110	531525	15290	Not Accredited
Symbii Hospice Bear River	Hospice	1153 North Main, Suite B 100/110	Logan	UT	84341-2573	461550	UT000157	Not Accredited
Symbii	Hospice	308 E. 4500	Murray	UT	84107	46-1606	HOSPICE-	Not Accredited
Symbii Therapy Bear River	Therapy Group	1153 North Main, Suite B 100/110	Logan	UT	84341-2573	U000115204	n/a	Not Accredited
The Pines Home Health	Home Health	6719 E. 2nd Street , Ste A-2	Prescott Valley	AZ	86314-2661	037455	HHA9983	CHAP
The Pines Hospice	Hospice	6719 E. 2nd Street , Ste A	Prescott Valley	AZ	86314-2661	031559	HSPC8180	Not Accredited

Zion's Way Home Health	Home Health	39 6th Avenue / PO Box 1015	Page	AZ	86040-0470	037290	HHA5463	Not Accredited
Zion's Way Home Health	Home Health	1173 South 250 West, Suite 401	St. George	UT	84770	467243	HHA-106473	Not Accredited
Zion's Way Hospice	Hospice	43 6th Avenue / PO Box 1015	Page	AZ	86040-1015	031594	HSPC5462	Not Accredited
Zion's Way Hospice	Hospice	1173 South 250 West, Suite 401	St George	UT	84770	461559	Hospice-106446	Not Accredited

Recently Acquired Entities Awaiting CHOW or Initial Medicare Approval

Agency/Facility Name	Type	Street Address	City	State	ZIP Code	CCN	State Lic. No.	Accrediting Body	Acquired
Ardent Home Health of Fresno	Home Health	2040 N Winery Ave., Ste. 101	Fresno	CA	93703	559016	TBD	CHAP	08/16/22
Ardent Hospice	Hospice	16486 Bernardo Center Drive, Ste. 348	San Diego	CA	92128	551767	550002248	CHAP	08/16/22
Ardent Hospice of Fresno	Hospice	2040 N Winery Ave., Ste. 102	Fresno	CA	93703	751750	550002795	CHAP	08/16/22
Ardent Hospice of the Valley	Hospice	601 High Street, Ste. E	Delano	CA	93215	A01585	550004430	CHAP	08/16/22
Bella Terra Hospice of the Desert	Hospice	75410 Gerald Ford Drive, Ste 202	Palm Desert	CA	92211	751714	550002340	CHAP	08/16/22
Benefit Home Health Care	Home Health	5426 N Academy Blvd., #200	Colorado Springs	CO	80918	067517	TBD	ACHC	05/01/23
Benefit By Your Side	Homecare	5426 N Academy Blvd., #200	Colorado Springs	CO	80918	n/a	TBD	Not Accredited	05/01/23

First Call Hospice	Hospice	6929 Sunrise Boulevard, Ste 180	Citrus Heights	CA	95610-3100	05-1721	TBD	Not Accredited	06/16/21
Pasco/SW Hospice	Hospice	2208 E. Main St	Cortez	CO	81321-4222	TBD	17WQ2M	ACHC	n/a
Pasco/SW Hospice - Grand Junction	Hospice	2764 Compass Dr., Ste 244	Grand Junction	CO	81506-8722	TBD	1732M9	ACHC	n/a
Riverside Hospice	Hospice	402 SE G Street	Grants Pass	OR	97526-3066	TBD	16-1098	ACHC	n/a
Sierra	Hospice	2305 Ives Court,	Reno	NV	89503		TBD	TBD	n/a

Entities Owned by **Pinnacle Senior Living LLC**

Agency/Facility Name		Street Address	City	State	ZIP Code	CCN	State Lic. No.	Accrediting Body
Barber Station	Assisted Living	3266 East Barber Valley	Boise	ID	83716	N/A	RC-1271	Not Accredited
Brenwood Park Assisted Living	Assisted Living	9535 West Loomis Road	Franklin	WI	53132	N/A	0015615	Not Accredited
Bridgewater	Assisted	900 Autumn	Granbury	TX	76048	N/A	104663	Not Accredited
California Mission Inn	Assisted Living	8417 Mission Drive	Rosemead	CA	91770-1188	N/A	198603161	Not Accredited
California Mission Inn – Rose Manor	Assisted Living	4825 Earle Avenue	Rosemead	CA	91770-1176	N/A	198603163	Not Accredited
Cambridge Square Assisted Living	Assisted Living	2700 Avenue N	Rosenberg	TX	77471	N/A	150253	Not Accredited
Canyon Creek Memory Care	Assisted Living	4257 Lowes Drive	Temple	TX	76502	N/A	307403	Not Accredited
Cedar Hill	Assisted	602 East Belt	Cedar Hill	TX	75104-2260	N/A	149182	Not Accredited

Citrus Hills	Assisted	142 South	Orange	CA	92869-3842	N/A	306004783	Not Accredited
Cottonwood Manor Assisted Living	Assisted Living	1450 South Military Avenue	Green Bay	WI	54304	N/A	0015625	Not Accredited
Cranberry Court Assisted Living I	Assisted Living	2230 14th Street	Wisconsin Rapids	WI	54494-6408	N/A	0015632	Not Accredited
Cranberry Court Assisted Living II	Assisted Living	2230 James Court	Wisconsin Rapids	WI	54494-7952	N/A	0015631	Not Accredited
Deer Creek Assisted Living	Assisted Living	747 West Pleasant Run Road	DeSoto	TX	75115-3852	N/A	149102	Not Accredited
Desert Springs Senior Living	Assisted Living	6650 W. Flamingo Road	Las Vegas	NV	89103	N/A	410-AGC-42	Not Accredited
Desert View	Assisted	3890 N. Buffalo	Las Vegas	NV	89129	N/A	8809-AGC-2	Not Accredited
Grand Court of Mesa	Assisted Living	262 East Brown Road	Mesa	AZ	85201	N/A	AL4168C	Not Accredited
Harbor View Assisted Living	Assisted Living	2115 Cappaert Road	Manitowoc	WI	54220	N/A	0015630	Not Accredited
Heritage Assisted Living of Twin Falls	Assisted Living	622 Filer Avenue West	Twin Falls	ID	83301-4533	N/A	RC-1227	Not Accredited
Kenosha	Assisted	3109 30th	Kenosha	WI	53140	N/A	0015616	Not Accredited
Lake Pointe Villa Assisted Living	Assisted Living	190 Lake Pointe Drive	Oshkosh	WI	54904	N/A	0016733	Not Accredited
Lakeshore Assisted	Assisted Living	5250 Medical Drive	Rockwall	TX	75032	N/A	104650	Not Accredited
Las Fuentes	Assisted	1035 Scott Drive	Prescott	AZ	86301	N/A	AL9771C	Not Accredited
Lexington	Assisted	5440 Ralston	Ventura	CA	93003-6002	N/A	565850111	Not Accredited

Lo-Har Senior Living	Assisted Living	768 Dorothy Street	El Cajon	CA	92019	N/A	374603673	Not Accredited
Madison Pointe Senior Living	Assisted Living	705 Ziegler Road	Madison	WI	53714	N/A	0015621	Not Accredited
Mainplace Senior Living	Assisted Living	1800 & 1832 W. Culver Avenue	Orange	CA	92868-4127	N/A	306005636	Not Accredited
Maple Meadows Assisted Living	Assisted Living	1001 Primrose Lane	Fond du Lac	WI	54935	N/A	0016731	Not Accredited
McFarland Villa Assisted Living	Assisted Living	5206 Paulson Court	McFarland	WI	53558	N/A	0015622	Not Accredited
Meadow Creek Assisted Living	Assisted Living	2400 West Pleasant Run Road	Lancaster	TX	75146	N/A	148442	Not Accredited
Meadow View Assisted Living	Assisted Living	4606 Mishicot Road	Two Rivers	WI	54241	N/A	0015626	Not Accredited
Mesa Springs Independent Living	Independent Living	7171 Buffalo Gap Road	Abilene	TX	79606	N/A	N/A	Not Accredited
Mountain Terrace Senior Living CBRF	Assisted Living	3402 Terrace Court	Wausau	WI	54401	N/A	0015628	Not Accredited
Mountain Terrace Senior Living RCAC	Assisted Living	3312 Terrace Court	Wausau	WI	54401	N/A	0015634	Not Accredited

Mountain View Retirement Village	Assisted Living	7900 North La Canada Drive	Tucson	AZ	85704	N/A	AL9760C	Not Accredited
North Point	Assisted	3109 12th Street	Kenosha	WI	53144	N/A	0016740	Not Accredited
Paris Chalet	Assisted	2410 Stillhouse	Paris	TX	75462	N/A	147909	Not Accredited
Park Place	Assisted	2305 Ives Court	Reno	NV	89503-1400	N/A	333-AGC-27	Not Accredited
Parkside	Assisted	2330 Bruce	Neenah	WI	54956	N/A	0016732	Not Accredited
Pleasant Point Senior Living (CBRF)	Assisted Living	8600 Corporate Drive	Racine	WI	53406-3777	N/A	0015617	Not Accredited
Pleasant Point Senior Living (RCAC)	Assisted Living	8500 Corporate Drive	Racine	WI	53406-3783	N/A	0015617	Not Accredited
Riverview Village Senior Living	Assisted Living	W176 N9430 Rivercrest Drive	Menomonee Falls	WI	53051	N/A	0015619	Not Accredited
Robins Landing at Brookfield	Assisted Living	2800 N. Calhoun Rd.	Brookfield	WI	53005	N/A	0019533	Not Accredited
Robins Landing at New Berlin	Assisted Living	2900 S Moorland Rd.	New Berlin	WI	53151	N/A	0019532	Not Accredited
Rockbrook Assisted	Assisted Living	2215 Rockbrook Drive	Lewisville	TX	75067	N/A	104672	Not Accredited
Rose Court	Assisted	2935 North 18th	Phoenix	AZ	85016	N/A	AL8634C	Not Accredited
Santa Maria Terrace	Assisted Living	1405 E. Main St.	Santa Maria	CA	93454	N/A	425801863	Not Accredited
Scandinavian Court Assisted Living	Assisted Living	346 Scandinavian Court	Denmark	WI	54208	N/A	0015623	Not Accredited
Sherwood Village	Assisted Living	102 South Sherwood	Tucson	AZ	85710	N/A	AL9495C	Not Accredited

Stoughton Meadows Assisted Living	Assisted Living	2321 Jackson St.	Stoughton	WI	53589	N/A	0015620	Not Accredited
The Shores of Sheboygan	Assisted Living	3315 Superior Ave.	Sheboygan	WI	53081	N/A	0015629	Not Accredited
The Shores of Sheboygan	Assisted Living	3319 Superior Ave.	Sheboygan	WI	53081	N/A	0015627	Not Accredited
Villa Court Assisted	Assisted Living	3985 S. Pearl Street	Las Vegas	NV	89121-7205	N/A	9444-AGC-0	Not Accredited
Villa Court Assisted	Assisted Living	4025 S. Pearl Street	Las Vegas	NV	89121-7238	N/A	9454-AGC-0	Not Accredited
Whittier Glen Assisted Living	Assisted Living	10615 Jordan Road	Whittier	CA	90603-2932	N/A	198602162	Not Accredited
Willow Brooke Point Senior Living CBRF	Assisted Living	1800 Bluebell Lane	Stevens Point	WI	54481	N/A	0015624	Not Accredited
Willow Brooke Point Senior Living RCAC	Assisted Living	1801 Lilac Lane	Stevens Point	WI	54481	N/A	0015633	Not Accredited
Windsor Court Senior Living	Assisted Living	1101 Jameson Street	Weatherford	TX	76086	N/A	030057	Not Accredited
Wisteria Place Assisted Living	Assisted Living	3202 South Willis Street	Abilene	TX	79605	N/A	307579	Not Accredited
Wisteria Place Independent Living	Independent Living	3917 Wisteria Way	Abilene	TX	79605	N/A	N/A	Not Accredited

OFFICE LEASE

THIS LEASE, made this 26th day of September, 2023, between **TAPIO PROFESSIONAL CENTER, LLC** hereinafter referred to as Lessor, and **Orchard Prairie Healthcare LLC** to as Lessee, on the following terms and conditions:

1. Premises: The Lessor does hereby lease to Lessee, and Lessee does hereby lease from Lessor, those certain premises ("Leased Premises") as per Exhibit "A", situated in the City of Spokane County of Spokane State of Washington, described as follows:

Space 109 in the Yellow Building, consisting of approximately 1582 rentable square feet, located in the project commonly known as The Tapio Professional Center having a street address of 104 S. Freya St, Spokane WA 99202 and legally described as L1-10 B12 & L1-12 B13 & L1-12 B14 & L5-6 B11 Kaufman's 2nd Addition AND L14 B3 Rossvale Addition and vacated alleyway (now Spokane)("Building").

Commencing June 1st, 2024, Lessee shall lease Space 109 as specified in Exhibit "A".

2. Term: Term of 4 years commencing on the 1st day of June, 2024, and ending at the expiration of the 31st day of May, 2028.

3. Rent: Lessee hereby accepts and leases said Leased Premises for said period and agrees to pay a monthly rental of

June 1st, 2024 – May 31st, 2025	**$1,900.00 per month**
June 1st, 2025 – May 31st, 2026	**$1,976.00 per month**
June 1st, 2026 – May 31st, 2027	**$2,055.00 per month**
June 1st, 2027 – May 31st, 2028	**$2,137.00 per month**

without offset or demand, in advance on the first business day of each calendar month during the term of this Lease at the office of Goodale & Barbieri Company, 818 W. Riverside Avenue, Suite 300, Spokane, WA 99201 or at such other place as the Lessor may from time to time designate in writing. Notwithstanding any reference to the area of the Leased Premises or expression of rent as a value per unit of area, the rental described herein is a final negotiated value which shall not be adjusted based upon any calculation or recalculation of the area of the Leased Premises.

A. Upon executing the Lease, Lessee has paid to Lessor the sum of $1,900.00 as first month's rent and is non-refundable. If the Lessee does not occupy the premises under the conditions provided under sections 2, 3, or 4 of Exhibit B- FIRST ADDENDUM TO LEASE AGREEMENT, the first month's rent shall be kept by the Lessor as a Lease termination fee.

4. Security Deposit: Upon executing the Lease, Lessee has paid to Lessor the sum of $1,900.00 as security for performance of Lessee of its obligations hereunder. This deposit shall not bear interest. If Lessee defaults in the performance of any of its obligations hereunder, Lessor may, but shall not be obligated, to use all or any part of the security deposit to cure

Lessee's default or to compensate Lessor for any loss or damage which it may have suffered by reason of Lessee's default. In such an event, Lessee shall deposit with Lessor the amount so applied within five (5) days after written demand by Lessor. If Lessee shall have fully complied with this Lease, but not otherwise, this deposit shall be returned to Lessee within sixty (60) days after the end of the term. Lessee agrees that Lessor shall have the right to commingle the security deposit with other funds. If Lessor sells or assigns or otherwise transfers its interest in the Lease, Lessor may transfer the deposit to the new lessor. Upon such transfer, Lessor shall be relieved from all liability for return of the deposit and Lessee shall look solely to the new lessor for the return of the deposit.

5. Use: The Lessee will use and occupy said Leased Premises for general business and for no other purpose. Lessee agrees that in the operation of the business to be conducted on said Leased Premises and in any occupancy thereof the Lessee shall comply with all the laws, rules and regulations of the government of the United States, State of Washington, and local jurisdictions, and will do nothing to increase the insurance rates on the Building. Lessee agrees not to use any machinery or equipment in the Leased Premises which might be injurious to the Building or which might cause noise or vibration which would be objectionable to other Lessee's. Upon termination of the Lease, Lessee shall quit and surrender the Leased Premises in as good state and condition as reasonable use and wear and tear thereof will permit, damage by the elements or fire excepted.

6. Alterations/Fixtures: Lessee agrees to make no alterations of the Leased Premises without Lessor's written consent. Any alterations to the Leased Premises shall be made at Lessee's expense and shall become the property of Lessor at the termination of this Lease. Upon termination of this Lease, Lessee shall have the right to remove all movable improvements, furnishings and trade fixtures placed therein by Lessee which can be removed without material injury to the Leased Premises and will repair any damage by the elements occasioned by such removal. Lessee shall keep the Leased Premises, Lessee's leasehold interest, the Building and the land free and clear from any liens and lien claims arising or performed, materials furnished or obligations incurred by or on behalf of Lessee. Lessee shall indemnify and hold Lessor harmless from any liability for losses or damage which is resulting directly or indirectly from any such liens or lien claim or from any work performed on or about the Leased Premises by Lessee, its agents, employees, contractors or subcontractors. If any such lien or lien claim is filed against the Leased Premises, the Building, the land or Lessee's leasehold interest, Lessee shall cause the same to be discharged within 30 days after the date of filing.

7. Liability: Except to the extent limited by the section captioned "Waiver of Subrogation" in this Lease, Lessee agrees to indemnify Lessor against and save Lessor harmless from all demands or claims, of whatsoever nature, and all reasonable expenses incurred in investigating or resisting the same, for injury to person, loss of life, or damage to property occurring on the Leased Premises or on any common areas of the Building arising out of Lessee's use and occupancy or due to the act or neglect of Lessee, its agents or employees.

Lessor shall not be liable to the Lessee, its employees, agents, representatives or customers for damages arising out of or in any way connected with any defects now in said Leased Premises or hereinafter occurring in or about said Leased Premises, or other parts of the

Building and approaches under the control of the Lessor, unless the Lessor has actual knowledge of the defect and has had a reasonable opportunity to remedy the same. Lessor shall not be liable for any damage to or theft of property or personal injuries caused by the acts or omissions of other Lessee's of the Building or of the public.

8. Subletting/Assignment: Lessee shall not assign this Lease or any part thereof and shall not let or sublet the whole or any portion of the Leased Premises without the written consent of Lessor or Lessor's agent, which consent shall not be unreasonably withheld. This Lease shall not be assignable by operation of law. Any assignment of this Lease shall not extinguish nor diminish the liability of the Lessee herein. In the event of any assignment or subletting so consented to, Lessee shall pay a minimum charge of one (1) month's rent to Goodale & Barbieri Company for its services in connection with such assignment or subletting. If consent is once given by the Lessor to the assignment of this Lease, or any interest therein, Lessor shall not be barred from afterwards refusing to consent to any further assignment.

9. Casualty/Rebuilding:

A. Substantial Damage. If the Building in which the Leased Premises is located is damaged by fire or any other cause to such extent that the cost of restoration, as reasonably estimated by Lessor, will equal or exceed thirty percent (30%) of the replacement value of the Building (exclusive of foundations) just prior to the occurrence of the damage, or if insurance proceeds sufficient for restoration of the Building are for any reason unavailable, then Lessor may, no later than the sixtieth day following the damage, give Lessee a notice of election to terminate this Lease without regard to the extent of damage to the Leased Premises. In the event of such election, this Lease shall be deemed to terminate on the third day after the giving of such notice, and Lessee shall surrender possession of the Leased Premises within a reasonable time thereafter, and rent shall be apportioned as of the date of Lessee's surrender or as described in the following sentence and any rent paid for any period beyond such date shall be repaid to Lessee. In the event Lessor does not give Lessee the notice of election to terminate this Lease as described above, to the extent that the Leased Premises are rendered untenantable, rent shall proportionately abate, except in the event such damage resulted from or was contributed to, directly or indirectly, by the act, fault or neglect of Lessee, in which event rent shall abate only to the extent Lessor receives proceeds from any rental income insurance policy to compensate Lessor for loss of rent hereunder. No damages, compensation or claim shall be payable by Lessor for inconvenience, loss of business or annoyance arising from any repair or restoration of any portion of the Leased Premises or the Building.

B. Less Substantial Damage. If the cost of restoration of the Building as estimated by Lessor shall amount to less than thirty percent (30%) of said replacement value of the Building and insurance proceeds sufficient for restoration are available, Lessor shall restore the Building and the Leased Premises (with improvements substantially comparable in quality to the improvements to the Leased Premises originally provided by Lessor hereunder) as quickly as is reasonably practical in light of the nature of the damage, subject to delays beyond Lessor's control and delays in the making of insurance adjustments to Lessor. To the extent that the Leased Premises are rendered untenantable, rent shall proportionately abate, except in the event such damage resulted from or was contributed to, directly or indirectly, by the act, fault or

neglect of Lessee, in which event rent shall abate only to the extent Lessor receives proceeds from any rental income insurance policy to compensate Lessor for loss of rent hereunder. No damages, compensation or claim shall be payable by Lessor for inconvenience, loss of business or annoyance arising from any repair or restoration of any portion of the Leased Premises or the Building.

C. Destruction During the Last Year of Term. In case the Leased Premises shall be substantially destroyed by fire or by other cause at any time during the last twelve (12) months of the term of this Lease, either Lessor or Lessee may terminate this Lease upon written notice to the other within thirty (30) days of the date of such destruction.

D. Tenant Improvements. Lessor will not carry insurance of any kind on any improvements paid for by Lessee or on Lessee's furniture, furnishings, fixtures, equipment or appurtenances of Lessee under this Lease and Lessor shall not be obligated to repair any damage thereto or replace the same.

10. Insurance: Lessee agrees to carry and maintain in full force and effect and at its sole cost throughout the term of the Lease a policy of commercial general liability insurance, insuring against any and all claims for injury or death of persons and loss of or damage to property occurring in, on or about the Leased Premises in the amount of at least One Million Dollars ($1,000,000) for each occurrence of bodily injury liability and at least Five-Hundred Thousand Dollars ($500,000) for each occurrence of property damage or a One Million Dollar ($1,000,000) single limit insurance policy. The policy shall name Lessor as an additional insured and shall be primary insurance coverage as to Lessor and all other insurance carried by Lessor shall be excess coverage secondary to the coverage provided by Lessee. Lessee agrees to carry state industrial insurance in the state of Washington or workers compensation in other states with employer's liability or stop gap coverage with limits of Five-Hundred Thousand Dollars ($500,000). The policy shall also provide that it may not be canceled or materially modified without thirty (30) days prior written notice to Lessor. Lessee shall furnish Lessor with a certificate evidencing the issuance of such insurance policy and renewal certificates prior to the expiration of any expiring policy.

11. Waiver of Subrogation: Lessor and Lessee each mutually release the other from every right, claim and demand which may hereafter arise in favor of either arising out of or in connection with any loss occasioned by fire and such other perils as are included in the provisions of the normal extended coverage clauses of fire insurance policies, and do hereby waive all rights of subrogation in favor of insurance carriers arising out of any such losses and sustained by either the Lessor or the Lessee in or to the Leased Premises or Building or any property therein.

12. Notices: All notices to be given by the parties hereto shall be in writing and may either be served personally or may be deposited in the United States mail, postage prepaid, by either registered or certified mail, and if to be given Lessor, shall be addressed to Lessor at the office of Goodale & Barbieri Company, 818 W. Riverside Avenue, Suite 300, Spokane, WA 99201 (or such other address as Lessor may provide by notice), or if to be given Lessee, shall be addressed to Lessee at the Leased Premises whether or not Lessee has departed from, abandoned, or

vacated the Leased Premises. Notices shall be deemed received upon the earlier of actual receipt or three (3) days after due deposit in the mail as provided above.

13. Services/Utilities: As long as Lessee is not in default in any of the provisions of this Lease, Lessor shall, during ordinary business hours, of generally recognized business days, furnish a reasonable amount of electricity (i.e., normal lighting and low power usage office equipment), heat, water, elevator service, normal office air conditioning when so equipped, but shall not be liable nor shall rental be abated for interruption of said service caused by accident or necessity for repairs or improvements, or for any other reason beyond its control. Lessee shall be responsible for their own separately metered electricity, or if not separately metered, then their pro-rata share of the meter for any connected suites. If in Lessor's opinion, Lessee uses more than a reasonable amount of electricity and/or water or if Lessee requires use of the Leased Premises beyond 8:00 a.m. to 6:00 p.m. weekdays then Lessee shall, upon notification by Lessor, pay for such excess usage.
Lessee shall also pay Lessee's proportionate share of increases in Utility Expenses for each Lease Year following the Base Year for this Lease. **2023** shall be the Base Year for this Lease.

Lessee's percentage of Utility Expenses for the Building is 1582 sq. ft. / 92,834 sq. ft. = 1.71%

As soon as reasonably possible after the expiration of each calendar year, Lessor shall determine and certify to Lessee the actual Utility Expenses for the previous calendar year per rentable square foot in the Tapio Professional Center and the amount applicable to the Premises. If such certification shows that Lessee's share of Utility Expenses exceeds Lessee's proportionate share for such Utility Expenses for the Base Year, then Lessee shall, within twenty (20) days after receiving Lessor's certification, pay to Lessor as Additional Rent the entire amount of such deficiency. Utilities are defined to include electricity, gas, oil, water, sewer and trash removal.

14. Repairs/Access: Lessor shall perform all normal maintenance and repairs to the Leased Premises which Lessor reasonably determines necessary to maintain the Leased Premises; provided that Lessor shall not be required to maintain or repair any property of Lessee or any appliances (such as water heaters, refrigerators, microwaves and the like) which are part of the Leased Premises. Lessee shall take good care of the Leased Premises. Lessee shall not make any alterations, additions or improvements ("Alterations") in or to the Leased Premises, or make changes to locks on doors, or add, disturb or in any way change any plumbing or wiring ("Changes") without first obtaining the written consent of Lessor and, where appropriate, in accordance with plans and specifications approved by Lessor. In performing any Alterations or Changes, Lessee shall comply with all applicable rules, regulations, laws and ordinances. Lessee shall reimburse Lessor for any reasonable sums expended for examination and approval of architectural or mechanical plans and specifications of the Alterations and Changes and direct costs reasonably incurred during any inspection or supervision of the Alterations or Changes. All damages or injury done to the Leased Premises or Building by Lessee or by any person for whom Lessee would be responsible under Washington law, including but not limited to the cracking or breaking of any glass of windows and doors, shall be paid for by Lessee.

Lessee shall permit Lessor and its agents to enter into and upon the Leased Premises at all reasonable times (or at any time in the event of damage to the Building or other emergency) for

the purpose of inspecting the same or for the purpose of cleaning, repairing, altering or improving the Leased Premises or the Building. Nothing herein contained shall be construed as an agreement on the part of Lessor to make any alterations whatsoever. Upon reasonable notice, Lessor shall have the right to enter the Leased Premises for the purpose of showing the Leased Premises to prospective Lessee's within the period one hundred eighty (180) days prior to the expiration or sooner termination of the lease term. Lessor may enter the Leased Premises without notice in the event of an emergency.

15. Signs: Lessee will not inscribe any inscription or post, place, or in any manner display any sign, notice, picture, placard, or poster, or any advertising matter whatsoever anywhere in or about the Leased Premises or said Building where it may be visible from the public corridors or from outside the Building without first obtaining Lessor's written consent thereto. Any sign so placed on the Leased Premises shall be upon the understanding and agreement that Lessee will remove the same at the termination of the Lease and repair any damage or injury to the Leased Premises used thereby; and, if not removed by Lessee, then Lessor may remove same or repair any damage at Lessee's expense. In the event there becomes due to any governmental agency a charge connected with any sign of Lessee, Lessee shall pay such charge in a prompt manner.

16. Default: The occurrence of any one or more of the following shall be an "Event of Default" by Lessee under this Lease:

A. Payment. Failure by Lessee to fulfill any monetary obligation including the payment of rent required to be made by Lessee hereunder, within five (5) days of when due. In addition to all other payments and obligations required of Lessee under this Lease, Lessee shall pay as a late charge the amount of 10% of any payment not received by Lessor within 5 days of the date due, which late charge shall be paid within 10 days of notice by Lessor to Lessee that the late charge is due.

B. Nonmonetary Default. Failure by Lessee to observe or perform any of the nonmonetary covenants, conditions or provisions of this Lease to be observed or performed by Lessee within thirty (30) days of receipt of notice from Lessor specifying such nonmonetary default; provided that if the nature of the nonmonetary default is such that more than thirty (30) days is reasonably required to cure the same, then Lessee shall have such longer period to cure such default as is reasonably necessary provided Lessee commences such cure within said thirty (30) day period and thereafter diligently prosecutes such cure to completion.

C. Insolvency. An assignment by Lessee for the benefit of creditors, insolvency of Lessee, Lessee's failure to pay its debts in the ordinary course of business, or the filing by or against Lessee of a petition to have Lessee adjudged bankrupt or a petition for reorganization or arrangement under any law relating to bankruptcy or the reorganization of the debts of individuals or corporations, or the appointment of a trustee or receiver to take possession of substantially all of Lessee's assets on the property or of interest in the Lease.

17. Lessor's Remedies: Following any "event of default", Lessor may thereafter exercise any of the following remedies, all of which remedies shall, to the greatest extent possible be cumulative, and such that the exercise of one shall not exclude any other:

A. Terminate Lease. Terminate the Lease and Lessee's right to possession of the Leased Premises by any lawful means and upon such notice as may be required hereunder and by law, in which case this Lease shall terminate and Lessee shall surrender possession of the Leased Premises to Lessor. In such event Lessor shall be entitled to recover from Lessee all past due rent and other payments due hereunder plus the value at the time of award of the amount by which the unpaid rent and other payments due hereunder for the balance of the lease term after the time of such award (discounted to present value at the discount rate of the Federal Reserve Bank of San Francisco plus 1%) exceeds the amount of such loss for the same period that Lessee proves Lessor could have reasonably avoided. Unpaid installments of rent and any other sums due Lessor hereunder shall bear interest at the lesser of the rate of 18% per annum or the maximum interest rate allowable under applicable law from the date such sums are due until fully paid.

B. Continue Lease. Continue the Lease in effect whether or not Lessee shall have abandoned the Leased Premises, and relet or attempt to relet all of any portion of the Leased Premises upon such terms and conditions as Lessor in its sole discretion may deem advisable in which event the rents received on such reletting shall be applied first to the expenses of reletting and collection, including necessary renovation and alteration of the Leased Premises, reasonable attorneys' fees and real estate commissions paid, and thereafter to payment of all sums due or to become due Lessor hereunder. If a sufficient sum shall not be thus realized to pay such sums and other charges, Lessee shall pay Lessor any and all deficiencies with interest at the lesser of the rate of 18% per annum or the maximum interest rate allowable under applicable law until paid.

C. Lessor's Right to Cure. If Lessee's defaults in performance of any of its obligations hereunder, Lessor may, at its option (but without obligation to do so), pay such amounts or perform such obligations as required to cure any default of Lessee, all on the behalf of and at the expense of Lessee, and may do all necessary work and make all necessary payments in connection therewith, including but not limited to, the payment of any reasonable attorneys' fees, costs, or charges in connection with any legal action which may have been brought. Lessee shall pay Lessor the amount so paid by Lessor upon demand, with interest at the lesser of the rate of 18% per annum or the maximum interest rate allowable under applicable law until paid.

D. Other Remedies; Further Damages. Pursue any other remedy available to Lessor at law or equity, including the right to recover any other amounts necessary to compensate Lessor for all reasonably foreseeable damages proximately caused by Lessee's failure to perform its obligations under the Lease.

18. Removal of Property. If Lessee shall fail to remove any of its property of any nature whatsoever from the Leased Premises at the termination of the Lease or when Lessor has a right to reenter, Lessor may, at its option, remove and store said property without liability for loss thereof or damage thereto, such storage shall be for the account of and at the expense of Lessee. If Lessee shall not pay the cost of storing any such property after it has been stored for a period of thirty (30) days or more, Lessor may, at its option sell, or permit to be sold, any or all of such property at public or private sale, in such manner and at such times and places as Lessor in its

sole discretion may deem proper, without notice to Lessee, and shall apply the proceeds of such sale, first to the cost and expense of such sale, including reasonable attorneys' fees actually incurred; second, to the payment of the cost and charges for storing any such property; third, to the payment of any sums or money that may or thereafter become due Lessor from Lessee under any of the terms of the Lease; and fourth, the balance, if any, to Lessee.

19. Attorneys' Fees: In the event of any action at law or in equity between Lessor and Lessee to enforce any of the provisions, rights or obligations hereunder, the unsuccessful party to such litigation agrees to pay to the successful party all costs and expenses, including reasonable attorneys' fees incurred therein by the successful party, and if such successful party shall recover judgment in any such action or proceeding, such costs and expenses and attorneys' fees shall be included in and as a part of such judgment.

20. No Waiver of Covenants: Time is and shall be of the essence of this Lease and of each and every part thereof, and any waiver by the Lessor of any breach of the Lessee shall not be construed or considered to be a waiver of any future similar breach nor of any other breach hereof. None of the covenants, terms or conditions of this Lease required to be performed by Lessee shall be in any manner altered, waived, modified or abandoned except by written instrument duly signed and delivered by Lessor.

21. Delayed Possession: In the event of the inability of Lessor to deliver possession of the Leased Premises at the time of the commencement of the term of this Lease, neither Lessor nor its agents shall be liable for any damage caused thereby, nor shall this Lease thereby become void or voidable, nor shall the term herein specified be in any way extended, but in such event Lessee shall not be liable for any rent until such time as Lessor can deliver possession; provided, however, that in the event that possession is delayed over ninety (90) days without being caused by Lessee, Lessee shall have the right to terminate this Lease.

22. Subordination: This Lease is subject and is hereby subordinated to all present and future mortgages, deeds of trust and other encumbrances affecting the demised Leased Premises or the property of which said Leased Premises are a part. The Lessee agrees to execute, at no expense to the Lessor, any instrument which may be deemed necessary or desirable by the Lessor to further effect the subordination of this Lease to any mortgage, deed or trust or encumbrances. Lessee hereby irrevocably appoints and constitutes the Lessor as the true and lawful attorney of Lessee at any time for Lessee, and in Lessee's name, place and stead, to execute proper subordination agreements to this effect.

23. Condemnation: In the event any part of the property upon which the Building is located or of the Building is taken by public authority, then the Lessor may cancel this Lease upon sixty (60) days written notice to the Lessee, and all damages shall belong to the Lessor.

24. Holding Over: If Lessee, with the consent, expressed or implied, of the Lessor, shall hold over after the expiration of the term of this Lease, the Lessee shall remain bound by all the terms, covenants, and agreements hereof, except that the tenancy shall be one from month to month. During such tenancy, Lessee agrees to pay to Lessor 125% of the rate of rental last payable under this Lease, unless a different rate is agreed upon by Lessor. Lessor acknowledges and agrees that

this Section does not grant any right to Lessee to holdover, and that Lessee may also be liable to Lessor for any and all damages or expenses which Lessor may have to incur as a result of Lessee's holdover.

25. Heirs/Assigns: The rights, liabilities, and remedies provided for herein shall extend to the heirs, legal representatives, successors and, so far as the terms of this Lease permit, assigns of the parties hereto; and the words "Lessor" and "Lessee" and their accompanying verbs or pronouns, wherever used in this Lease, shall apply equally to all persons, firms or corporations which may be or become parties hereto.

26. Rules: Lessee agrees to abide by the rules and regulations governing the Building which may be made by Lessor from time to time, and will use all reasonable methods to induce customers, clients and all persons invited by Lessee into said Building to observe the same.

27. Taxes: The rent to be paid is exclusive of any sales tax, business and occupation tax, or any taxes based on rents, and should any such taxes apply, or be enacted during the term of this Lease, the rent shall be increased by such amount. Lessee shall pay all personal property taxes which respect to property of Lessee located on the Leased Premises or in the Building, including all improvements which were paid for by Lessee.

28. Tenant Improvements: Lessor shall also provide signage in the building directory and building standard signage on Lessee main entrance door at Lessee's expense. No other improvements shall be made by Lessor.

29. Transfer of Lessor's Interest: In the event of any transfers of Lessor's interest in the Leased Premises or in the Building, other than a transfer for security purposes only, the transferor shall be automatically relieved of any and all obligations and liabilities on the part of Lessor accruing from and after the date of such transfer and such transferee shall have no obligation or liability with respect to any matter occurring or arising prior to the date of such transfer.

30. Hazardous Materials: Lessee shall not dispose of or otherwise allow the release of any hazardous waste or materials in, on or under the Leased Premises or the Building, or any adjacent property, or in any improvements placed on the Leased Premises. Lessee represents and warrants to Lessor that Lessee's intended use of the Leased Premises does not involve the use, production, disposal or bringing on the Leased Premises of any hazardous waste or materials. As used in this Section, the term "hazardous waste or materials" includes any substance, waste or material defined or designated as hazardous, toxic or dangerous (or any similar term) by any, now or hereafter in effect. Lessee shall promptly comply with all such statutes, regulations, rules and ordinances, and if Lessee fails to so comply Lessor may, after reasonable prior notice to Lessee (except in case of emergency) effect such compliance itself. Lessee shall immediately reimburse Lessor for all costs incurred in effecting such compliance.

Lessee agrees to indemnify and hold harmless Lessor against any and all losses, liabilities, suits, obligations, fines, damages, judgments, penalties, claims, charges, cleanup costs, remedial actions, costs and expenses (including, without limitation, consultant fees, attorneys'

fees and disbursements) which may be imposed on, incurred or paid by, or asserted in connection with (i) any misrepresentation, breach of warranty or other default by Lessee under this Lease, or (ii) the acts or omissions of Lessee, or any subtenant or other person for whom Lessee would otherwise be liable, resulting in the release of any hazardous waste or materials.

31. Estoppel Certificate: The Lessee agrees upon not less than ten (10) days prior written notice from Lessor to execute, acknowledge and deliver to Lessor, at no expense to the Lessor, any reasonable instrument which may be deemed necessary or desirable by the Lessor to confirm the status of the Lease, including but not limited to the amount and status of rental payments, remaining term and existence or absence of defaults. In the event Lessor provides Lessee, in the same manner as required for a notice to Lessee, with an instrument reciting the status of the Lease and Lessee fails to execute and deliver to Lessor such instrument either in the form provided by Lessor or as corrected to the best of the knowledge of Lessee, then such instrument shall be presumed accurate in the form provided by Lessor and may be conclusively relied upon by any third party.

32. Agency Disclosure: At the signing of this agreement Goodale and Barbieri Company represented Tapio Professional Center, LLC. Each party signing this document confirms that prior oral and/or written disclosure of agency was provided to him/her in this transaction.

33. Relocation: Lessee agrees the Lessor may relocate Lessee to another space in the Building or any of the other Buildings within the Tapio Professional Center complex containing at least the same amount of rentable space as the Leased Premises, provided that the Rent is not increased above the amount payable hereunder and that the costs of relocating Lessee are limited to costs of altering the new space to make it comparable to the Leased Premises, are borne by Lessor.

34. Termination on Sale or Redevelopment: As a material consideration to Lessor for this Lease, Lessee expressly agrees that Lessor may, in its sole discretion, sell or pursue redevelopment of the Property at any time during the Lease Term. In the event that Lessor elects to redevelop the Property, Lessor shall provide Lessee with 12 months' prior written notice of Lessor's intent to redevelop the Property. Upon receipt of notice, Lessee agrees during said 12 month notice period to abide by all of the terms and conditions of the Lease and any and all extensions, revisions or renewals thereof. Lessee further agrees that all of Lessee's rights and obligations under Lessee's Lease shall terminate on the redevelopment date contained in Lessor's notice. In the event that Lessor elects to sell the Property, Lessor shall provide Lessee with written notice that Lessor intends to sell, or has sold, the Property. Upon receipt of notice, Lessee agrees during said 12 month notice period to abide by all of the terms and conditions of the Lease and any and all extensions, revisions or renewals thereof. Lessee further agrees that all of Lessee's rights and obligations under Lessee's Lease shall terminate 12 months following its receipt of such notice unless the purchaser of the Property notifies Lessee within such 12 month period that the Lease shall not terminate as provided herein. In the event the Lease does not terminate pursuant to this Subsection, the terms of the Lease shall remain in full force and effect.

35. Exhibits and Riders:

Exhibit A – Plan-Leased Premises

Rider #1 – The Tapio Professional Center Building Rules and Regulations
Schedule 'A' – Tapio Office Center Telephone Installation Policy

IN WITNESS WHEREOF the parties hereto have executed this Lease the day and year first above written.

LESSOR:
TAPIO PROFESSIONAL CENTER, LLC

By: _____

Its: Manager

Date: 10/3/23

LESSEE:
Orchard Prairie Healthcare LLC

By: _____

Its: Market Leader

Date: 8/26/23

LESSOR ACKNOWLEDGEMENT

STATE OF WASHINGTON }
} ss.
COUNTY OF SPOKANE }

On this 3rd day of October, 2023, before me personally appeared Thomas Barbieri to me known to be Manager of **TAPIO PROFESSIONAL CENTER, LLC,** that executed the within and foregoing instrument, and acknowledged the said instrument to be the free and voluntary act and deed of said corporation, for the uses and purposes therein mentioned, and on oath stated that they were authorized to execute said instrument and that the seal affixed thereto is the corporate seal of said corporation.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal, the day and year above written.

TONIA L WILHELM
APPOINTMENT EXPIRES November 09, 2026
NOTARY PUBLIC
COMM # 22035051
STATE OF WASHINGTON

NOTARY PUBLIC in and for the State of Washington
residing at Spokane County
My commission expires on 11/9/26

LESSEE ACKNOWLEDGEMENT

STATE OF WASHINGTON }
} ss.
COUNTY OF SPOKANE }

I certify that I know or have satisfactory evidence that Kyle Ambrose is the person who appeared before me, and said person acknowledged that He/She signed this instrument and acknowledged it to be His/Her free and voluntary act for the uses and purposes mentioned in the instrument.
Given under my hand and seal of office this 26th day of September, 2023.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal, the day and year above written.

LIANA ALBANO
Notary Public - State of Idaho
Commission Number 20225234
My Commission Expires Oct 31, 2028

NOTARY PUBLIC in and for the State of Washington
residing at 1903 E Cougar Creek Dr. Meridian, ID 83642
My commission expires on 10/31/2028

Exhibit A
Leased Premises

Suite 109 Yellow Flag Building
Floorplan not available

Rider #1

TAPIO PROFESSIONAL CENTER
RULES AND REGULATIONS

1. Lettering upon the directory boards and the doors as required by Lessee shall be in accordance with Tapio Professional Center standards and subject to Lessor's approval, and shall be made by the sign company designated by Lessor. The cost of the directory boards and all other lettering costs shall be paid by Lessee at lease execution in the amount of $225.00, of which price is subject to change. The directories of Tapio Professional Center will be provided exclusively for the display of the name and location of Lessee's; and Lessor reserves the right to exclude any other names therefrom.

2. No additional locks shall be placed upon any doors of Leased Premises, and Lessee agrees not to have any duplicate keys made without the consent of Lessor. If more than two (2) keys for any door lock are desired, such additional keys shall be paid for by Lessee. Upon termination of this Lease, Lessee shall surrender all keys. In the event not all keys are received/returned, Lessee will be charged for such missing keys, up to the total expense to re-key the Leased Premises.

3. No furniture, freight, supplies not carried by hand, or equipment of any kind shall be brought into or removed from Tapio Professional Center without the consent of Lessor. Lessor shall have the right to limit the weight and size and to designate the position of all safes and other heavy property brought into Tapio Professional Center. Such furniture, freight, equipment, safes and other heavy property shall be moved in or out of Tapio Professional Center only at the times and in the manner permitted by Lessor. Lessor will not be responsible for loss or damage to any of the items above referred to, and all damages done to Leased Premises or Tapio Professional Center or Property by moving or maintaining any such items shall be repaired at the expense of Lessee. Any merchandise not capable of being carried by hand shall utilize hand trucks equipped with rubber tires and rubber side guards.

4. The entrances, corridors, and stairways shall not be obstructed by Lessee, or used for any other purpose than ingress or egress to and from Leased Premises. Lessee shall not bring into or keep any animal, except seeing eye dogs, within Tapio Professional, *with the exception of guide animals for the disabled,* or any bicycle or other type of vehicle, except in designated areas permitted by Lessor.

5. Lessee shall not disturb other occupants of Tapio Professional Center by making any undue or unseemly noise, or otherwise. Lessee shall not, without Lessor's written consent, install or operate in or upon Leased Premises any machine or machinery causing noise or vibration perceptible outside Leased Premises, electric heater, stove, or machinery of any kind or carry on any mechanical business thereon, or keep or use thereon oils, burning fluids, camphene, kerosene, gasoline, or other combustible materials. No explosives shall be brought into Tapio Professional Center.

6. Lessee shall not mark, drive nails, screw or drill into woodwork or plaster, or paint or in any

way deface Tapio Professional Center or any part thereof, or Leased Premises or any part thereof, or fixtures therein; except that pictures and similar decorations may be hung by means approved by Lessor. The expense of remedying any breakage, damage or stoppage resulting from a violation of this rule shall be borne by Lessee.

7. Canvassing, soliciting and peddling in Tapio Professional Center are prohibited and each Lessee shall cooperate to prevent such activity.

8. The request of Lessee's will be attended to only upon application to the office of Goodale & Barbieri Company. Lessor employees shall not perform any work or do anything outside of their regular duties, except on issuance of special instructions from the office of Goodale & Barbieri Company. If Tapio Professional Center employees are made available for the assistance of any Lessee's, Lessor shall be paid for their services by such Lessee's at reasonable hourly rates. No Tapio Professional Center employee will admit any person (Lessee or otherwise) to any office without specific instructions from the office of Goodale & Barbieri Company.

9. Lessor reserves the right to close and keep locked all entrance and exit doors of Tapio Professional Center on Saturdays, Sundays and legal holidays and between the hours of 5:00 p.m. of any day and 8:00 a.m. of the following day and during such further hours as Lessor may deem advisable for the adequate protection of Tapio Professional Center and the property of the Lessee's.

10. Lessor assumes no responsibility for and shall not be liable for any damage resulting from any error in regard to any identification of Lessee or its employees and from admission to or exclusion from Tapio Professional Center by such outside agency.

11. Lessor shall supply the following janitor services throughout Tapio Professional Center, except those Lessee's who have agreed to provide their own janitorial service:

    a. Dusting, removal of waste paper, sweeping, vacuuming and basic cleaning on a schedule determined by Lessor. This janitor service will not be furnished on nights when Leased Premises are occupied after 9:30 p.m.

    b. Exterior Window washing once per year.

    c. Basic cleaning of common areas including stairs, hallways, and restrooms.

12. Lessee shall exercise care and caution to ensure that all water faucets or water apparatus, electricity and gas are carefully and entirely shut off and all windows closed, if operational, before Lessee or its employees leave Tapio Professional Center, so as to prevent waste or damage. Lessee shall be responsible for any damage to Leased Premises or Tapio Professional Center or Property and for all damage or injuries sustained by other Lessee's or occupants of Tapio Professional Center arising from Lessee's failure to observe this provision.

13. Lessor may at any time change the name of the Tapio Professional Center or Property.

14. Lessee shall not hang or display anything in the windows of Tapio Professional Center without the Lessor's written consent in order to preserve the exterior appearance of Tapio Professional Center.

15. Lessor reserves the right to exclude or expel from Tapio Professional Center any person who, in the judgment of Lessor, is under the influence of liquor or drugs, or who shall in any manner do any act in violation of any of the rules and regulations of Tapio Professional Center.

16. Lessor reserves the right to make such other and further reasonable regulation as in its judgment may from time to time be needed or desirable for the safety, care and cleanliness of Leased Premises or Tapio Professional Center or Property and the preservation of good order therein.

17. Lessor, at all times during the term of this Lease, shall provide adequate parking for Lessee subject to reasonable rules and regulations of Lessor. Lessee and his agents, customers, clients, or any other such person, shall not leave vehicles overnight or on weekends in parking lots so as not to hinder parking lot maintenance and winter snow removal. Lessor reserves the right to rearrange parking at any time during the course of this Lease, which may or may not include property either adjacent to or close to existing parking lots. Bicycles, mopeds, etc., are not allowed inside buildings, at landscaped areas, or vehicle maneuvering areas. Bicycle racks are provided at strategic locations in the complex.

18. The United States Post Office has issued a directive to our complex, which we must comply with in order to continue uninterrupted mail service. Lessee's cooperation is necessary. Proper mailing address includes the Company Name, Tapio Professional Center, **(color)** Flag Building, **Suite ---,** 104 S. Freya, Spokane, WA 99202. If the subject mail is directed to a particular person, the person's name and company name must be included.

Sample:

XYZ Company, Inc.
Tapio Professional Center
(color) Flag Building, Suite ___
104 S. Freya
Spokane, Washington 99202-____

Mr. John A. Jones III
XYZ Company Inc.
Tapio Professional Center
(color) Flag Bldg., Suite ___
104 S. Freya
Spokane, WA 99202-____

Lessor shall provide exterior nameplate for Lessee on assigned mailbox at no charge to Lessee. Lessor will also provide mailbox key. In case of theft or loss of said key, complex manager should be notified so a duplicate key may be ordered. Cost for this service shall be assessed at $30.00 to the Lessee as Lessor does not retain a duplicate key. It is Lessee's responsibility to provide a list of company name(s) and persons who shall be receiving mail and affix the list to the interior of this mailbox to facilitate mail delivery.

19. The conference room is located in Tapio Professional Center, Blue Flag Building and is available on a first-come, first-serve basis and requires a minimum of 24 hours scheduling

notice. The character of the conference room is intended to be on a privileged basis, not a right, and is to be used for meetings of more people than may be accommodated within the Lessee's own suite. Any Lessee using the conference room in excess, determined by the amount of space that each Lessee rents as compared to the entire complex, will be expected to provide conference space within his own suite. This room is designated a **"NO SMOKING AREA"** and a **"NO FOOD OR DRINK AREA".**

20. The Tapio Professional Center requires that Lessees with privately owned telephone systems have them installed in their office suite rather than the common building equipment room. If common equipment rooms contain Lessee telephone equipment, the Tapio Professional Center makes no guarantees, implied or otherwise, for the safety of this equipment, the monitoring of equipment, or equipment damage (including fire or flood). Lessee agrees, that under no circumstances, shall B & C Telephone be permitted to install, or be contracted to do work in the Lessee space and/or equipment rooms at the Tapio Professional Center. Before Lessees contract with a telephone installation company, they and the proposed phone installer should become familiar with the Tapio Professional Center Telephone installation Policy, copy of which is attached hereto as Schedule 'A'. It is the recommended policy that the telephone vendors make an appointment with the Building Manager for a customized phone installation prior to contacting the Lessee

Schedule 'A'

TAPIO OFFICE CENTER
TELEPHONE INSTALLATION POLICY

Failure of the Installer and/or Tenant to comply with the following building policies will cause himself and his company to be barred from working in the common equipment rooms in this office complex until all monetary charges are paid including any cleaning expenses or damage.

1. Business cards must be applied on all equipment installed in the equipment room.
   A. One card with Installer Identification.
   B. One card with Tenant Identification.

2. Telephone Company must have pre-approved location by the Building Manager of any Telephone equipment to be installed in the office building equipment room.

3. After finishing his work in the equipment room, the Installer must clean up any papers, wires, clippings, scrap insulation, etc., before leaving the building.

4. While having access to the building equipment room, the Installer is responsible for the previously installed phone systems of other Tenants. If another Tenant's phone system should have its service interrupted while the Phone Installer is working in the equipment room, the Installer will be held responsible for the repair of that system.

5. If smudges on ceiling tiles occur and/or if the edges of ceiling tiles get damaged while being removed during the phone installation, then the Installer will be responsible for their replacement with new ceiling tiles.

5. Installer must vacuum any areas in the offices in which, during the phone installation, he causes the need for vacuuming. To do so, Installer needs to provide his own vacuum.

7. If Installer is working over a Tenant's desk during the phone installation, then he must provide and place a drop cloth over the desk for protection while he works.

8. At no time and under no condition will an Installer run surface wire in the common equipment room.

9. Dustproof and waterproof protective covers are required on equipment in the common equipment room.

10. If common equipment rooms contain tenant phone systems, and if Lessee would like to have a radio connected to the phone equipment, then the policy of the complex is that the radio be installed in Lessee's office suite. This allows Lessee access to the radio for any adjustments that may be required in channel selections.

Exhibit B
FIRST ADDENDUM TO LEASE AGREEMENT

TENANT:	**ORCHARD PRAIRIE HEALTHCARE LLC** **Address**: C/O Pennant Service Center 1675 E. Riverside Drive, Suite 200, Eagle, ID 83616
LANDLORD:	**TAPIO PROFESSIONAL CENTER LLC** **Address:** C/O Goodale & Barbieri Company 818 W. Riverside Avenue, Suite 300, Spokane, WA 99201

THIS FIRST ADDENDUM TO LEASE AGREEMENT ("First Addendum") is made and entered into by and between Orchard Prairie Healthcare LLC ("Tenant") and Tapio Professional Center LLC ("Landlord"), each a ("Party") and collectively the ("Parties"), effective as of the date of the Lease identified below.

RECITALS

A. This First Addendum is Exhibit B to a Lease Agreement entered into by Tenant and Landlord, entitled Office Lease (referred to herein as the "Lease") in regard to the Leased Premises located at 104 S. Freya Street, Spokane, WA 99202;

B. The Parties acknowledge that Tenant is in the process of preparing and submitting a Certificate of Need application to the Washington State Department of Health (WSDH) for authorization to provide home health services in Spokane, Washington, and the surrounding area. It is anticipated that the WSDH will make a determination on Tenant's Certificate of Need application prior to June 1, 2024.

C. The Parties acknowledge that in order for Tenant to submit a complete application Tenant must have office space in the Spokane area available for conducting home health services. Such office space can be available to Tenant by ownership of lease.

D. The Parties desire that the Lease will not become effective and Tenant will not obtain possession of the Leased Premises in the event Tenant's Certificate of Need application is denied by the WSDH.

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

1. In the event that on or before June 1, 2024, Tenant's Certificate of Need application is granted by the WSDH, then all rights, obligations, responsibilities and duties under the Lease shall be in full force and Tenant shall have the right to possession of the Leased Premises beginning June 1, 2024.

2. In the event that on or before June 1, 2024, Tenant's Certificate of Need application is denied by WSDH then, within five (5) days of receiving WSDH's determination, Tenant shall notify Landlord

of the WSDH determination. The Lease shall terminate on the date notice of WSDH's determination is provided by Tenant to Landlord. First month's rent shall not be refunded.

3. In the event Tenant does not receive notification of a WSDH determination on or before June 1, 2024, then Tenant shall not take possession of the Leased Premises and the Lease shall terminate effective June 1, 2024. First month's rent shall not be refunded.

4. In the event the space 109 in the Yellow Flag building is not available or has been leased to another party, then the Landlord shall substitute an available space in its place with Tenants approval. If no suites are available that meet Tenants needs, this lease will be null and void. First month's rent shall not be refunded.

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

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

Signature:	Signature:
ORCHARD PRAIRIE HEALTHCARE LLC	**TAPIO PROFESSIONAL CENTER LLC**
Name: Kyle Ambrose	Name: T Lan Barbieri
Title: Market Leader	Title: Manager
Date: 9/26/2023	Date: 10/3/23

EXHIBIT 5

LEE L. JOHNSON
TREASURER
SYMBOL HEALTHCARE, INC.

direct line (208) 401-1369
direct fax (208) 576-6909
lee.johnson@pennantservices.com

June 6, 2023

Via Email to FSLCON@doh.wa.gov

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

Dear Mr. Hernandez:

In accordance with WAC 246-310-080, **Orchard Prairie Healthcare LLC**, hereby submits a letter of intent proposing to establish a Medicare certified/Medicaid eligible home health agency. In conformance with the requirements of WAC, the following information is provided:

1. A Description of the Extent of Services Proposed:
Orchard Prairie Healthcare LLC is proposing to establish a Medicare certified/Medicaid eligible home health agency in **Spokane County**, including all required home health services.

2. Estimated Cost of the Proposed Project:

The capital expenditure associated with this project is estimated at $5,000.

3. Description of the Service Area:

The primary service area for the hospice agency will be **Spokane County**.

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

Sincerely,

Orchard Prairie Healthcare LLC
By:

Lee L. Johnson, Treasurer
Direct office line: (208) 401-1369

Pennant Group Affiliate

LANGUAGE ACCESS PLAN AND POLICY

2019

TABLE OF CONTENTS

Summary of Nondiscrimination in Health Programs and Activities

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

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

The rule covers:

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

Protections under the rule

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

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

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

Enforcement

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

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

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

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

LANGUAGE ACCESS POLICY

Purpose

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

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

Scope

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

Policy Statement

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

Policy

Operation will;

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

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

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

GRIEVANCE POLICY AND PROCEDURE

Purpose

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

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

Scope

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

Policy Statement

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

Policy

Operation will;

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

Procedure

Operation shall;

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

Discrimination Grievance Form

Name	
Address	
City, State, ZIP	
Telephone Number	
Email address	

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

Name	
Address	
City, State, ZIP	
Telephone number	

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

Description of the action you would like to see taken

Signature	
Date of Complaint	

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

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

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

Notice of Non-discrimination

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

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

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

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

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

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

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

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

ELEMENTS AND PROCEDURES

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

ELEMENT 1: Assessment: Needs and Capacity

ELEMENT 2: Oral Language Assistance Services

ELEMENT 3: Written Translations

ELEMENT 4: Policies and Procedures

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

ELEMENT 6: Staff Training

ELEMENT 7: Assessment: Access and Quality

ELEMENT 8: Procurement of Language Assistance Services

ELEMENT 1: Assessment of Needs and Capacity

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

Description

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

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

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

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

PROCEDURE

Operation shall;

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

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

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

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

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

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

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

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

ELEMENT 2: Oral Language Assistance Services

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

Description

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

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

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

PROCEDURE

Operation shall;

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

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

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

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

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

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

ELEMENT 3: Written Translations

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

Description

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

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

PROCEDURE

Operation shall;

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

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

c. Use the services of qualified, professional translators.

ELEMENT 4: Policies and Procedures

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

Description

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

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

PROCEDURE

Operation shall;

a. Implement this Language Access Plan and policy.

b. Regularly monitor the efficacy of services provided.

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

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

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

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

Description

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

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

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

PROCEDURE

Operation shall;

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

b. Distribute and make available resources.

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

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

ELEMENT 6: Staff Training

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

Description

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

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

PROCEDURE

Operation shall;

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

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

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

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

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

f. Provide ongoing training as needed.

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

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

ELEMENT 7: Assessment of Access and Quality

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

Description

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

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

PROCEDURE

Operation shall;

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

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

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

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

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

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

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

ELEMENT 8: Procurement of Language Assistance Services

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

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

PROCEDURE

Operation shall;

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

Appendix A: Definitions

Auxiliary Aids and Services

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

Disability

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

Effective Communication

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

Qualified Bilingual/Multilingual Staff

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

Qualified Interpreter

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

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

Qualified Translator

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

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

Language Access

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

Language Assistance Services

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

Limited English Proficiency (LEP)

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

Meaningful Access

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

Plain Language

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

Preferred Language

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

Taglines

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

Translation

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

Translator

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

Vital Document

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

Appendix B: Language Access Related Resources

LEP.gov

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

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

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

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

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

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

YOUTUBE VIDEOS

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

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

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

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

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

EXHIBIT 6
ADMISSION CRITERIA AND PROCESS
Policy No. 2-003.1

PURPOSE

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

POLICY

A patient 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.

A patient will be accepted for care based on consideration. Consideration will be given to the adequacy and suitability of organization personnel, resources to provide the required services, and the reasonable expectation that the patient's medical, nursing, rehabilitative, and social needs can be adequately met in the patient's place of residence.

While a patient will be accepted for services based on his/her medical needs, the patient's ability to pay for such services, either through state or federal assistance programs, private insurance, or personal assets are factors that will be considered.

The organization reserves the right not to accept a patient who does not meet the admission criteria.

A patient will be referred to other resources if the organization cannot meet his/her needs.

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

Admission Criteria

1. The patient must be under the care of a physician (or other authorized licensed independent practitioner). The patient's physician (or other authorized licensed independent practitioner) must order and approve the provision of any service. A skilled service must be ordered.

2. The patient must desire home care services.

3. Manito Home Health will consider for acceptance any patient who is appropriate for home care, regardless of payment source.

4. The patient must reside within the geographical area which the Manito Home Health services.

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

6. Services may be provided to a patient insured by Medicare who has a primary need for skilled nursing, physical and/or speech therapy on an intermittent basis and is homebound. (A patient is considered to be homebound if he/she has a condition that restricts his/her ability to leave his/her place of residence except with the aid of supportive devices, the use of special transportation, the assistance of another person, or if he/she has a condition which is such that leaving his/her home is medically contraindicated.)

7. Acceptance for home care services will be realistically based on the patient's willingness and ability to function in a noninstitutional environment, and the willingness, ability, and availability of family/caregiver or significant individuals to participate in the care.

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

PROCEDURE

1. The organization will utilize referral information provided by the family/caregiver, health care clinicians from acute care facilities, skilled or intermediate nursing facilities, other agencies, and physician offices in the determination of eligibility for admission to the program. If the patient's physician (or other authorized licensed independent practitioner) does not make the request for service, he/she will be contacted for start of care orders prior to the evaluation visit and initiation of services.

    A. If the patient resides in an assisted living facility, it will be determined the type of state license the facility holds, if any, and the required services the facility is obligated to provide.

    B. A copy of the patient's service agreement with the facility will be viewed to ensure that home health services ordered and provided are not duplicative of those services or required to be provided by the facility.

2. The Clinical Supervisor will assign clinical organization personnel to conduct initial assessments of eligibility for services within seven (7) days of receipt and acceptance of referral information and/or discharge from referring facility.

    A. The initial assessment visit must then be performed either within seven (7) days of the referral, or within 48 hours of the patient's return home, or on the start of care date ordered by the physician (or other authorized licensed independent practitioner).

    B. The patient's most critical needs for home care services must be identified during the initial assessment and must be met in a timely fashion.

C. The initial assessment and comprehensive assessment must be conducted by a registered nurse unless physical therapy or speech language pathology is the only requested service for that patient. In those cases, the physical therapist or speech therapist may conduct the initial assessment and the comprehensive assessment. These assessments may be conducted by the occupational therapist if the need for occupational therapy establishes program eligibility.

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

   A. Patient's geographical location

   B. Complexity of the patient's medical needs and level of care required

   C. Organization personnel's education and experience

   D. Organization personnel's special training and their 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 (or other authorized licensed independent practitioner), the referral source, and 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 organization for services.

   C. Approved delays may occur based on the request of patient, designated family member, legal representative, or referral source, or the patients physician or practitioner

   D. Approved delays may occur when the agency has challenges in contacting the patient, designated family member, or legal representative.

5. A nurse or therapist will attempt to make an initial contact prior to the patient's hospital discharge if possible or appropriate. The initial home visit will be made within 48 hours after the patient's discharge from a facility or as ordered by the physician (or other authorized licensed independent practitioner).

6. During the initial assessment visit, the admitting clinician will assess the patient's eligibility for home care services according to the admission criteria to determine or confirm:

   A. Level of services required

   B. Eligibility (meets admission criteria)

C. Qualifying face-to-face encounter date, if completed within 90 days prior to admission. (See "Face-to-Face Encounter Procedure" Addendum 2-003.A.)

D. Source of payment

7. Upon acceptance into service, the patient will be provided with an organization brochure and various educational materials providing the patient and family/caregiver with sufficient information on:

    A. Nature and goals of care and service

    B. Hours during which care and service is available

    C. Access to care after hours

    D. Care costs/charges, to the patient, if any, for care, treatment or service

    E. Organization mission, objectives, and the scope of care provided both directly and through contractual agreement

    F. Safety information

    G. Infection control information

    H. Emergency preparedness plans

    I. Available community resources

    J. Complaint/grievance process

    K. Written information regarding the availability and indications for use of the state and ACHC Home Health Hot Line telephone numbers

    L. Advance Directives

    M. Other organization 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

    O. Notice of privacy practices

8. Patient rights and responsibilities will be explained and a written copy will be provided to the patient and family/caregiver. If a face-to-face encounter has not been completed prior to admission, the clinician will explain the requirement that a face-to-face encounter visit with their physician (or other authorized licensed independent practitioner) must be completed within 30 days of admission.

9. The admitting clinician will document that the above information has been furnished to the patient and family/caregiver, and they will also document any information not understood by the patient and family/caregiver.

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

11. The patient or his/her representative will sign the required forms indicating acceptance of services and receipt of patient rights and privacy information.

12. Refusal of services will be documented in the clinical record. Notification of the Clinical Supervisor, physician (or other authorized licensed independent practitioner), and referral source will follow with appropriate documentation in the clinical record.

13. The admitting clinician will consult with the Clinical Supervisor concerning the patient's condition following the initial visit. Based on the clinical personnel's assessment of the patient's eligibility for admission, the patient will be admitted for services or referred to alternate sources for care.

14. If the patient is accepted for home health care, an initial plan of care will be developed in consultation with the physician (or other authorized licensed independent practitioner) and the patient and then submitted to the physician for signature.

15. The initial written assessment will be completed within 24 hours of the initial assessment/admission visit. All documentation needed to develop the plan of care will be completed and turned into the office no later than the next business day.

16. A comprehensive assessment must be completed within five (5) calendar days of the patient's start of care. (See "Initial and Comprehensive Assessment" Policy No. 4-018.)

    A. Each patient must receive a patient-specific comprehensive assessment that identifies the need for home care and that meets the patient's medical, nursing, rehabilitative, social, and discharge planning needs.

    B. Outcomes and Assessment Information Set (OASIS) data must be collected on all patients receiving skilled services except antepartum and postpartum patients, patients under the age of 18, and patients with payer source other than Medicare or Medicaid. OASIS data collection is not required for patients who are receiving only personal care or support services (receiving only homemaker services). The OASIS data will be collected during the comprehensive assessment. The assessment tool must include the exact use of the current versions of the OASIS data set.

17. The time frames apply for weekend, holiday, and weekday admissions.

18. A clinical record will be initiated for each patient admitted for home health services.

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

20. The following individuals will be notified of non-admits:

    A. Patient

B. Physician (or other authorized licensed independent practitioner)

C. Referral source (if not MD)

Policy No. 2-003.6

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

22. In the instance where a patient does not meet the stated criteria for admission to the program, the Executive Director/Administrator in consultation with the Medical Director may decide upon exceptions, with the request of the referring party and/or the patient.

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

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

CHARITY CARE

Policy No. 3-007.1

PURPOSE

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

POLICY

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

Manito Home Health will establish objective criteria and financial screening procedures for determining eligibility for charity care.

The organization will consistently apply the charity care policy.

PROCEDURE

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

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

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

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

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

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

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

Policy No. 3-007.2

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

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

PATIENT BILL OF RIGHTS

Policy No. 2-002.1

PURPOSE

To encourage awareness of patient rights and provide guidelines to assist patients in making decisions regarding care and for active participation in care planning.

POLICY

Each patient will be an active, informed participant in his/her plan of care. To ensure this process, the patient will be empowered with certain rights and responsibilities as described. If a state court has not adjudged a patient to lack legal capacity to make health care decisions as defined by state law, the patient may designate someone to act as his/her representative to exercise the patient's rights. This representative, on behalf of the patient, may exercise any of the rights provided by the policies and procedures established by the organization.

If the patient has been adjudged to lack legal capacity to make health care decisions as established by state law by a court of proper jurisdiction:

1. The rights of the patient may be exercised by the person appointed by the state court to act on the patient's behalf OR

2. The patient may exercise his or her rights to the extent allowed by court order

To assist with fully understanding patient rights, all policies will be available to the organization personnel, patients, and his/her representatives as well as other organizations and the interested public.

PROCEDURE

1. The patient will be informed verbally and in writing during the initial evaluation visit, in advance of furnishing care of their rights.

2. The Patient Bill of Rights statement defines the right of the patient to:

    A. Exercise and understand his or her rights and responsibilities as a patient and not to be subject to discrimination or reprisal for exercising these rights.

    B. Have his or her property treated with respect, consideration, and recognition of patient dignity and individuality.

    C. Voice grievances regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of the organization and must not be subjected to discrimination or reprisal for doing so.

D. Receive an investigation by the organization of complaints made by the patient or the patients family or guardian regarding treatment or care that is (or fails to be) furnished, or regarding lack of respect for the patient's property by anyone furnishing services on behalf of the organization, and must document both the existence of the complaint and the resolution of the complaint.

E. Be informed in advance about care to be furnished (including the Medicare Home Health Benefit, if applicable) organization scope of services and service limitations and of any changes in the care to be furnished.

F. Be advised in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished.

G. Be advised in advance of any change, orally and in writing, in the plan of care before the change is made.

H. The completion of all assessments and care to be furnished, based on the comprehensive assessment. The organization shall ensure that the patient receives all services outlined in the plan of care.

I. The establishment and revision of the plan of care, including the disciplines that will furnish the care and the frequency of visits as well as any changes in the care to be furnished.

J. The expected outcomes of care, including patient-identified goals, and anticipated risks and benefits; as well as any factors that could impact treatment effectiveness.

K. Be advised in advance of the right to participate in planning the care or treatment and in planning changes in the care and treatment.

L. The right to be free from mental, physical, sexual and/or verbal abuse, including injuries of unknown source, neglect, misappropriation of property, or exploitation

M. Be able to refuse care or treatment after the consequences of refusing care or treatment are presented. Receive appropriate care without discrimination in accordance with physician orders.

N. Be advised that the Home Health Agency complies with Subpart 1 of 42 CFR 489 and receive written policies and procedures regarding Advance Directives, including a description of an individual's right under applicable state law and how rights are implemented by the organization.

O. Receive Advance Directives information, orally and in writing, prior to or at the time of the first home visit, as long as the information is furnished before care is provided.

P. Confidentiality of the clinical records maintained by the organization and the policies and procedures for disclosure. (See "Patient Privacy Rights" Policy No. 2-014.)

Q. Be advised of the organization's policies and procedures regarding disclosure of clinical records.

R. Be informed, verbally and in writing and before care is initiated of the extent to which:

1. Payment may be expected from Medicare, Medicaid, or any other federally funded or aided program known to the organization
2. Charges for services that will not be covered by Medicare
3. Charges that the individual may have to pay

S. Be informed verbally and in writing of any changes in payment information as soon as possible, in advance of the next home visit, that the organization becomes aware of the change.

T. Receive in writing, prior to the start of care, the telephone numbers for the State Home Health Hotline and the ACHC Hotline, including hours of operation, and the purpose of the hotlines to receive complaints or questions about the organization. (Patient will be given ACHC address as well.)

U. To have communication needs met. (See Policy No. 2-040 "Facilitating Communication")

1. The organization shall provide verbal and written notice of the patient's rights and responsibilities in the patient's primary or preferred language and in a manner the individual understands, free of charge, with the use of a competent interpreter if necessary, no later than the completion of the second visit from a skilled professional.

V. Use the hotlines to lodge complaints concerning the implementation of Advance Directive requirements.

W. Be informed of organizational ownership and control.

X. Patient privacy rights related to the collection of the Outcome and Assessment Information Set (OASIS):

1. The right to be informed that OASIS information will be collected and the purpose of the collection
2. The right to have the information kept confidential
3. The right to be informed that OASIS information will not be disclosed except for legitimate purposes allowed by the Federal Privacy Act
4. The right to refuse to answer questions
5. The right to see, review and request changes on their assessment

Y. To be informed of anticipated outcomes of care and of any barriers in outcome achievement.

Z. To be fully informed of one's responsibilities.

AA. Choosing a health care provider, including an attending physician or other authorized licensed practitioner and identifying visiting personnel with proper identification.

BB. The organization's transfer and discharge policies.

CC. The contact information for the agency administrator, including the administrator's name, business address, and business phone number in order to receive complaints.

DD. The names, addresses, and telephone numbers of the following Federally-funded and state-funded entities that serve the area where the patient resides:

1. Agency on Aging

2. Center for Independent Living

3. Protection and Advocacy Agency

4. Aging and Disability Resource Center

5. Quality Improvement Organizations

3. When additional state or federal regulations exist regarding Patient Rights, the Patient Bill of Rights statement must include those components.

4. The admitting clinician will provide each patient or his/her representative with a written copy of the Patient Bill of Rights on admission.

5. The Patient Bill of Rights statement will be explained (verbally/orally) and distributed to the patient prior to the initiation of organization services. This explanation will be in a language, communication method or manner he/she can reasonably be expected to understand and free of charge.

6. The patient will be requested to sign the Patient Bill of Rights form. The original form will be kept in the patient's clinical record. A copy will be maintained by the patient. The patient's refusal to sign will be documented in the clinical record, including the reason for refusal.

7. The admitting clinician will document that the patient has received a copy of the Patient Bill of Rights.

A. If the patient is unable to understand his/her rights and responsibilities, documentation in the clinical note will be made.

B. In the event a communication barrier exists, if possible, special devices or interpreters will be made available.

C. Written information will be provided to patients in English and predominant non-English languages of the population served.

8. When the patient's representative signs the Patient Bill of Rights form, an explanation of that relationship must be documented and kept on file in the clinical record.

9. Within four (4) business days of the initial evaluation visit, the organization shall provide written notice of the transfer and discharge policies, provide contact information of the administrator, provide written notice of the rights and responsibilities, and obtain signature from the patient or legal representative to confirm that they have received a copy of the notice of rights and responsibilities.

10. The family or guardian may exercise the patient's rights when a patient is incompetent or a minor.

11. Supervisory visits with clinical disciplines will be conducted to ensure these rights are honored and protected according to organization policy.

12. All organization personnel, both clinical and non-clinical, will be oriented to the patient's rights and responsibilities prior to the end of their orientation program, as well as annually.

NONDISCRIMINATION POLICY AND GRIEVANCE PROCESS

Policy No. 2-039.1

PURPOSE

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

POLICY

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

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

In accordance with the Age Discrimination Act of 1975, Section 1557 of the Affordable Care Act (ACA) of 2010 and its implementing regulation, Manito Home Health will not, directly or through

contractual or other arrangements, discriminate on the basis of age in the provision of services unless age is a factor necessary to the normal operation or the achievement of any statutory objective.

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

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

PROCEDURE

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

2. Manito Home Health will identify an organization or person in their service area who can interpret or translate for persons with limited English proficiency and who can disseminate information to and communicate with sensory impaired persons. These contacts will be listed and kept in the policy manual. (See "Facilitating Communication" Policy No. 2-040.)

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

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

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

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

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

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

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

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

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

12. Manito Home Health will issue a written decision in response to the appeal no later than 30 days after its filing.

13. The Section 504/ADA Compliance Coordinator/Section 1557 Civil Rights Coordinator will maintain the files and records of Manito Home Health relating to such grievances.

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

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

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

REFERRAL DISCLOSURE AND CARE DECISIONS

Policy No. 1-004.1

PURPOSE

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

POLICY

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

[Cross-reference "Intake Process" Policy No. 4-066, "Admission Criteria and Process" Policy No. 2-003, "Transfer/Referral Criteria and Process" Policy No. 4-043, "Initial and Comprehensive Assessment" Policy No. 4-018, "Ongoing Assessments" Policy No. 4-019, "Physician Participation in Plan of Care" Policy No. 4-002, and "Verification of Physician Orders" Policy No. 4-003]

PROCEDURE

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

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

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

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

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

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

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

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

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

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

EXHIBIT 7

ORIENTATION
Policy No. 1-022.1

PURPOSE

To provide guidelines for the orientation process.

POLICY

All personnel will be required to attend an orientation program upon employment and at the time of reassignment. The goal of orientation will be to inform and instruct new personnel regarding Manito Home Health's mission, policies and procedures, benefits (if applicable), the performance appraisal process, competency testing, as well as individual responsibilities and relationships to other personnel.
All personnel will demonstrate knowledge and proficiency in skills appropriate to their assigned responsibilities during the orientation period.
All clinical personnel prior to being assigned to care must present documentation of current CPR certification. CPR certification must be renewed per American Heart Association guidelines.
(See "Competency Based Orientation" Policy No. 3-002.)

PROCEDURE

1. The orientation content for all personnel will include the following as applicable and appropriate to the care and service provided:
   A. General company orientation including the organization's mission/philosophy, policy and procedures, environmental safety program, etc.
   B. Review of organizational chart and lines of authority and responsibility
   C. Hours of work
   D. Job related responsibilities (job description), including orientation to equipment, if applicable
   E. Care and services provided by the organization
   F. Baseline skills assessments as applicable to job classification

G. Infection prevention and control within the organization and the home care setting
H. Performance standards
I. Ongoing patient care needs

J. Confidentiality of organization and patient information/HIPAA regulations
K. Documentation requirements (record keeping and requirements)
L. OSHA compliance
M. Handling of hazardous medications and other materials
N. Medical Device Reporting/Incident Reporting
O. Equal Employment Opportunity Act
P. Ethical issue identification and resolution including conflict of interest, professional boundaries, etc.
Q. Sexual Harassment Act
R. Compensation and benefits information (salary/wages, benefits, etc.)
S. Unemployment and workers' compensation
T. Malpractice coverage, as applicable
U. Collective bargaining information, as applicable
V. Drug testing
W. Drug diversion
X. Family/State Medical Leave Act
Y. Cultural Diversity and communication barriers
Z. Client/Patient Rights including Advance Directives

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

AA. Standards of Conduct and Ethical Issues
BB. Quality (Performance) Improvement Plan and activities

CC. Compliance Plan and employee compliance responsibilities
DD. Emergency Management Plan
EE. Handling of patient complaints/grievances

Policy No. 1-022.3

FF. Telehealth or telemedicine services for patient consultation and the transmission of health data, such as vital signs as applicable
GG. If applicable, conveying of charges for care/services and OASIS requirements

2. During the orientation process, the organization will provide comprehensive training drug diversion. (See "Comprehensive Controlled Substances Diversion Prevention Program" Addendum 1-022.B)
3. The orientation process, for all personnel will consist of both didactic and field supervision. Observation visits will be made by an appropriate supervisor to assess the skills demonstrated by new or reassigned personnel as well as reinforce the information presented during classroom time.
4. The orientation process for contract personnel will consist of the following:
   A. For contract personnel, the contracted organization will have one (1) member of the organization that has been oriented to Manito Home Health policies, procedures, and information presented during orientation. That individual will be responsible for orienting other contract personnel from that organization to Manito Home Health.
   B. For personnel the organization individually contracts with, a preceptor will be assigned during the orientation process.
5. During the orientation process, the supervisor will be responsible for evaluating the knowledge and skills of the personnel being oriented. Any areas of concern will be brought to the immediate attention of the new personnel. Appropriate guidance/monitoring will be provided or additional training recommended, if needed.
6. Assigned personnel will orient newly assigned personnel or volunteers to their responsibilities and to the patient needs when changes in patient assignment occur. The following will be included as appropriate:
   A. Patient needs including physical, psychosocial, and environmental aspects of care and service
   B. Personnel responsibilities
   C. Specific care and services to be provided

7. Orientation of new and reassigned personnel may include verbal or written instructions. Orientation may be provided in the patient's home.
8. Orientation of current employees assigned to new job classifications will include.
   A. Lines of authority and responsibility
   B. Hours of work
   C. Job responsibilities
   D. Skills assessment as applicable to the specific job classification
   E. Documentation responsibilities

9. A Personnel Orientation Checklist (See "Personnel Orientation Checklist" Addendum 1-022.A) will be completed for all new personnel. New personnel will sign and date when their orientation has been completed.
10. The supervisor will sign and date the checklist when new personnel have completed all the required activities.
11. The probationary period will be 90 days, during which time the orientation process may be extended if the supervisor, or employee feels it is warranted.

ADDENDUM 1-022.A

PERSONNEL ORIENTATION CHECKLIST

Manito Home Health

PERSONNEL ORIENTATION CHECKLIST

Name: _____ Date: _____

CHECKLIST	DATE	ORIENTATION BY WHOM	PERSONNEL INITIALS
1. Tour of office/Introduction of organization personnel			
2. Introduction to work stations			
3. Completion of all employment forms			
4. Personnel file A. Application B. Sign job description (copy to personnel) C. Professional license, certification, registration, CPR documentation, as appropriate D. Driver's license, as appropriate E. Proof of auto insurance, as appropriate F. Physical exam, drug test, as appropriate G. TB Screening, as appropriate H. Hep B vaccination, as appropriate I. Standard precautions orientation J. Criminal background/National Sex Offender Registry checks K. OIG Exclusion list check verification			
5. Name and Photo Identification			
6. The orientation content for all personnel will include the following as applicable and appropriate to the care and service provided: A. General orientation to organization, including philosophy, mission, and purpose, policies and procedures, environmental safety program B. Review of organizational chart and lines of authority and responsibility C. Hours of work D. Job related responsibilities E. Care and services provided by the organization F. Baseline skills assessments as applicable to job classification G. Infection prevention and control within the organization and home care setting H. Performance standards I. Confidentiality of organization and patient information/HIPAA J. Documentation requirements (Record keeping and reporting) K. OSHA compliance L. Medical Device Reporting M. Equal Employment Opportunity Act N. Ethical issue identification, resolution and boundaries/Standards of Conduct O. Sexual Harassment Act P. Compensation and benefits Q. Unemployment and workers compensation R. Malpractice coverage, as applicable S. Collective bargaining information, as applicable T. Drug testing U. Family/State Medical Leave Act V. Cultural Diversity/Communication Barriers W. Patient/Client Rights and handling of patient complaints X. Advance Directives Y. Conflict of Interest			

CHECKLIST	DATE	ORIENTATION BY WHOM	PERSONNEL INITIALS
Z. Performance Improvement Plan AA. Incident/Variance reporting BB. Compliance Program/Employee Responsibilities CC. Emergency Management Plan DD. OASIS documentation, as appropriate EE. Home Health charges, as appropriate FF. Job specific: medical equipment, special populations			
7. Orientation to job description and job responsibilities (list or cross-reference)			
8. Skills/Competency Assessment (list or cross-reference)			

Manito Home Health

EXHIBIT 8

CONSULTING, PROFESSIONAL, AND OPERATIONAL SUPPORT SERVICES AGREEMENT
(Administrative Services)

Effective Date: **November 22, 2021**

CONSULTANT: **Pennant Services, Inc., a Nevada corporation**

Address: 1675 E. Riverside Drive, Ste. 150,
Eagle, ID 83616

Phone: (208) 401-1400

Fax: (208) 401-1401

FACILITY: **Orchard Prairie Healthcare LLC d/b/a**

Address: 1675 E. Riverside Drive, Ste. 150,
Eagle, ID 83616

Phone:

Fax:

FEIN: **87-3670377**

THIS CONSULTING, PROFESSIONAL, AND OPERATIONAL SUPPORT SERVICES AGREEMENT ("Agreement") is made and entered into by and between the above-named Consultant and Agency as of the Effective Date, with respect to the following facts and intentions:

R E C I T A L S

A. Agency is an independently operated, licensed and certified Home Health, Hospice and/or Home Care Agency operating from the address set forth above (the "Agency Primary Location");

B. Consultant is a provider of centralized consulting, professional, and operational support designed to aid the efficient, competitive, and sound operation of entities like Agency;

C. Agency desires to engage the services of Consultant to assist Agency personnel with aspects of Agency's operations and activities, in order to facilitate Agency personnel's focus on Agency's primary mission of rendering superior hospice services to the Agency's patients and clients.

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

TERMS AND CONDITIONS

1. Incorporation of Exhibits and Recitals. The Recitals set forth above, as well as the exhibits attached hereto, are incorporated herein by this reference as if fully set forth herein.

2. Consultant's Duties. The Consultant agrees to provide such of the following services ("Services") as Agency, at Agency's option and request from time to time, desires to obtain from Consultant during the term of this Agreement, and to perform its duties hereunder in a good, professional and workmanlike manner. Such duties shall include, without limitation (herein the "Services"):

2.1. General Consultant's Duties, Generally.

2.1.1. Consultant will provide Services in substantial conformance to applicable federal and state laws and the established policies of Consultant and Agency in effect from time to time, and Consultant will conduct periodic self-audit/compliance reviews in order to ensure that Consultant substantially complies with federal, state and local statutes and regulations applicable to the provision of the Services. Agency hereby grants to Consultant a limited power of attorney to act in Agency's name and stead for the convenience of Agency and/or Consultant, provided that this power shall not be used except in conjunction with the enumerated Services under this Agreement.

2.1.2. Consultant shall make clear to all parties with whom it deals in the course of rendering the Services that it is an independent contractor and not an employer, employee, partner, co-venturer, or management Agency of Agency. At all times while in the Agency and while with Agency's patients, Consultant's employees and representatives shall wear uniforms and/or badges clearly indicating their affiliation with Consultant.

2.2. Specific Duties of Consultant. During the term of this Agreement, Consultant shall provide to Agency the specific Services listed in Exhibit A at the request of the Agency. In the event of any conflict between the terms of Exhibit A and the terms contained in the main body of this Agreement, the terms of Exhibit A shall control. Consultant's duties shall specifically not include (i) the rendition of any direct care to patients or residents, (ii) maintenance or handling of patient trust property, or (iii) any other service not specifically enumerated herein as a part of the Services and requested by Agency, all of which shall be the sole duty and domain of Agency, its administrators, caregivers and other staff.

3. Agency's Duties. Agency shall:

3.1. Operate its business in and from the Agency in substantial compliance with applicable laws and regulations, and maintain all federal and state licenses and certifications required to operate the Agency and provide Services to patients (collectively the "Licenses"). Agency shall perform all duties required of a licensee and provider under applicable local, state and federal laws, codes, regulations and provider agreements affecting the operation of the Agency. Within five (5) days of receipt, Agency shall deliver to Consultant notification of any actual revocation or suspension of its Licenses.

3.2. Not unreasonably restrict or limit the Consultant's right to exercise its independent professional judgment, including its right to recommend Services to be rendered

and to render such Services using such methods, technologies and procedures as Consultant deems appropriate.

3.3. Timely furnish Consultant with such information and materials as might ordinarily be expected for Consultant to perform its duties hereunder. Agency shall be solely responsible to assure the accuracy and completeness of all information provided by Agency and its personnel to Consultant, and Consultant shall be entitled to rely thereon without inquiry or diligence of any kind.

3.4. As and to the extent that Consultant's employees and agents require access to the Agency to perform the Services, Agency shall provide adequate working space, equipment and access to Agency's staff for the provision of Services. Equipment and materials placed at the Agency by Consultant shall be used exclusively for the purposes of this Agreement. Upon termination or at Consultant's request, Agency shall return equipment and materials, in the same condition as when delivered to Agency, reasonable wear and tear excepted.

3.5. In addition to the foregoing, during the term of this Agreement, Agency shall cooperate with Consultant and Consultant's other client agencies and businesses as more fully set forth in Exhibit A.

4. Compensation.

4.1. For and in consideration of the Services to be provided under this Agreement, the Agency shall pay to the Consultant as the "Consultant Compensation" a monthly consulting fee equal to five percent (5.0%) of Agency's gross revenue from all sources. A reasonable estimate of anticipated monthly Consultant Compensation shall be paid on or before the first (1st) day of each month during the Term hereof, and shall be "trued up" at the beginning of the next following month with such following month's estimated payment. Payment for any partial month of the Term shall be prorated based on the number of days during the month that Consultant served under this Agreement. In the event Agency closes during any month during the Term, the Consultant Compensation for any such month or partial month shall be calculated, at Consultant's option, based on historical revenues and patient mix. At Consultant's option Consultant shall be entitled to deduct the Consultant Compensation from sums collected for Agency by Consultant, and shall provide Agency with invoices (or if paid by deduction accountings) for the monthly fee by the last day of the month following the month of service.

4.2. In addition to and not as part of the Consultant Compensation, Agency shall reimburse Consultant for all costs and expenses advanced, incurred, or paid by Consultant in the rendition of Services.

5. Insurance.

5.1. Both Consultant and Agency agree to maintain general and professional liability insurance during the term of this agreement in an amount not less than One Million Dollars ($1,000,000) per claim and Three Million Dollars ($3,000,000) in the aggregate.

5.2. Both parties agree to maintain such other and further insurance as may be required by law or the terms of any agreement to which they are parties, including without

limitation worker's compensation insurance (where required by law), crime insurance, directors and officers coverage, automobile and similar liability, and property and casualty insurance, and will list Agency as named insured on all obtained policies.

5.3. All insurance policies shall be issued by insurance companies with a policyholder rating of at least "B+" in the most recent version of Best's Key Rating Guide.

6. Term and Termination. The Term of this Agreement shall commence on the Effective Date and continue thereafter for a period of one (1) year. This Agreement shall automatically extend for additional periods of one (1) year each unless written notice of termination is given not less than sixty (60) days prior to the end of the then-current term. Notwithstanding anything contained herein to the contrary, either party may terminate this Agreement and the Term hereof at any time during the Term upon sixty (60) days written notice; further, in the event of (i) abandonment by a party of its duties hereunder, (ii) nonpayment of any Consultant Compensation within five (5) days after delivery of invoice or other written demand therefor; (iii) any breach or violation of this Agreement (other than non- payment of Consultant Compensation) which is not cured within thirty (30) days following delivery of written notice of such breach or violation, (iv) any material violation of law or regulations, or loss or failure of license or licensure, or violation of the eligibility requirements for reimbursement under any government program by a party, or (v) the occurrence or existence of any condition, practice, procedure, action, inaction or omission of, by or involving a party which, in the reasonable opinion of the other party constitutes either a threat to the health, safety, and welfare of any patient or client or a violation of any law, regulation, requirement, Licenses, eligibility or material agreement governing Agency's or Consultant's operation, then the other party shall have the right to summarily and immediately terminate this Agreement upon written notice to the first party.

7. Regulatory Changes. Agency and Consultant mutually agree that in the event local, state or federal government agencies promulgate regulations which materially affect the terms of this Agreement, including but not limited to changes affecting the cost of providing Services hereunder, this Agreement shall be immediately subject to renegotiation upon the initiative of either party.

8. Warranties.

8.1. Agency's Warranties. Agency hereby makes the following warranties and representations to Consultant in connection with Consultant's entry into this Agreement, which warranties shall survive the termination of this Agreement:

8.1.1. Agency is properly licensed by the State in which the Agency's operation(s) is located by the proper licensing and certification authorities for such State, and all permits and licenses required for the operation of Agency's business(es) have been received and are now currently effective.

8.1.2. As of the Effective Date, except as specifically disclosed on Schedule 1 attached hereto and incorporated herein, there is no litigation, administrative proceedings, event, or hold or similar lien on State or Federal payments to Agency, either underway or threatened, nor are there arbitration proceedings or governmental investigations relating to the Agency, or the business conducted thereon underway or threatened against Agency or brought by the Agency

8.1.3. To the best of Agency's knowledge, the business operations of the Agency at the Commencement Date comply with all local, State and Federal zoning, labor and other applicable laws, ordinances, rules and regulations applicable to the Agency.

8.1.4. Agency has been duly formed in the state of its domicile and remains in good standing in such state, and (if operating in a state other than its domicile) has been duly registered and authorized to do business in the state where its business operation(s) is located and is in good standing in that state as well.

8.1.5. Agency is authorized to consummate the transactions covered by this Agreement.

8.2. Consultant's Warranties. Consultant hereby makes the following warranties and representations to Agency in connection with Agency's entry into this Agreement, which warranties shall survive the termination of this Agreement:

8.2.1. Consultant is a Nevada corporation in good standing, and is registered to do business in, and is in good standing with, the State of Idaho.

8.2.2. Consultant is authorized to consummate the transactions covered by this Consulting Agreement.

9. Licensure, Eligibility and Compliance.

9.1. Consultant acknowledges that its activities under this Agreement may be governed by, *inter alia*, the United States Department of Health and Human Services' Office of the Inspector General's ("OIG") Compliance Program Guidance for Home Health Agencies and/or the OIG's Compliance Program Guidance for Hospices. Consultant represents and warrants that neither Consultant nor any individual or entity with a direct or indirect ownership or control interest of five percent (5%) or more in Consultant, nor any director, officer, agent or employee of such party, is debarred, suspended or excluded under any state or federal healthcare program it is currently eligible to participate in Medicare, Medicaid, and all other federally funded health care programs and is not subject to any sanction or exclusion by any of those programs. Consultant agrees to immediately disclose any actual or threatened federal, state or local investigations or imposed sanctions of any kind, in progress or initiated subsequent to the date of entering into this Agreement. Consultant further represents and warrants that it is not currently sanctioned under any applicable state or federal fraud and abuse statutes, including exclusion from any state or federal health care program. If, during the term of this Agreement, Consultant, its parent, or any officer, director or owner receives such a sanction, or notice of proposed sanction, Consultant shall provide notice of and a full explanation of such sanction or proposed sanction and the period of its duration within ten (10) days of receipt. Agency reserves the right to terminate the Agreement immediately upon receipt of notice that Consultant has been sanctioned under fraud and abuse statutes and/or any other federal, state or local regulation.

9.2. If the Agency Primary Location is located in the state of Texas, Consultant agrees to complete, execute and deliver to Agency upon request a Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion for Covered Contracts on Form 2046 as promulgated by the Texas Department of Protective & Regulatory Services.

9.3. Consultant acknowledges that it has received a copy of Agency's Code of Conduct, and agrees to abide by the provisions thereof governing Vendors and Vendor services.

10. Consultant's Schedule and Availability.

10.1. Consultant shall be reasonably available on an on-call basis to the Agency to fulfill Consultant's duties hereunder.

10.2. Nothing in this Agreement shall be construed as limiting or restricting in any manner Consultant's right to render the same or similar services to other individuals or entities, including but not limited to, other hospice and in-home care during or subsequent to the Term of this Agreement; similarly, nothing in this Agreement shall require Agency to exclusively use all of Consultant's services in the Agency during the Term of this Agreement.

10.3. Consultant's employees and representatives are entitled to be reasonably absent for annual vacations, sick leave, continuing education, and personal reasons; provided that in the event of any absence Consultant shall consult with the Agency concerning the impending absence and cooperate with the Agency in providing alternate resources to Agency to temporarily fulfill Consultant's duties during the period of absence.

11. Contractual Relationship.

11.1. Independent Contractor. It is expressly acknowledged by both parties that Consultant is an independent contractor. Nothing herein is intended to be construed to create an employer-employee, partnership, joint venturer or other relationship between Consultant and the Agency. Agency has and shall retain all statutory liability and responsibility for the continued operation of the Agency as the licensee under Agency's Licenses. No provision of this Agreement shall create any right in the Agency to exercise control or direction over the manner or method by which Consultant performs its duties or renders Services hereunder, nor shall Consultant exercise control or direction over the manner or method by which Agency operates or serves its patients and clients; provided always, that services shall be provided in a manner consistent with all applicable laws, rules and regulations of all governmental authorities, and Agency's Code of Conduct. Agency will not withhold from compensation payable to Consultant hereunder, or be in any way responsible for, any sums for income tax, employment insurance, Social Security, or any other agency and Consultant agrees that the payment of all such amounts as may be required by law are and shall be the sole responsibility of Consultant.

11.2. Fair Market Value. The amounts to be paid to Consultant hereunder have been determined by the parties through good faith and arms-length bargaining to be the fair market value of the services to be rendered hereunder. No amount paid or to be paid hereunder is intended to be, nor will it be construed as, an offer, inducement or payment, whether directly or indirectly, overtly or covertly, for the referral of patients by Consultant to Agency, or by Agency to Consultant, or for the recommending or arranging of the purchase, lease or order of any item or service. For purposes of this section, Consultant and Agency will include each such entity and any affiliate thereof. No referrals are required under this Agreement.

11.3. Work Product. The work product created in the course of Consultant's services under this agreement shall be the exclusive property of Consultant, and all manuals, forms, and documents (including without limitation, all writings, drawings, blueprints, pictures, recordings, computer or machine readable data, and all copies or reproductions thereof) which result from, describe or relate to the services performed or to be performed pursuant to this agreement or the results thereof, including without limitation all notes, data, reports or other information received or generated in the performance of this Agreement (excepting data incorporated in medical records required to be kept and maintained by Agency), shall be the exclusive property of Consultant and shall be delivered to Consultant upon request.

11.4. Non-Solicitation of Consultant's Employees. During the term of this Agreement, Agency shall not solicit the services of, or hire as an employee or independent contractor at the Agency, any Consultant employee, agent or representative who provided, managed or otherwise was involved in the provision of Services to Agency within the previous twelve (12) months (a "Restricted Employee"). Nothing herein shall preclude Agency from advertising available positions or opportunities by posting in the Agency or through newspaper ads or other generally accepted recruiting mediums. The parties acknowledge that the restrictions set forth in this Article are reasonable in scope and important to Consultant's business interests, and that the enforcement of this Article does not restrict Agency from engaging in Services for its own account. In the event that Agency hires a Restricted Employee, Agency shall pay a recruiting fee to Consultant in the amount of Seven Thousand Five Hundred and No/100 Dollars ($7,500.00) per Restricted Employee hired.

12. Indemnification.

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

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

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

13. Access to Books and Records. Pursuant to 42 U.S.C. §1395x(V)(1)(l), during the four (4) year period after completion of services hereunder, the Agency will, upon written request, make available to the Secretary of Health and Human Services or to the Comptroller General, or their duly authorized representatives, this Agreement, books, documents, and

records that are necessary to certify the nature and extent of costs incurred by the Agency under the provisions of this Agreement. This provision shall be in force for any twelve (12) month period during which the total value of services provided or goods delivered hereunder is Ten Thousand Dollars ($10,000) or more. This section shall have no effect unless Consultant is deemed a "subcontractor" under any regulation adopted under the provision of the United States Code cited above.

14. Privacy.

14.1. HIPAA Applicability and Compliance. Agency may be a "Covered Entity" under, and required to comply with, the applicable provisions of the Health Insurance Portability and Accountability Act of 1996 as amended ("HIPAA") and the regulations and guidelines pertaining thereto (collectively with HIPAA the "HIPAA Rules"), and to obtain sufficient assurances that its contracting parties will appropriately safeguard patients' "Protected Health Information" ("PHI") as defined in the HIPAA Rules. In the course of performing Consultant's services, duties and obligations herein, Consultant may receive, create or obtain access to PHI. Consultant agrees to maintain the security and confidentiality of PHI, as required of Agency by applicable laws and regulations, including without limitation the HIPAA Rules, and to execute and deliver such additional documentation and assurances as Agency may reasonably request to comply with HIPAA and any amendments thereto and related laws and regulations, including, but not limited to, the Business Associate Agreement attached hereto as Exhibit B.

14.2. Correlation of Record Handling Requirements. In the event of any conflict between the requirements of this Article 14 and/or between the various laws, statutes, ordinances and regulations relating to or otherwise affecting the subject matter thereof, the requirement or applicable law that that presents the most stringent standard for compliance, as reasonably determined by Agency, shall be followed, such that compliance is achieved or maximized in all cases.

14.3. Confidential Information. Consultant shall preserve the confidentiality of all private, confidential and/or proprietary information disclosed to or discovered by Consultant in connection with this Agreement, including, without limitation, nonpublic financial information, manuals, protocols, policies, procedures, marketing, and strategic information, Agency lists, computer software, training materials, resident/patient health information, resident/patient records, and resident/patient care and outcomes data ("Confidential Information") as and to the extent required by law. Consultant shall not use for its own benefit or disclose or otherwise disseminate to third parties, directly or indirectly, any Confidential Information without prior written consent from Agency, provided however that if Consultant grants Agency access to, and Agency uses, Consultant's databases or information sharing mechanisms, Agency's information may be provided to similar agencies and Agency hereby grants Agency's consent to such information sharing as a condition to Agency's receipt of access to such mechanisms and the data they contain form time to time. Upon termination of this Agreement, all Confidential Information and copies thereof shall be returned to Agency. Consultant and Agency shall comply with applicable federal, state and local laws and regulations with respect to all Confidential Information, including, but not limited to, any disclosures thereof pursuant to this section.

15. Notices. All notices which are required or which may be given pursuant to the terms of this Agreement shall be in writing and shall be sufficient in all respects if given in writing and delivered personally or by registered or certified mail, return receipt requested, or

by a comparable commercial delivery system, and notice shall be deemed to be given on the date hand-delivered or on the date which is three (3) business days after the date deposited in United States mail, or with a comparable commercial delivery system, with postage or other delivery charges thereon prepaid, at the addresses first set forth above or such other addresses as Agency and Consultant may designate by written notice to the other from time to time.

16. Arbitration.

16.1. Any controversy, dispute or claim arising in connection with the interpretation, performance or breach of this Lease, including any claim based on contract, tort or statute, shall be determined by final and binding, confidential arbitration with Judicial Mediation and Arbitration Service ("JAMS/Endispute") in Ada County, Idaho, provided that if JAMS/Endispute (or any successor organization thereto) no longer exists, then such arbitration shall be administered by the American Arbitration Association ("AAA") in accordance with its then-existing Commercial Arbitration Rules, and the sole arbitrator shall be selected in accordance with such AAA rules. Any arbitration hereunder shall be governed by the United States Arbitration Act, 9 U.S.C. 1-16 (or any successor legislation thereto), and judgment upon the award rendered by the arbitrator may be entered by any state or federal court having jurisdiction thereof. Neither Agency, Consultant, nor the arbitrator shall disclose the existence, content or results of any arbitration hereunder without the prior written consent of all parties; provided, however, that either party may disclose the existence, content or results of any such arbitration to its partners, officers, directors, employees, agents, attorneys and accountants and to any other Person to whom disclosure is required by applicable Legal Requirements, including pursuant to an order of a court of competent jurisdiction. Unless otherwise agreed by the parties, any arbitration hereunder shall be held at a neutral location selected by the arbitrator in Ada County, Idaho. The cost of the arbitrator and the expenses relating to the arbitration (exclusive of legal fees) shall be borne equally by Agency and Consultant unless otherwise specified in the award of the arbitrator, in which case such fees and costs paid or payable to the arbitrator shall be included in "reasonable costs and attorneys' fees" for purposes of Section 17.2, and the arbitrator shall specifically have the power to award to the prevailing party pursuant to such Section 17.2 such party's costs and expenses, including fees and costs paid to the arbitrator.

16.2. NOTICE: BY INITIALING IN THE SPACE BELOW YOU ARE AGREEING TO HAVE ANY DISPUTES ARISING IN THIS "ARBITRATION OF DISPUTES" PROVISION DECIDED BY NEUTRAL ARBITRATION AS PROVIDED HEREIN AND BY IDAHO LAW AND YOU ARE GIVING UP ANY RIGHTS YOU MIGHT POSSESS TO HAVE SUCH DISPUTE LITIGATED IN A COURT OR JURY TRIAL. BY INITIALING IN THE SPACE BELOW, YOU ARE GIVING UP YOUR JUDICIAL RIGHTS TO DISCOVERY AND APPEAL, UNLESS THOSE RIGHTS ARE SPECIFICALLY INCLUDED IN THIS "ARBITRATION OF DISPUTES" PROVISION. IF YOU REFUSE TO SUBMIT TO ARBITRATION AFTER AGREEING TO THIS PROVISION, YOU MAY BE COMPELLED TO ARBITRATE UNDER THE AUTHORITY OF THE IDAHO CODE OF CIVIL PROCEDURE. YOUR AGREEMENT OF THE PARTIES TO THIS ARBITRATION PROVISION IS VOLUNTARY.

BY INITIALLING BELOW YOU AFFIRM THAT YOU HAVE READ AND UNDERSTAND THE FOREGOING AND AGREE TO SUBMIT DISPUTES ARISING OUT OF THE MATTERS INCLUDED IN THIS "ARBITRATION OF DISPUTES" PROVISION TO NEUTRAL ARBITRATION.

CONSULTANT AGENCY

17. Miscellaneous.

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

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

17.3. This Agreement shall be governed by the laws of the State of Idaho. Notwithstanding anything contained herein to the contrary, venue for any action involving this Agreement shall lie solely in Ada County, Idaho.

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

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

17.6. This Agreement shall binding upon the parties hereto, their heirs, successors and assigns. Notwithstanding the foregoing, the parties mutually acknowledge that a material and substantial consideration in the parties' mutual execution of this Agreement is the identity and reputation of the other party, and each party's subjective perception of the other's value to and compatibility with such party and its officers, employees, facilities and

patients. As such, notwithstanding anything contained herein to the contrary, this Agreement and the rights of the parties hereunder are personal to the parties and may not be assigned or subcontracted to, nor shall the duties and responsibilities of either hereunder be delegated to or rendered by, any other person or entity without the express prior written consent of the other party, which consent may be granted or denied, conditionally or unconditionally, by a party in its sole, absolute and unfettered discretion.

17.7. Notwithstanding the expiration or earlier termination of this Agreement, the obligations and/or liabilities of the parties hereunder, relating to events, occurring during the Term, to which the parties' indemnification obligations under Section 12 apply, shall continue in full force and effect after the Agreement terminates, subject to applicable statutes of limitation. Additionally, the covenants of the parties under Sections 11.4, 13, 14 and 16 shall survive the termination of this Agreement.

17.8. This Agreement is solely between the parties hereto, and shall not create any right or benefit in any third party, including without limitation any creditor, agent, partner, employee or affiliate of Current Operator, or any entity or agency having jurisdiction of any of the Licenses, the Agency or the operation of the business therein.

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

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

CONSULTANT:

PENNANT SERVICES, INC.
a Nevada corporation

BY: _____
John Gochnour
Authorized Agent
Date: November 22, 2021

AGENCY:

Orchard Prairie Healthcare LLC,
a Nevada limited liability company

BY: _____
Brian Wayment
Authorized Agent
Date: November 22, 2021

EXHIBIT A
CONSULTING, PROFESSIONAL, AND
OPERATIONAL SUPPORT SERVICES AGREEMENT
(Administrative Services)

THIS EXHIBIT A supplements the foregoing CONSULTING, PROFESSIONAL, AND OPERATIONAL SUPPORT SERVICES AGREEMENT (the "Agreement") made and entered into by and between the therein-named Consultant and Agency and forms a part thereof. The specific duties and obligations described herein may or may not be performed by either party, depending upon the needs, preferences and requests of the other from time to time. The lists of duties and activities are not exhaustive, but where certain duties or activities are expressly limited, excluded or proscribed hereby, such activities shall not be requested or performed. Consultant's services shall be rendered on a non-exclusive basis, and Consultant shall have no duty to limit its services solely to Agency. Any service to be rendered by Consultant hereunder may be, at Consultant's sole option, rendered on a joint or "pooled" basis with or to Agency and other clients of Consultant. Consultant may provide any of its services hereunder through the use or assistance of subcontractors, but such subcontractors shall be subject to all of the terms and conditions of this Agreement. Although Consultant shall have discretion to make certain decisions regarding its Services for Agency in the day-to-day rendition of such services, Agency shall remain solely responsible for all decisions and actions made by, at, for or involving Agency and the operation of Agency's business.

SPECIFIC SERVICES TO BE RENDERED BY CONSULTANT:

1. Accounting.

A. Provides regular financial statements, analysis and reports to Agency management and Agency's lenders and customers.

B. Provides billing and collections oversight and assistance, including without limitation general compliance counseling, provided however that Agency shall be solely responsible for assessment, billing and collection compliance.

C. Tracks lockbox and other revenues, as well as all expenses submitted to Consultant, including without limitation capital projects expenses, and consults on the advisability of major capital expenditures.

D. Provides accounts payable processing based on Agency-supplied payables data.

E. Provides payroll services based upon Agency-generated payroll data; including without limitation providing separate payrolls for key employee groups as deemed prudent by Consultant or requested by Agency.

F. Assists in the preparation and filing of cost reports and other required financial filings and reports.

G. Oversees borrowing and other financial relationships and acts as liaison for lenders and outside accounting and financial consultants, and assists in procuring, maintaining and complying with the terms of financing and credit relationships, which may, with

Agency's acquiescence AND at Consultant's sole option, be created on a standalone basis for Agency or jointly in concert with some or all of Consultant's other clients.

2. Human Resources.

A. Procures and assists Agency in administering employee benefits plans as requested by Agency for its employees, such as health, dental, defined benefit, defined contribution, life insurance, disability, employee assistance programs and other benefits which may, with Agency's acquiescence AND at Consultant's sole option, be created on a standalone basis for Agency or jointly or in concert with some or all of Consultant's other clients.

B. Provides sample form non-nursing policy and procedure manuals, employee handbooks and hiring, performance evaluation and disciplinary forms and the like, to facilitate the efficient establishment and conduct of employer-employee relations; provided that all manuals, materials and template forms provided in connection therewith shall be and remain the property of Consultant and may not be copied, reproduced, distributed or used other than with the express written permission of Consultant.

C. Provides general assistance with human resources, labor and employment questions and issues, including questions related to hiring, disciplining and separation of employees; provided that Consultant shall have no responsibility for hiring, discipline or separation of Agency employees, which responsibility shall be an remain the sole province of Agency.

D. Provides periodic in-services and other trainings as requested by Agency, including an annual training meeting or convention for Agency's Administrator and Director of Nursing (which may be offered simultaneously and in conjunction with the annual trainings for other of Consultant's clients), to assist managers and staff in the lawful and efficient conduct of their business affairs; provided that all trainings and materials provided in connection therewith shall be and remain the property of Consultant and may not be copied, reproduced, distributed or used other than with the express written permission of Consultant.

E. Provides, as requested by Agency, independent third-party investigation of employment-related allegations of managerial and/or staff misconduct and recommendations (but not directives) with respect thereto.

3. Legal Services.

A. Provides general legal counsel consisting of limited legal services and assistance, including litigation management, corporate filings and governance assistance, legal compliance tools, licensing assistance and similar services; provided however that Consultant shall render no legal advice or court representation in any jurisdiction where an employee of Consultant is not licensed to do so unless otherwise permitted by law.

B. Provides contract review, processing and general assistance with vendor, customer and other contracts; and Agency hereby authorizes Consultant to negotiate and enter into contracts on Agency's behalf as Agency's agent solely for such limited purpose, but Consultant shall not be bound to perform such contracts for Agency. Consultant is also authorized to include Agency in "pooled" or joint contracts with other of Consultant's clients,

provided that in no event shall Agency ever be jointly, severally or in any other way authorized, bound or liable for the acts or omissions of Consultant or any other client of Consultant for or under any such contract or arrangement, and the scope of Consultant's authority shall not include obligating Agency in any way for the obligations of Consultant or any other person or entity.

C. Provides periodic legal, compliance, regulatory and similar in-services and other formal and informal trainings as requested by Agency, which may be offered simultaneously and in conjunction with the trainings for other of Consultant's clients. Such trainings shall include no nursing or direct care services by Consultant's representatives, but may or may not include, without limitation, assistance with proper patient charting and similar activities when performed in connection with in-services, medical records, survey readiness reviews, mock surveys and other similar consulting and training, in order to assist nursing leadership and staff in the lawful, prudent and efficient conduct of caregiving operations; provided that all trainings and materials provided in connection therewith shall be and remain the property of Consultant and may not be copied, reproduced, distributed or used other than with the express written permission of Consultant.

D. Provides assistance in labor and employment matters, including collective bargaining and other labor relations activities, and processing of state and federal employment (e.g., EEOC, DFEH, OCR, NLRB and similar agencies and programs) claims.

4. Risk Management.

A. Interfaces with insurance brokers and carriers to procure and maintain necessary and desirable insurance coverages. Consultant may, at Consultant's option and unless Agency objects, provide coverages under "pooled risk arrangements or "blanket" policies that cover other clients of Consultant, and Agency shall pay its allocated share of the premiums for such coverages based on the rating and risk profile of Agency as determined by Consultant, the broker and/or the insurance underwriters setting the premium. In addition, Consultant may provide such services, at Consultant's option, through captives or pooled insurance arrangements with other clients of Consultant or other insureds.

B. Provides, itself or through brokers or outside consultants, limited loss prevention evaluations and services.

C. Provides worker's compensation coverages, training, resources and systems, which may or may not include, at Consultant's option, assisting Agency, either for Agency's own account with third-party carriers, or under self-insurance certificates issued to Consultant or Agency, to self-insure for worker's compensation and other risks.

5. Information Technology.

A. Provides basic technology services, including assistance with computer, peripheral and network installations and troubleshooting where Agency uses hardware and software supported by Consultant.

B. Provides centralized Internet, Intranet, and other technology programs

and services to promote the efficient, accurate and timely collection and collation of operating and other business data.

C. Provides assistance in designing and maintaining web addresses, email services and informational websites for the Agency.

D. Provides centralized purchasing and procurement services and counseling for Agency's planning, acquisition and use of technology products and services.

6. Miscellaneous Services.

A. Provides periodic CEO-in-Training ("CIT") and Leadership programs, as well as other formal and informal trainings as requested by Agency, which may be offered simultaneously and in conjunction with the trainings for other of Consultant's clients. Such trainings shall include no nursing or direct care services by Consultant's representatives, but may or may not include, without limitation, assistance with filing of nursing home administrator and similar certification and licensing applications, and other similar assistance, consulting and training, in order to assist Agency leadership and staff in obtaining and maintaining necessary and appropriate certifications and licenses; provided that all trainings and materials provided in connection therewith shall be and remain the property of Consultant and may not be copied, reproduced, distributed or used other than with the express written permission of Consultant

B. Provides centralized purchasing opportunities from vendors, and service providers; provided that (i) Agency shall not be required to participate on any such purchasing cooperative or arrangement, (ii) Agency shall never be liable for the expenses, acts or omissions of Consultant or other clients of Consultant under such arrangements, but shall be responsible solely for its own purchases thereunder, (iii) catalogs, materials and forms provided in connection therewith shall be and remain the property of Consultant and may not be copied, reproduced, distributed or used other than with the express written permission of Consultant, and (iv) Consultant shall be authorized to act as Agency's agent for the limited purpose of negotiating and entering into such arrangements, but not for actually committing to the ordering of any product or service or the incurrence of any obligation thereunder, which shall be the sole province of Agency.

ADDITIONAL DUTIES TO BE PERFORMED BY AGENCY:

Without limiting any other duty or obligation of Agency at law or under the Agreement, Agency shall do all of the following:

7. Agency shall be solely responsible for (i) naming and managing its own Governing Body as required by applicable laws and regulations, (ii) hiring, supervising and evaluating its administrator and other employees, and (iii) overseeing the day-to-day conduct of its business and related activities.

8. Agency shall be solely responsible for providing a safe and sanitary environment for Agency personnel.

9. Agency shall be solely responsible for (i) operating its business in and from the

Agency location(s) in substantial compliance with applicable laws and regulations, (ii) maintaining all federal and state licenses and certifications required to operate the Agency and provide Services to patients and clients, (iii) performing all duties required of a licensee and provider under applicable local, state and federal laws, codes, regulations and provider agreements affecting the operation of the Agency, and (iv) notifying Consultant of any threatened, pending or actual revocation or suspension of its Licenses.

10. Timely furnish Consultant with such information and materials as might ordinarily be expected for Consultant to perform its duties hereunder. Agency shall be solely responsible to assure the accuracy and completeness of all information provided by Agency and its personnel to Consultant, and Consultant shall be entitled to rely thereon without inquiry or diligence of any kind.

11. Agency shall not unreasonably restrict or limit Consultant's access to necessary information, and acknowledges Consultant's right to exercise its independent professional judgment, including recommending Services and rendering such Services using such methods, technologies and procedures as Consultant deems appropriate.

12. Consultant's corporate address: 1675 E. Riverside Drive, Suite 150, Eagle, ID 83616, shall serve Agency's mailing address and address for service of process.

13. If requested by Consultant, Agency shall send delegates to Consultant's customer service teams, operator forums, evaluation and other service teams, trainings, and other committees and events as reasonably requested and available. In addition, to the extent available Agency delegates shall from time to time participate, both as trainees and trainers, in training and leadership conferences and events for the benefit of Consultant and others.

14. With Agency's acquiescence, and at Consultant's expense to the extent the trainee does not provide value to Agency, Agency agrees to periodically serve as a training site for Consultant's employees, providing (where available) preceptorship and organized training for CITs and other trainees of Consultant. In the event that a compensated trainee does not provide full value to Agency during his/her training program, Consultant shall pay directly, or reimburse Agency for, the portion of the trainee's compensation and training expenses that exceed the reasonable value provided.

Exhibit B

BUSINESS ASSOCIATE AGREEMENT

AGREEMENT EFFECTIVE DATE:	November 22, 2021
COVERED ENTITY:	**ORCHARD PRAIRIE HEALTHCARE LLC** ADDRESS: , ,
BUSINESS ASSOCIATE:	**PENNANT SERVICES, INC.** ADDRESS: 1675 E. RIVERSIDE DRIVE, SUITE 150, EAGLE, ID 83616

This Business Associate Agreement ("Agreement") is made and entered into as of the Effective Date listed in this Exhibit B, and between the above-listed Covered Entity and Business Associate, with reference to the following facts:

RECITALS

WHEREAS, Business Associate has been engaged to provide staffing services to Covered Entity pursuant to a separate agreement (the "Services Agreement"), and, in connection with those services, Covered Entity may need to disclose to Business Associate, or Business Associate may need to create on Covered Entity's behalf, certain Protected Health Information (as defined below) that is subject to protection under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("HITECH Act"), and regulations promulgated thereunder by the U.S. Department of Health and Human Services to implement certain privacy and security provisions of HIPAA (the "HIPAA Regulations"), codified at 45 C.F.R. Parts 160 and 164; and

WHEREAS, pursuant to the HIPAA Regulations, all business associates of Covered Entity, as a condition of doing business with Covered Entity, must agree in writing to certain mandatory provisions regarding the privacy and security of PHI (as defined below).

NOW THEREFORE, IN CONSIDERATION OF THE FOREGOING, and the mutual promises and covenants contained herein, Business Associate and Covered Entity agree as follows:

AGREEMENT

Definitions.

Unless otherwise specified in this Agreement, all terms not otherwise defined shall have the meanings established in Title 45, Parts 160 and 164, of the United States Code of Federal Regulations, as amended from time to time. Further, capitalized terms used, but not otherwise defined, in this Agreement shall have the meanings set forth in HIPAA, the HIPAA Regulations and the HITECH Act.

1.1 *Breach* shall have the meaning given to such term in 42 U.S.C. § 17921, and shall include the unauthorized acquisition, access, use, or disclosure of PHI which compromises the security or privacy of such information.

1.2 *Business Associate* shall have the meaning given to such phrase under the HIPAA Regulations and the HITECH Act, including, but not limited to, 45 C.F.R. § 160.103 and 42 U.S.C. § 17938, respectively. For purposes of this Agreement, "Business Associate" shall also refer specifically to the entity or individual set forth in the Preamble above.

1.3 *Covered Entity* shall have the meaning given to such phrase under the HIPAA Regulations including, but not limited to, 45 C.F.R. § 160.103. For purposes of this Agreement, "Covered Entity" shall also refer specifically to the entity set forth in the Preamble above.

1.4 *Data Aggregation* shall have the meaning given to such phrase under the Privacy Rule, including, but not limited to, 45 C.F.R. § 164.501.

1.5 *Designated Record Set* means a group of records maintained by or for Covered Entity that may include (i) medical records and billing records about Individuals maintained by or for a covered health care provider, (ii) the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan, or (iii) records used, in whole or in part, by or for Covered Entity to make decisions about Individuals.

1.6 *Electronic Health Record* shall have the meaning given to such phrase in the HITECH Act, including, but not limited to, 42 U.S.C. § 17921(5).

1.7 *Electronic Protected Health Information* ("ePHI") means individually identifiable health information that is transmitted by, or maintained in, electronic media.

1.8 *Health Care Operations* shall have the meaning given to such phrase under the Privacy Rule, including, but not limited to, 45 C.F.R. § 164.501.

1.9 *Individual* has the same meaning as the term *individual* in 45 C.F.R. § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).

1.10 *Privacy Rule* shall mean the Standards for Privacy of Individually Identifiable Health Information codified at 45 C.F.R. Part 160 and Part 164, Subparts A and E, as amended by the HITECH Act and as may otherwise be amended from time to time.

1.11 *Protected Health Information* ("PHI") means any information, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an Individual; the provision of health care to an Individual; or the past, present or future payment for the provision of health care to an Individual; and (ii) that identifies the Individual or with respect to which there is a reasonable basis to believe the information can be used to identify that Individual; and (iii) shall include the definition as set forth in the Privacy Rule including, but not limited to, 45 C.F.R. § 160.103. For purposes of this Agreement, PHI shall include ePHI.

1.12 *Required By Law* shall have the same meaning as the phrase *required by law* in 45 C.F.R. § 164.103.

1.13 *Secretary* means the Secretary of the U.S. Department of Health and Human Services or his/her designee.

1.14 *Security Incident* means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

1.15 *Security Rule* shall mean the HIPAA Regulations that are codified at 45 C.F.R. Part 160 and Part 164, Subparts A and C, as amended by the HITECH Act and as may otherwise be amended from time to time.

1.16 *Unsecured PHI* shall mean PHI that is not secured through the use of a technology or methodology specified by the Secretary in guidance or as otherwise defined in 42 U.S.C. § 17932(h).

Scope of Agreement.

This Agreement applies to the PHI of Covered Entity to which Business Associate may be exposed as a result of the services that Business Associate will provide to Covered Entity pursuant to the Services Agreement. Business Associate shall abide by HIPAA, the HIPAA Regulations and the HITECH Act with respect to PHI of Covered Entity, as outlined below.

Obligations and Activities of Business Associate.

3.1 *Permitted Uses*. Except as otherwise limited in this Agreement, Business Associate may use PHI (i) for the proper management and administration of Business Associate, (ii) to carry out the legal responsibilities of Business Associate, or (iii) for Data Aggregation purposes for the Health Care Operations of Covered Entity. Business Associate may use PHI to provide services to Covered Entity under the Services Agreement provided that Business Associate shall not use PHI in any manner that would constitute a violation of the Privacy Rule or the HITECH Act if so used by Covered Entity.

3.2 *Permitted Disclosures*. Business Associate may disclose PHI (i) for the proper management and administration of Business Associate; (ii) to carry out the legal responsibilities of Business Associate; (iii) as Required By Law; or (iv) for Data Aggregation purposes for the Health Care Operations of Covered Entity. Business Associate may disclose PHI to provide services to Covered Entity under the Services Agreement, provided that Business Associate shall not disclose PHI in any manner that would constitute a violation of the Privacy Rule or the HITECH Act if so disclosed by Covered Entity.

3.2.1 In addition, if Business Associate discloses PHI to a third party, for Business Associate's management and administration purposes as specified in Section 3.2, Business Associate must obtain, prior to making any such disclosure, (i) reasonable written assurances from such third party that the PHI will be held as confidential as provided pursuant to this Agreement and only disclosed as Required By Law or for the purposes for which it was disclosed to such third party; and (ii) a written agreement from such third party to immediately notify Business Associate of any breaches of confidentiality of the PHI, to the extent such third party has obtained knowledge of such breach.

3.3 *Prohibited Uses and Disclosures*. Business Associate shall not use or disclose PHI for fundraising or marketing purposes. In accordance with 42 U.S.C. § 17935(a), Business Associate shall not disclose PHI to a health plan for payment or Health Care Operations purposes if the patient has requested this special restriction, and has paid out of pocket in full for the health care item or service to which the PHI solely relates. Business Associate shall not directly or indirectly receive remuneration in exchange for PHI, except with the prior written consent of Covered Entity and Individual and as permitted by 42 U.S.C. § 17935(d)(1) and (2); however, this prohibition shall not affect payment by Covered Entity to Business Associate for services provided pursuant to the Services Agreement.

3.4 *Other Business Associates.* As part of its providing functions, activities, and/or services to Covered Entity, Business Associate may disclose information, including PHI, to other business associates of Covered Entity, and Business Associate may use and disclose information, including PHI, received from other business associates of Covered Entity as if this information was received from, or originated with, Covered Entity.

3.5 *Safeguards for Protection of ePHI*. Business Associate agrees to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of Covered Entity. In accordance with 42 U.S.C. § 17931 of the HITECH Act, Business Associate shall be directly responsible for full compliance with the policies and procedures and documentation requirements of the HIPAA Security Rule, including, but not limited to, 45 C.F.R. §§ 164.308, 164.310, 164.312, and 164.316. Business Associate shall implement and at all times use all appropriate safeguards to prevent any use or disclosure of PHI not authorized under this Agreement.

3.6 *Reporting of Unauthorized Uses or Disclosures and Security Incidents*. Business Associate agrees to report to Covered Entity in writing any access, use or disclosure of the PHI not provided for or permitted by this Agreement and, any Security Incidents of which Business Associate (or Business Associate's employee, officer or agent) becomes aware. Business Associate shall so notify Covered Entity pursuant to this Section within twenty-four (24) hours after Business Associate becomes aware of such unauthorized use, disclosure or Security Incident. The notice to be provided pursuant to this Section shall be substantially in the same form as **Exhibit 1**, which is attached hereto.

3.7 *Reporting of Breach of Unsecured PHI*. Business Associate agrees to report to Covered Entity any Breach of Unsecured PHI of which Business Associate (or Business Associate's employee, officer or agent) becomes aware without unreasonable delay and in no case later than the next business day after Business Associate learns of such Breach, except where a law enforcement official determines that a notification would impede a criminal investigation or cause damage to national security. Business Associate's notification to Covered Entity hereunder shall be substantially in the same form as **Exhibit 1**.

3.8 *Agents and Subcontractors.* Business Associate agrees to ensure that any agent, including a subcontractor, to whom Business Associate provides PHI, agrees in writing to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such PHI, and implement the safeguards required by Section 3.5 above with respect to ePHI.

3.9 *Mitigation of Unauthorized Uses or Disclosures*. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate or one of its agents or subcontractors in violation of the requirements of this Agreement.

3.10 *Authorized Access to PHI*.

3.10.1 *Individual Requests for Access*. Business Associate shall cooperate with Covered Entity to fulfill all requests by Individuals for access to the Individual's PHI that are approved by Covered Entity. Business Associate shall cooperate with Covered Entity in all respects necessary for Covered Entity to comply with 45 C.F.R. §164.524 and applicable State law. If Business Associate receives a request from an Individual for access to PHI, Business Associate shall immediately forward such request to Covered Entity.

3.10.2 *Scope of Disclosure*. Covered Entity shall be solely responsible for determining the scope of PHI and/or Designated Record Set with respect to each request by an Individual for access to PHI. In the event that Covered Entity decides to charge a reasonable cost-based fee for the reproduction and delivery of PHI to an Individual, Covered Entity shall deliver a

portion of this fee to Business Associate in the event any such reproduction or delivery is made by Business Associate, and in proportion to the amount of work done by Business Associate in producing and delivering the PHI.

3.10.3 Designated Record Set. To the extent that Business Associate maintains PHI in a Designated Record Set and at the request of Covered Entity, Business Associate agrees to provide access to PHI in a Designated Record Set to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 C.F.R. § 164.524 and applicable State law. If Business Associate maintains PHI in a Designated Record Set, and maintains an Electronic Health Record, then Business Associate shall provide such Designated Record Set in electronic format to enable Covered Entity to fulfill its obligations under the HITECH Act, including, but not limited to, 42 U.S.C. § 17935(e).

3.10.4 Patient Right to Amend to PHI. A patient has the right to have Covered Entity amend his/her PHI, or a record in a Designated Record Set for as long as the PHI is maintained in the Designated Record Set, in accordance with 42 C.F.R. §164.526. To the extent that Business Associate maintains PHI in a Designated Record Set, Business Associate agrees to make any amendment(s) to PHI in a Designated Record Set at the request of Covered Entity in accordance with 45 C.F.R. § 164.526. Within fifteen (15) business days following Business Associate's amendment of PHI as directed by Covered Entity, Business Associate shall provide written notice to Covered Entity confirming that Business Associate has made the amendments or addenda to PHI as directed by Covered Entity and containing any other information as may be necessary for Covered Entity to provide adequate notice to the Individual in accordance with 45 C.F.R. §164.526.

3.11 Accounting for Disclosures.

3.11.1 Disclosures. In the event that Business Associate makes any disclosures of PHI that are subject to the accounting requirements of the Privacy Rule 45 C.F.R. §164.528 and/or the HITECH Act including, but not limited to, 42 U.S.C. § 17935(c))[1], Business Associate shall report such disclosures to Covered Entity within three (3) days of such disclosure. The notice by Business Associate to Covered Entity of the disclosure shall include the name of the Individual, the recipient, the reason for disclosure, and the date of the disclosure. Business Associate shall maintain a record of each such disclosure that shall include: (i) the date of the disclosure; (ii) the name and, if available, the address of the recipient of the PHI; (iii) a brief description of the PHI disclosed; and (iv) a brief description of the purpose of the disclosure. Business Associate shall maintain this record for a period of six (6) years and make it available to Covered Entity upon request in an electronic format so that Covered Entity may meet its disclosure accounting obligations under 45 C.F.R. §164.528. If Covered Entity provides a list of its business associates to an Individual in response to a request by an Individual for an accounting of disclosures, and the Individual thereafter specifically requests an accounting of disclosures from Business Associate, then Business Associate shall provide an accounting of disclosures to such Individual.

3.11.2 Electronic Health Record. Business Associate acknowledges that, to the extent Business Associate maintains an Electronic Health Record for Covered Entity, Business Associate is only required to provide an Individual with an accounting of disclosures related to treatment, payment or Health Care Operations for a period of three (3) years prior to such Individual's request. Therefore, upon request by an Individual to Covered Entity for an accounting of disclosures related to treatment, payment or Health Care Operations, Business Associate shall provide to Covered Entity, within three (3) days of Business

[1] The provisions of 42 U.S.C. § 17935(c) become effective on the following dates: (i) for users of electronic health records as of January 1, 2009, this section shall apply to disclosures made by the Covered Entity on and after January 1, 2014; (ii) for covered entities that acquire an electronic health record after January 1, 2009, this section shall apply to disclosures made by the Covered Entity after the later of January 1, 2011 or the date it acquires an electronic health record.

Associate's receipt of a written request from Covered Entity, an accounting of such disclosures for the three (3) year period prior to such request. Notwithstanding this Section, a record of disclosures pertaining to information disclosed by Business Associate for treatment, payment or Health Care Operations shall be maintained in accordance with Section 3.11.1, above.

3.12 *Secretary's Right to Audit*. Business Associate agrees to make its internal practices, books, and records relating to the use and disclosure of PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity, available to the Secretary for purposes of the Secretary determining Covered Entity's and/or Business Associate's compliance with HIPAA, the HIPAA Regulations and the HITECH Act. No attorney-client, or other legal privilege will be deemed to have been waived by Business Associate by virtue of this provision of the Agreement. Business Associate shall provide to Covered Entity a copy of any PHI and related documents that Business Associate provides to the Secretary concurrently with providing such documents to the Secretary.

3.13 *Data Ownership*. All PHI shall be deemed owned by Covered Entity unless otherwise agreed in writing.

3.14 *Compliance*. To the extent Business Associate is to carry out a Covered Entity's obligation under the HIPAA Privacy Regulations, Business Associate shall comply with the requirements of the Privacy Regulations that apply to Covered Entity in the performance of such obligation.

4 **Obligations of Covered Entity**.

4.1 *Notice of Privacy Practices*. Upon written request by Business Associate, Covered Entity shall provide Business Associate with Covered Entity's then current Notice of Privacy Practices.

4.2 *Revocation of Permitted Use or Disclosure of PHI*. Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by the patient to use or disclose PHI of Covered Entity, to the extent that such changes may affect Business Associate's use or disclosure of PHI of Covered Entity.

4.3 *Restrictions on Use or Disclosure of PHI*. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 C.F.R. § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

4.4 *Requested Uses or Disclosures of PHI*. Except for Data Aggregation or management and administrative activities of Business Associate, Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the HIPAA Regulations if done by Covered Entity.

5 **Term and Termination**.

5.1 *Term*. The term of this Agreement shall be coterminous with the Services Agreement. However, Business Associate shall have a continuing obligation to safeguard the confidentiality of PHI received from Covered Entity after the termination of the Services Agreement.

5.2 *Termination Without Cause*. Either party may terminate this Agreement without cause or penalty by the delivery of a written notice from the terminating party to the other party. Such termination is effective thirty (30) calendar days from the date that the other party receives such notice.

5.3 *Termination for Cause*. A breach of any provision of this Agreement by Business Associate shall constitute a material breach of this Agreement and shall provide grounds for immediate termination

of this Agreement by Covered Entity, any provision in this Agreement to the contrary notwithstanding.

5.4 *Judicial or Administrative Proceedings*. Either party may terminate the Agreement, effective immediately, if (i) the other party is named as a defendant in a criminal proceeding for a violation of HIPAA, the HIPAA Regulations, the HITECH Act, or other security or privacy laws or (ii) a finding or stipulation that the other party has violated any standard or requirement of HIPAA, the HIPAA Regulations, the HITECH Act or other security or privacy laws is made in any administrative or civil proceeding in which the party has been joined.

5.5 *Effect of Termination*.

5.5.1 Except as provided in Section 5.5.2, herein, upon termination of this Agreement for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity, including PHI in possession of any Business Associate's subcontractors and retain no copies or backup records of such PHI in any form or medium. Business Associate shall certify in writing to Covered Entity that such PHI has been destroyed.

5.5.2 In the event that Business Associate determines that returning or destroying the PHI is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction unfeasible. Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures to those purposes that make the return or destruction of the PHI unfeasible, for so long as Business Associate maintains such PHI.

6 **Breach Pattern or Practice**.

If either party (the "Non-Breaching Party") knows of a pattern of activity or practice of the other party (the "Breaching Party") that constitutes a material breach or violation of the Breaching Party's obligations under this Agreement, the Non-Breaching Party shall either (i) terminate this Agreement in accordance with Section 5 above, or (ii) take reasonable steps to cure the breach or end the violation. If the steps are unsuccessful, the Non-Breaching Party must terminate the Agreement if feasible. The Non-Breaching Party shall provide written notice to the Breaching Party of any pattern of activity or practice of the Breaching Party that the Non-Breaching Party believes constitutes a material breach or violation of the Breaching Party's obligations under this Agreement within three (3) days of discovery and shall meet with the Breaching Party's Privacy Coordinator to discuss and attempt to resolve the problem as one of the reasonable steps to cure the breach or end the violation.

7 **Disclaimer**.

Covered Entity makes no warranty or representation that compliance by Business Associate with this Agreement, HIPAA, the HIPAA Regulations, or the HITECH Act will be adequate or satisfactory for Business Associate's own purposes. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.

8 **Certification**.

To the extent that Covered Entity determines that such examination is necessary to comply with Covered Entity's legal obligation pursuant to HIPAA, the HIPAA Regulations, and the HITECH Act, Covered Entity or its authorized agents or contractors may, at Covered Entity's expense, examine Business Associate's facilities, systems, procedures (including but not limited to review of training procedures for Business Associate's staff) and records as may be necessary for such agents or contractors to certify to Covered Entity the extent to which Business Associate's security safeguards comply with HIPAA, the HIPAA Regulations, the HITECH Act, and this Agreement.

9 **Indemnification**.

Notwithstanding any contrary provision in the Services Agreement, Business Associate agrees to indemnify, defend and hold harmless Covered Entity, its shareholders, directors, officers, employees, affiliates, and agents ("Indemnified Party") against all actual and direct losses suffered by the Indemnified Party from any breach of this Agreement, negligence or wrongful acts or omissions, including, without limitation, failure to perform its obligations under this Agreement or Breach of Unsecured PHI, by Business Associate or its employees, directors, officers, subcontractors, agents or other members of its workforce. Accordingly, on demand, Business Associate shall reimburse the Indemnified Party for any and all actual and direct losses, liabilities, lost profits, fines, penalties, costs or expenses (including reasonable attorneys' fees) which may for any reason be incurred by Indemnified Party or imposed upon the Indemnified Party by reason of any suit, claim, action, proceeding or demand by any third party, as a result of the Business Associate's breach hereunder.

10 **Compliance With State Law**.

Business Associate acknowledges that Business Associate and Covered Entity may have confidentiality and privacy obligations under applicable State law. If any provisions of this Agreement or HIPAA/HIPAA Regulations/HITECH Act conflict with state law regarding the degree of protection provided for PHI and patient medical records, then Business Associate shall comply with the more restrictive requirements.

11 **Miscellaneous**.

11.1 *Amendment*. Business Associate and Covered Entity agree to take such action as is necessary to amend this Agreement from time to time to enable Covered Entity to comply with the requirements of HIPAA, the HIPAA Regulations and the HITECH Act. This Agreement may not be modified, nor shall any provision hereof be waived or amended, except in a writing duly signed and agreed to by Business Associate and Covered Entity.

11.2 *Interpretation*. The provisions of this Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HIPAA Regulations, the HITECH Act, the Privacy Rule and the Security Rule. The parties agree that any ambiguity in this Agreement shall be resolved in favor of a meaning that complies and is consistent with HIPAA, the HIPAA Regulations, the HITECH Act, the Privacy Rule and the Security Rule.

11.3 *No Third Party Beneficiaries*. Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than Business Associate and Covered Entity, and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.

11.4 *Notices*. All notices or other communications required or permitted hereunder shall be in writing and shall be deemed given or delivered (i) when delivered personally, against written receipt; (ii) if sent by registered or certified mail, return receipt requested, postage prepaid, when received; (iii) when received by facsimile transmission; or (iv) when delivered by a nationally recognized overnight courier service, prepaid, and shall be sent to the addresses set forth on the signature page of this Agreement or at such other address as each party may designate by written notice to the other by following this notice procedure.

11.5 *Regulatory References*. A reference in this Agreement to a section in the HIPAA Regulations or the HITECH Act means the section as in effect or as amended, and for which compliance is required.

11.6 *Assistance in Litigation or Administrative Proceedings*. Business Associate shall make itself, and any subcontractors, employees or agents, available to Covered Entity, at no cost to Covered Entity, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being

commenced against Covered Entity, its directors, officers or employees based upon a claimed violation of HIPAA, the HIPAA Regulations, the HITECH Act, the Privacy Rule, the Security Rule, or other laws relating to security and privacy, except where Business Associate or its subcontractor, employee or agent is a named adverse party.

11.7 *Subpoenas*. In the event that Business Associate receives a subpoena or similar notice or request from any judicial, administrative or other party arising out of or in connection with this Agreement, including, but not limited to, any unauthorized use or disclosure of PHI, Business Associate shall promptly forward a copy of such subpoena, notice or request to Covered Entity and afford Covered Entity the opportunity to exercise any rights it may have under law.

11.8 *Survival*. The respective rights and obligations of Business Associate under Section 3 et seq. of this Agreement shall survive the termination of this Agreement. In addition, Section 5.5 (Effect of Termination), Section 7 (Disclaimer), Section 9 (Indemnification), Section 10 (Compliance with State Law), Section 11.4 (Notices), Section 11.6 (Assistance in Litigation and Administrative Proceedings), Section 11.7 (Subpoenas), and Section 11.9 (Governing Law) shall survive the termination of this Agreement.

11.9 *Governing Law*. This Agreement shall be governed by and construed in accordance with the laws of the state in which the covered entity is principally located to the extent that the provisions of HIPAA, the HIPAA Regulations or the HITECH Act do not preempt the laws of that state.

11.10 *Independent Contractors*. Covered Entity and Business Associate shall be independent contractors and nothing in this Agreement is intended nor shall be construed to create an agency, partnership, employer-employee, or joint venture relationship between them.

[Signature Page to follow]

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

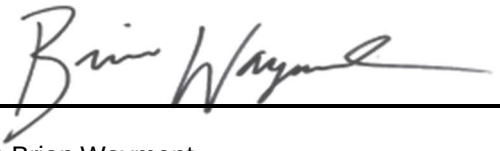
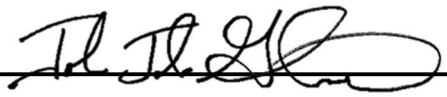
COVERED ENTITY: Orchard Prairie Healthcare LLC	**BUSINESS ASSOCIATE: PENNANT SERVICES, INC.**
Sign: 	**Sign:** 
Name: Brian Wayment	Name: John J. Gochnour
Title: Authorized Agent	Title: Authorized Agent
DateNovember 22, 2021	Date: November 22, 2021

Exhibit 1

Notification to Orchard Prairie Healthcare LLC of
Unauthorized Use or Disclosure of PHI/Breach of Unsecured PHI

Attn: Privacy Officer
Orchard Prairie Healthcare LLC
Phone:
Fax:
Email: _____

This notification is made pursuant to Sections 3.6 and 3.7 of the Business Associate Agreement between Covered Entity and Business Associate.

Business Associate hereby notifies Covered Entity that there has been a breach of protected health information ("PHI") that Business Associate has used or has had access to under the terms of the Business Associate Agreement.

Description of the breach: _____
_____

Date of the breach: _____

Date of the discovery of the breach: _____

Number of individuals affected by the breach: _____

The types of PHI that were involved in the breach (e.g., full name, Social Security number, date of birth, home address, account number): _____
_____

Description of what Business Associate is doing to investigate the breach, mitigate losses, and protect against further breaches: _____
_____
_____
_____

Business Associate contact information: _____
_____
_____

EXHIBIT 8

CONSULTING, PROFESSIONAL, AND OPERATIONAL SUPPORT SERVICES AGREEMENT
(Clinical Services)

Effective Date:	**November 22, 2021**
CONSULTANT:	**Cornerstone Service Center, Inc., a Nevada corporation**
Address:	1675 E. Riverside Drive, Ste. 200, Eagle, ID 83616
Phone:	(208) 401-1400
Fax:	(208) 401-1401
FACILITY:	**Orchard Prairie Healthcare LLC d/b/a**
Address:	1675 E. Riverside Drive, Suite 150, Eagle, ID 83616
Phone:	
Fax:	
FEIN:	87-3670377

THIS CONSULTING, PROFESSIONAL, AND OPERATIONAL SUPPORT SERVICES AGREEMENT ("Agreement") is made and entered into by and between the above-named Consultant and Agency as of the Effective Date, with respect to the following facts and intentions:

R E C I T A L S

A. Agency is an independently operated, licensed and certified Home Health, Hospice and/or Home Care Agency operating from the address set forth above (the "Agency Primary Location");

B. Consultant is a provider of centralized consulting, professional, and operational support designed to aid the efficient, competitive, and sound operation of entities like Agency;

C. Agency desires to engage the services of Consultant to assist Agency personnel with aspects of Agency's operations and activities, in order to facilitate Agency personnel's focus on Agency's primary mission of rendering superior hospice services to the Agency's patients and clients.

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

TERMS AND CONDITIONS

1. Incorporation of Exhibits and Recitals. The Recitals set forth above, as well as the exhibits attached hereto, are incorporated herein by this reference as if fully set forth herein.

2. Consultant's Duties. The Consultant agrees to provide such of the following services ("Services") as Agency, at Agency's option and request from time to time, desires to obtain from Consultant during the term of this Agreement, and to perform its duties hereunder in a good, professional and workmanlike manner. Such duties shall include, without limitation (herein the "Services"):

2.1. General Consultant's Duties, Generally.

2.1.1. Consultant will provide Services in substantial conformance to applicable federal and state laws and the established policies of Consultant and Agency in effect from time to time, and Consultant will conduct periodic self-audit/compliance reviews in order to ensure that Consultant substantially complies with federal, state and local statutes and regulations applicable to the provision of the Services. Agency hereby grants to Consultant a limited power of attorney to act in Agency's name and stead for the convenience of Agency and/or Consultant, provided that this power shall not be used except in conjunction with the enumerated Services under this Agreement.

2.1.2. Consultant shall make clear to all parties with whom it deals in the course of rendering the Services that it is an independent contractor and not an employer, employee, partner, co-venturer, or management Agency of Agency. At all times while in the Agency and while with Agency's patients, Consultant's employees and representatives shall wear uniforms and/or badges clearly indicating their affiliation with Consultant.

2.2. Specific Duties of Consultant. During the term of this Agreement, Consultant shall provide to Agency the specific Services listed in Exhibit A at the request of the Agency. In the event of any conflict between the terms of Exhibit A and the terms contained in the main body of this Agreement, the terms of Exhibit A shall control. Consultant's duties shall specifically not include (i) the rendition of any direct care to patients or residents, (ii) maintenance or handling of patient trust property, or (iii) any other service not specifically enumerated herein as a part of the Services and requested by Agency, all of which shall be the sole duty and domain of Agency, its administrators, caregivers and other staff.

3. Agency's Duties. Agency shall:

3.1. Operate its business in and from the Agency in substantial compliance with applicable laws and regulations, and maintain all federal and state licenses and certifications required to operate the Agency and provide Services to patients (collectively the "Licenses"). Agency shall perform all duties required of a licensee and provider under applicable local, state and federal laws, codes, regulations and provider agreements affecting the operation of the Agency. Within five (5) days of receipt, Agency shall deliver to Consultant notification of any actual revocation or suspension of its Licenses.

3.2. Not unreasonably restrict or limit the Consultant's right to exercise its independent professional judgment, including its right to recommend Services to be rendered

and to render such Services using such methods, technologies and procedures as Consultant deems appropriate.

3.3. Timely furnish Consultant with such information and materials as might ordinarily be expected for Consultant to perform its duties hereunder. Agency shall be solely responsible to assure the accuracy and completeness of all information provided by Agency and its personnel to Consultant, and Consultant shall be entitled to rely thereon without inquiry or diligence of any kind.

3.4. As and to the extent that Consultant's employees and agents require access to the Agency to perform the Services, Agency shall provide adequate working space, equipment and access to Agency's staff for the provision of Services. Equipment and materials placed at the Agency by Consultant shall be used exclusively for the purposes of this Agreement. Upon termination or at Consultant's request, Agency shall return equipment and materials, in the same condition as when delivered to Agency, reasonable wear and tear excepted.

3.5. In addition to the foregoing, during the term of this Agreement, Agency shall cooperate with Consultant and Consultant's other client agencies and businesses as more fully set forth in Exhibit A.

4. Compensation.

4.1. For and in consideration of the Services to be provided under this Agreement, the Agency shall pay to the Consultant as the "Consultant Compensation" a monthly consulting fee equal to five percent (5.0%) of Agency's gross revenue from all sources. A reasonable estimate of anticipated monthly Consultant Compensation shall be paid on or before the first (1st) day of each month during the Term hereof, and shall be "trued up" at the beginning of the next following month with such following month's estimated payment. Payment for any partial month of the Term shall be prorated based on the number of days during the month that Consultant served under this Agreement. In the event Agency closes during any month during the Term, the Consultant Compensation for any such month or partial month shall be calculated, at Consultant's option, based on historical revenues and patient mix. At Consultant's option Consultant shall be entitled to deduct the Consultant Compensation from sums collected for Agency by Consultant, and shall provide Agency with invoices (or if paid by deduction accountings) for the monthly fee by the last day of the month following the month of service.

4.2. In addition to and not as part of the Consultant Compensation, Agency shall reimburse Consultant for all costs and expenses advanced, incurred, or paid by Consultant in the rendition of Services.

5. Insurance.

5.1. Both Consultant and Agency agree to maintain general and professional liability insurance during the term of this agreement in an amount not less than One Million Dollars ($1,000,000) per claim and Three Million Dollars ($3,000,000) in the aggregate.

5.2. Both parties agree to maintain such other and further insurance as may be required by law or the terms of any agreement to which they are parties, including without

limitation worker's compensation insurance (where required by law), crime insurance, directors and officers coverage, automobile and similar liability, and property and casualty insurance, and will list Agency as named insured on all obtained policies.

5.3. All insurance policies shall be issued by insurance companies with a policyholder rating of at least "B+" in the most recent version of Best's Key Rating Guide.

6. Term and Termination. The Term of this Agreement shall commence on the Effective Date and continue thereafter for a period of one (1) year. This Agreement shall automatically extend for additional periods of one (1) year each unless written notice of termination is given not less than sixty (60) days prior to the end of the then-current term. Notwithstanding anything contained herein to the contrary, either party may terminate this Agreement and the Term hereof at any time during the Term upon sixty (60) days written notice; further, in the event of (i) abandonment by a party of its duties hereunder, (ii) nonpayment of any Consultant Compensation within five (5) days after delivery of invoice or other written demand therefor; (iii) any breach or violation of this Agreement (other than non- payment of Consultant Compensation) which is not cured within thirty (30) days following delivery of written notice of such breach or violation, (iv) any material violation of law or regulations, or loss or failure of license or licensure, or violation of the eligibility requirements for reimbursement under any government program by a party, or (v) the occurrence or existence of any condition, practice, procedure, action, inaction or omission of, by or involving a party which, in the reasonable opinion of the other party constitutes either a threat to the health, safety, and welfare of any patient or client or a violation of any law, regulation, requirement, Licenses, eligibility or material agreement governing Agency's or Consultant's operation, then the other party shall have the right to summarily and immediately terminate this Agreement upon written notice to the first party.

7. Regulatory Changes. Agency and Consultant mutually agree that in the event local, state or federal government agencies promulgate regulations which materially affect the terms of this Agreement, including but not limited to changes affecting the cost of providing Services hereunder, this Agreement shall be immediately subject to renegotiation upon the initiative of either party.

8. Warranties.

8.1. Agency's Warranties. Agency hereby makes the following warranties and representations to Consultant in connection with Consultant's entry into this Agreement, which warranties shall survive the termination of this Agreement:

8.1.1. Agency is properly licensed by the State in which the Agency's operation(s) is located by the proper licensing and certification authorities for such State, and all permits and licenses required for the operation of Agency's business(es) have been received and are now currently effective.

8.1.2. As of the Effective Date, except as specifically disclosed on Schedule 1 attached hereto and incorporated herein, there is no litigation, administrative proceedings, event, or hold or similar lien on State or Federal payments to Agency, either underway or threatened, nor are there arbitration proceedings or governmental investigations relating to the Agency, or the business conducted thereon underway or threatened against Agency or brought by the Agency

8.1.3. To the best of Agency's knowledge, the business operations of the Agency at the Commencement Date comply with all local, State and Federal zoning, labor and other applicable laws, ordinances, rules and regulations applicable to the Agency.

8.1.4. Agency has been duly formed in the state of its domicile and remains in good standing in such state, and (if operating in a state other than its domicile) has been duly registered and authorized to do business in the state where its business operation(s) is located and is in good standing in that state as well.

8.1.5. Agency is authorized to consummate the transactions covered by this Agreement.

8.2. Consultant's Warranties. Consultant hereby makes the following warranties and representations to Agency in connection with Agency's entry into this Agreement, which warranties shall survive the termination of this Agreement:

8.2.1. Consultant is a Nevada corporation in good standing, and is registered to do business in, and is in good standing with, the State of Idaho.

8.2.2. Consultant is authorized to consummate the transactions covered by this Consulting Agreement.

9. Licensure, Eligibility and Compliance.

9.1. Consultant acknowledges that its activities under this Agreement may be governed by, *inter alia*, the United States Department of Health and Human Services' Office of the Inspector General's ("OIG") Compliance Program Guidance for Home Health Agencies and/or the OIG's Compliance Program Guidance for Hospices. Consultant represents and warrants that neither Consultant nor any individual or entity with a direct or indirect ownership or control interest of five percent (5%) or more in Consultant, nor any director, officer, agent or employee of such party, is debarred, suspended or excluded under any state or federal healthcare program it is currently eligible to participate in Medicare, Medicaid, and all other federally funded health care programs and is not subject to any sanction or exclusion by any of those programs. Consultant agrees to immediately disclose any actual or threatened federal, state or local investigations or imposed sanctions of any kind, in progress or initiated subsequent to the date of entering into this Agreement. Consultant further represents and warrants that it is not currently sanctioned under any applicable state or federal fraud and abuse statutes, including exclusion from any state or federal health care program. If, during the term of this Agreement, Consultant, its parent, or any officer, director or owner receives such a sanction, or notice of proposed sanction, Consultant shall provide notice of and a full explanation of such sanction or proposed sanction and the period of its duration within ten (10) days of receipt. Agency reserves the right to terminate the Agreement immediately upon receipt of notice that Consultant has been sanctioned under fraud and abuse statutes and/or any other federal, state or local regulation.

9.2. If the Agency Primary Location is located in the state of Texas, Consultant agrees to complete, execute and deliver to Agency upon request a Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion for Covered Contracts on Form 2046 as promulgated by the Texas Department of Protective & Regulatory Services.

9.3. Consultant acknowledges that it has received a copy of Agency's Code of Conduct, and agrees to abide by the provisions thereof governing Vendors and Vendor services.

10. Consultant's Schedule and Availability.

10.1. Consultant shall be reasonably available on an on-call basis to the Agency to fulfill Consultant's duties hereunder.

10.2. Nothing in this Agreement shall be construed as limiting or restricting in any manner Consultant's right to render the same or similar services to other individuals or entities, including but not limited to, other hospice and in-home care during or subsequent to the Term of this Agreement; similarly, nothing in this Agreement shall require Agency to exclusively use all of Consultant's services in the Agency during the Term of this Agreement.

10.3. Consultant's employees and representatives are entitled to be reasonably absent for annual vacations, sick leave, continuing education, and personal reasons; provided that in the event of any absence Consultant shall consult with the Agency concerning the impending absence and cooperate with the Agency in providing alternate resources to Agency to temporarily fulfill Consultant's duties during the period of absence.

11. Contractual Relationship.

11.1. Independent Contractor. It is expressly acknowledged by both parties that Consultant is an independent contractor. Nothing herein is intended to be construed to create an employer-employee, partnership, joint venturer or other relationship between Consultant and the Agency. Agency has and shall retain all statutory liability and responsibility for the continued operation of the Agency as the licensee under Agency's Licenses. No provision of this Agreement shall create any right in the Agency to exercise control or direction over the manner or method by which Consultant performs its duties or renders Services hereunder, nor shall Consultant exercise control or direction over the manner or method by which Agency operates or serves its patients and clients; provided always, that services shall be provided in a manner consistent with all applicable laws, rules and regulations of all governmental authorities, and Agency's Code of Conduct. Agency will not withhold from compensation payable to Consultant hereunder, or be in any way responsible for, any sums for income tax, employment insurance, Social Security, or any other agency and Consultant agrees that the payment of all such amounts as may be required by law are and shall be the sole responsibility of Consultant.

11.2. Fair Market Value. The amounts to be paid to Consultant hereunder have been determined by the parties through good faith and arms-length bargaining to be the fair market value of the services to be rendered hereunder. No amount paid or to be paid hereunder is intended to be, nor will it be construed as, an offer, inducement or payment, whether directly or indirectly, overtly or covertly, for the referral of patients by Consultant to Agency, or by Agency to Consultant, or for the recommending or arranging of the purchase, lease or order of any item or service. For purposes of this section, Consultant and Agency will include each such entity and any affiliate thereof. No referrals are required under this Agreement.

11.3. Work Product. The work product created in the course of Consultant's services under this agreement shall be the exclusive property of Consultant, and all manuals, forms, and documents (including without limitation, all writings, drawings, blueprints, pictures, recordings, computer or machine readable data, and all copies or reproductions thereof) which result from, describe or relate to the services performed or to be performed pursuant to this agreement or the results thereof, including without limitation all notes, data, reports or other information received or generated in the performance of this Agreement (excepting data incorporated in medical records required to be kept and maintained by Agency), shall be the exclusive property of Consultant and shall be delivered to Consultant upon request.

11.4. Non-Solicitation of Consultant's Employees. During the term of this Agreement, Agency shall not solicit the services of, or hire as an employee or independent contractor at the Agency, any Consultant employee, agent or representative who provided, managed or otherwise was involved in the provision of Services to Agency within the previous twelve (12) months (a "Restricted Employee"). Nothing herein shall preclude Agency from advertising available positions or opportunities by posting in the Agency or through newspaper ads or other generally accepted recruiting mediums. The parties acknowledge that the restrictions set forth in this Article are reasonable in scope and important to Consultant's business interests, and that the enforcement of this Article does not restrict Agency from engaging in Services for its own account. In the event that Agency hires a Restricted Employee, Agency shall pay a recruiting fee to Consultant in the amount of Seven Thousand Five Hundred and No/100 Dollars ($7,500.00) per Restricted Employee hired.

12. Indemnification.

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

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

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

13. Access to Books and Records. Pursuant to 42 U.S.C. §1395x(V)(1)(l), during the four (4) year period after completion of services hereunder, the Agency will, upon written request, make available to the Secretary of Health and Human Services or to the Comptroller General, or their duly authorized representatives, this Agreement, books, documents, and

records that are necessary to certify the nature and extent of costs incurred by the Agency under the provisions of this Agreement. This provision shall be in force for any twelve (12) month period during which the total value of services provided or goods delivered hereunder is Ten Thousand Dollars ($10,000) or more. This section shall have no effect unless Consultant is deemed a "subcontractor" under any regulation adopted under the provision of the United States Code cited above.

14. Privacy.

14.1. HIPAA Applicability and Compliance. Agency may be a "Covered Entity" under, and required to comply with, the applicable provisions of the Health Insurance Portability and Accountability Act of 1996 as amended ("HIPAA") and the regulations and guidelines pertaining thereto (collectively with HIPAA the "HIPAA Rules"), and to obtain sufficient assurances that its contracting parties will appropriately safeguard patients' "Protected Health Information" ("PHI") as defined in the HIPAA Rules. In the course of performing Consultant's services, duties and obligations herein, Consultant may receive, create or obtain access to PHI. Consultant agrees to maintain the security and confidentiality of PHI, as required of Agency by applicable laws and regulations, including without limitation the HIPAA Rules, and to execute and deliver such additional documentation and assurances as Agency may reasonably request to comply with HIPAA and any amendments thereto and related laws and regulations, including, but not limited to, the Business Associate Agreement attached hereto as Exhibit B.

14.2. Correlation of Record Handling Requirements. In the event of any conflict between the requirements of this Article 14 and/or between the various laws, statutes, ordinances and regulations relating to or otherwise affecting the subject matter thereof, the requirement or applicable law that that presents the most stringent standard for compliance, as reasonably determined by Agency, shall be followed, such that compliance is achieved or maximized in all cases.

14.3. Confidential Information. Consultant shall preserve the confidentiality of all private, confidential and/or proprietary information disclosed to or discovered by Consultant in connection with this Agreement, including, without limitation, nonpublic financial information, manuals, protocols, policies, procedures, marketing, and strategic information, Agency lists, computer software, training materials, resident/patient health information, resident/patient records, and resident/patient care and outcomes data ("Confidential Information") as and to the extent required by law. Consultant shall not use for its own benefit or disclose or otherwise disseminate to third parties, directly or indirectly, any Confidential Information without prior written consent from Agency, provided however that if Consultant grants Agency access to, and Agency uses, Consultant's databases or information sharing mechanisms, Agency's information may be provided to similar agencies and Agency hereby grants Agency's consent to such information sharing as a condition to Agency's receipt of access to such mechanisms and the data they contain form time to time. Upon termination of this Agreement, all Confidential Information and copies thereof shall be returned to Agency. Consultant and Agency shall comply with applicable federal, state and local laws and regulations with respect to all Confidential Information, including, but not limited to, any disclosures thereof pursuant to this section.

15. Notices. All notices which are required or which may be given pursuant to the terms of this Agreement shall be in writing and shall be sufficient in all respects if given in writing and delivered personally or by registered or certified mail, return receipt requested, or

by a comparable commercial delivery system, and notice shall be deemed to be given on the date hand-delivered or on the date which is three (3) business days after the date deposited in United States mail, or with a comparable commercial delivery system, with postage or other delivery charges thereon prepaid, at the addresses first set forth above or such other addresses as Agency and Consultant may designate by written notice to the other from time to time.

16. Arbitration.

16.1. Any controversy, dispute or claim arising in connection with the interpretation, performance or breach of this Lease, including any claim based on contract, tort or statute, shall be determined by final and binding, confidential arbitration with Judicial Mediation and Arbitration Service ("JAMS/Endispute") in Ada County, Idaho, provided that if JAMS/Endispute (or any successor organization thereto) no longer exists, then such arbitration shall be administered by the American Arbitration Association ("AAA") in accordance with its then-existing Commercial Arbitration Rules, and the sole arbitrator shall be selected in accordance with such AAA rules. Any arbitration hereunder shall be governed by the United States Arbitration Act, 9 U.S.C. 1-16 (or any successor legislation thereto), and judgment upon the award rendered by the arbitrator may be entered by any state or federal court having jurisdiction thereof. Neither Agency, Consultant, nor the arbitrator shall disclose the existence, content or results of any arbitration hereunder without the prior written consent of all parties; provided, however, that either party may disclose the existence, content or results of any such arbitration to its partners, officers, directors, employees, agents, attorneys and accountants and to any other Person to whom disclosure is required by applicable Legal Requirements, including pursuant to an order of a court of competent jurisdiction. Unless otherwise agreed by the parties, any arbitration hereunder shall be held at a neutral location selected by the arbitrator in Ada County, Idaho. The cost of the arbitrator and the expenses relating to the arbitration (exclusive of legal fees) shall be borne equally by Agency and Consultant unless otherwise specified in the award of the arbitrator, in which case such fees and costs paid or payable to the arbitrator shall be included in "reasonable costs and attorneys' fees" for purposes of Section 17.2, and the arbitrator shall specifically have the power to award to the prevailing party pursuant to such Section 17.2 such party's costs and expenses, including fees and costs paid to the arbitrator.

16.2. NOTICE: BY INITIALING IN THE SPACE BELOW YOU ARE AGREEING TO HAVE ANY DISPUTES ARISING IN THIS "ARBITRATION OF DISPUTES" PROVISION DECIDED BY NEUTRAL ARBITRATION AS PROVIDED HEREIN AND BY IDAHO LAW AND YOU ARE GIVING UP ANY RIGHTS YOU MIGHT POSSESS TO HAVE SUCH DISPUTE LITIGATED IN A COURT OR JURY TRIAL. BY INITIALING IN THE SPACE BELOW, YOU ARE GIVING UP YOUR JUDICIAL RIGHTS TO DISCOVERY AND APPEAL, UNLESS THOSE RIGHTS ARE SPECIFICALLY INCLUDED IN THIS "ARBITRATION OF DISPUTES" PROVISION. IF YOU REFUSE TO SUBMIT TO ARBITRATION AFTER AGREEING TO THIS PROVISION, YOU MAY BE COMPELLED TO ARBITRATE UNDER THE AUTHORITY OF THE IDAHO CODE OF CIVIL PROCEDURE. YOUR AGREEMENT OF THE PARTIES TO THIS ARBITRATION PROVISION IS VOLUNTARY.

BY INITIALLING BELOW YOU AFFIRM THAT YOU HAVE READ AND UNDERSTAND THE FOREGOING AND AGREE TO SUBMIT DISPUTES ARISING OUT OF THE MATTERS INCLUDED IN THIS "ARBITRATION OF DISPUTES" PROVISION TO NEUTRAL ARBITRATION.

CONSULTANT

AGENCY

17. Miscellaneous.

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

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

17.3. This Agreement shall be governed by the laws of the State of Idaho. Notwithstanding anything contained herein to the contrary, venue for any action involving this Agreement shall lie solely in Ada County, Idaho.

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

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

17.6. This Agreement shall binding upon the parties hereto, their heirs, successors and assigns. Notwithstanding the foregoing, the parties mutually acknowledge that a material and substantial consideration in the parties' mutual execution of this Agreement is the identity and reputation of the other party, and each party's subjective perception of the other's value to and compatibility with such party and its officers, employees, facilities and

patients. As such, notwithstanding anything contained herein to the contrary, this Agreement and the rights of the parties hereunder are personal to the parties and may not be assigned or subcontracted to, nor shall the duties and responsibilities of either hereunder be delegated to or rendered by, any other person or entity without the express prior written consent of the other party, which consent may be granted or denied, conditionally or unconditionally, by a party in its sole, absolute and unfettered discretion.

17.7. Notwithstanding the expiration or earlier termination of this Agreement, the obligations and/or liabilities of the parties hereunder, relating to events, occurring during the Term, to which the parties' indemnification obligations under Section 12 apply, shall continue in full force and effect after the Agreement terminates, subject to applicable statutes of limitation. Additionally, the covenants of the parties under Sections 11.4, 13, 14 and 16 shall survive the termination of this Agreement.

17.8. This Agreement is solely between the parties hereto, and shall not create any right or benefit in any third party, including without limitation any creditor, agent, partner, employee or affiliate of Current Operator, or any entity or agency having jurisdiction of any of the Licenses, the Agency or the operation of the business therein.

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

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

CONSULTANT:

CORNERSTONE SERVICE CENTER, INC.
a Nevada corporation

BY: _____
Brent Guerisoli
Authorized Agent
Date: November 22, 2021

AGENCY:

ORCHARD PRAIRIE HEALTHCARE LLC,
a Nevada limited liability company

BY: _____
Lee Johnson
Authorized Agent
Date: November 22, 2021

EXHIBIT A
CONSULTING, PROFESSIONAL, AND
OPERATIONAL SUPPORT SERVICES AGREEMENT
(Clinical Services)

THIS EXHIBIT A supplements the foregoing CONSULTING, PROFESSIONAL, AND OPERATIONAL SUPPORT SERVICES AGREEMENT (the "Agreement") made and entered into by and between the therein-named Consultant and Agency and forms a part thereof. The specific duties and obligations described herein may or may not be performed by either party, depending upon the needs, preferences and requests of the other from time to time. The lists of duties and activities are not exhaustive, but where certain duties or activities are expressly limited, excluded or proscribed hereby, such activities shall not be requested or performed. Consultant's services shall be rendered on a non-exclusive basis, and Consultant shall have no duty to limit its services solely to Agency. Any service to be rendered by Consultant hereunder may be, at Consultant's sole option, rendered on a joint or "pooled" basis with or to Agency and other clients of Consultant. Consultant may provide any of its services hereunder through the use or assistance of subcontractors, but such subcontractors shall be subject to all of the terms and conditions of this Agreement. Although Consultant shall have discretion to make certain decisions regarding its Services for Agency in the day-to-day rendition of such services, Agency shall remain solely responsible for all decisions and actions made by, at, for or involving Agency and the operation of Agency's business.

SPECIFIC SERVICES TO BE RENDERED BY CONSULTANT:

1. Technical & Compliance Resource.

A. Assists in the identification and, where requested by Agency the evaluation, of prospective candidates and contractors to serve in clinical and/or leadership roles in the Agency.

B. Assists in designing policies and procedures to periodically review the status of employees to ascertain continued compliance with local and state health regulations for the various specific categories of employees, and proper documentation of compliance.

C. Provides sample form clinical policy and procedure manuals, handbooks and forms; provided that all manuals, materials and forms provided in connection therewith shall be and remain the property of Consultant and may not be copied, reproduced, distributed or used other than with the express written permission of Consultant.

D. Provides a delegate to serve as a resource to and advisory member of the Agency's Quality Assessment and Performance Improvement Committee, who attends and participates in both quarterly and special QAPI meetings; provided that such delegate shall be subject to the same obligations of confidentiality as any other member of the Committee, but shall not be allowed to vote or direct the work of the Committee or the Agency.

E. Assists Agency management in preparing for, reviewing and responding to the various official surveys and inspections of Agency's premises and nursing practices.

F. Participates, solely as a resource and not as a director, in the development of patient care policies and systems for the Agency.

G. Assists in the identification and, where requested by Agency the evaluation, of prospective candidates and contractors to serve in nursing service, nursing, therapy service and other leadership and line staff roles in the Agency. In addition, and at Agency's request and at Agency's sole cost and expense, facilitates the sharing of nursing resource personnel, including specialists, among Agency and other clients of Consultant who wish to obtain such additional personnel and share the cost of hiring, training, and compensating such personnel.

H. Assists in designing policies and procedures to periodically review the health status of employees to ascertain freedom from infection, compliance with local and state health regulations for the various specific categories of employees, and proper documentation of compliance.

I. Participates, in an advisory capacity, with the utilization review committee to develop norms, standards and criteria for the design and conduct of the committee's medical care evaluation studies. However, Consultant shall not direct in any way the functions of the utilization review committee such as individual patient reviews.

J. Participates in the design and periodic evaluation of the Agency's staff development and nursing in-service programs, provided that all manuals, materials and forms provided in connection therewith shall be and remain the property of Consultant and may not be copied, reproduced, distributed or used other than with the express written permission of Consultant.

K. Provides periodic in-services and other formal and informal trainings as requested by Agency, which may be offered simultaneously and in conjunction with the trainings for other of Consultant's clients. Such trainings shall include no nursing, therapy or direct care services by Consultant's representatives, but may or may not include, without limitation, assistance with patient assessment, charting and similar activities when performed in connection with in-services, survey readiness reviews, mock surveys and other similar nursing consulting and training, in order to assist nursing leadership and staff in the lawful and efficient conduct of caregiving and therapy operations; provided that all trainings and materials provided in connection therewith shall be and remain the property of Consultant and may not be copied, reproduced, distributed or used other than with the express written permission of Consultant.

L. Assists in the development, implementation and periodic valuation of certified nursing assistant training programs and other experience-based nursing training activities, whether conducted by Agency or by a third-party educator at Agency's site under a nursing affiliation agreement.

ADDITIONAL DUTIES TO BE PERFORMED BY AGENCY:

Without limiting any other duty or obligation of Agency at law or under the Agreement, Agency shall do all of the following:

2. Agency shall be solely responsible for (i) naming and managing its own Governing Body as required by applicable laws and regulations, (ii) hiring, supervising and evaluating its administrator and other employees, and (iii) overseeing the day-to-day conduct of its business and related activities.

3. Agency shall be solely responsible for providing a safe and sanitary environment for Agency personnel.

4. Agency shall be solely responsible for (i) operating its business in and from the Agency location(s) in substantial compliance with applicable laws and regulations, (ii) maintaining all federal and state licenses and certifications required to operate the Agency and provide Services to patients and clients, (iii) performing all duties required of a licensee and provider under applicable local, state and federal laws, codes, regulations and provider agreements affecting the operation of the Agency, and (iv) notifying Consultant of any threatened, pending or actual revocation or suspension of its Licenses.

5. Timely furnish Consultant with such information and materials as might ordinarily be expected for Consultant to perform its duties hereunder. Agency shall be solely responsible to assure the accuracy and completeness of all information provided by Agency and its personnel to Consultant, and Consultant shall be entitled to rely thereon without inquiry or diligence of any kind.

6. Agency shall not unreasonably restrict or limit Consultant's access to necessary information, and acknowledges Consultant's right to exercise its independent professional judgment, including recommending Services and rendering such Services using such methods, technologies and procedures as Consultant deems appropriate.

7. Consultant's corporate address: 1675 E. Riverside Drive, Suite 150, Eagle, ID 83616, shall serve Agency's mailing address and address for service of process.

8. If requested by Consultant, Agency shall send delegates to Consultant's customer service teams, operator forums, evaluation and other service teams, trainings, and other committees and events as reasonably requested and available. In addition, to the extent available Agency delegates shall from time to time participate, both as trainees and trainers, in training and leadership conferences and events for the benefit of Consultant and others.

9. With Agency's acquiescence, and at Consultant's expense to the extent the trainee does not provide value to Agency, Agency agrees to periodically serve as a training site for Consultant's employees, providing (where available) preceptorship and organized training for CITs and other trainees of Consultant. In the event that a compensated trainee does not provide full value to Agency during his/her training program, Consultant shall pay directly, or reimburse Agency for, the portion of the trainee's compensation and training expenses that exceed the reasonable value provided.

Exhibit B

BUSINESS ASSOCIATE AGREEMENT

AGREEMENT EFFECTIVE DATE:	November 22, 2021
COVERED ENTITY:	**ORCHARD PRAIRIE HEALTHCARE LLC** ADDRESS: , ,
BUSINESS ASSOCIATE:	**CORNERSTONE SERVICE CENTER, INC.** ADDRESS: 1675 E. RIVERSIDE DRIVE, SUITE 200, EAGLE, ID 83616

This Business Associate Agreement ("Agreement") is made and entered into as of the Effective Date listed in this Exhibit B, and between the above-listed Covered Entity and Business Associate, with reference to the following facts:

RECITALS

WHEREAS, Business Associate has been engaged to provide staffing services to Covered Entity pursuant to a separate agreement (the "Services Agreement"), and, in connection with those services, Covered Entity may need to disclose to Business Associate, or Business Associate may need to create on Covered Entity's behalf, certain Protected Health Information (as defined below) that is subject to protection under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("HITECH Act"), and regulations promulgated thereunder by the U.S. Department of Health and Human Services to implement certain privacy and security provisions of HIPAA (the "HIPAA Regulations"), codified at 45 C.F.R. Parts 160 and 164; and

WHEREAS, pursuant to the HIPAA Regulations, all business associates of Covered Entity, as a condition of doing business with Covered Entity, must agree in writing to certain mandatory provisions regarding the privacy and security of PHI (as defined below).

NOW THEREFORE, IN CONSIDERATION OF THE FOREGOING, and the mutual promises and covenants contained herein, Business Associate and Covered Entity agree as follows:

AGREEMENT

Definitions.

Unless otherwise specified in this Agreement, all terms not otherwise defined shall have the meanings established in Title 45, Parts 160 and 164, of the United States Code of Federal Regulations, as amended from time to time. Further, capitalized terms used, but not otherwise defined, in this Agreement shall have the meanings set forth in HIPAA, the HIPAA Regulations and the HITECH Act.

1.1 *Breach* shall have the meaning given to such term in 42 U.S.C. § 17921, and shall include the unauthorized acquisition, access, use, or disclosure of PHI which compromises the security or privacy of such information.

1.2 *Business Associate* shall have the meaning given to such phrase under the HIPAA Regulations and the HITECH Act, including, but not limited to, 45 C.F.R. § 160.103 and 42 U.S.C. § 17938, respectively. For purposes of this Agreement, "Business Associate" shall also refer specifically to the entity or individual set forth in the Preamble above.

1.3 *Covered Entity* shall have the meaning given to such phrase under the HIPAA Regulations including, but not limited to, 45 C.F.R. § 160.103. For purposes of this Agreement, "Covered Entity" shall also refer specifically to the entity set forth in the Preamble above.

1.4 *Data Aggregation* shall have the meaning given to such phrase under the Privacy Rule, including, but not limited to, 45 C.F.R. § 164.501.

1.5 *Designated Record Set* means a group of records maintained by or for Covered Entity that may include (i) medical records and billing records about Individuals maintained by or for a covered health care provider, (ii) the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan, or (iii) records used, in whole or in part, by or for Covered Entity to make decisions about Individuals.

1.6 *Electronic Health Record* shall have the meaning given to such phrase in the HITECH Act, including, but not limited to, 42 U.S.C. § 17921(5).

1.7 *Electronic Protected Health Information* ("ePHI") means individually identifiable health information that is transmitted by, or maintained in, electronic media.

1.8 *Health Care Operations* shall have the meaning given to such phrase under the Privacy Rule, including, but not limited to, 45 C.F.R. § 164.501.

1.9 *Individual* has the same meaning as the term *individual* in 45 C.F.R. § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).

1.10 *Privacy Rule* shall mean the Standards for Privacy of Individually Identifiable Health Information codified at 45 C.F.R. Part 160 and Part 164, Subparts A and E, as amended by the HITECH Act and as may otherwise be amended from time to time.

1.11 *Protected Health Information* ("PHI") means any information, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an Individual; the provision of health care to an Individual; or the past, present or future payment for the provision of health care to an Individual; and (ii) that identifies the Individual or with respect to which there is a reasonable basis to believe the information can be used to identify that Individual; and (iii) shall include the definition as set forth in the Privacy Rule including, but not limited to, 45 C.F.R. § 160.103. For purposes of this Agreement, PHI shall include ePHI.

1.12 *Required By Law* shall have the same meaning as the phrase *required by law* in 45 C.F.R. § 164.103.

1.13 *Secretary* means the Secretary of the U.S. Department of Health and Human Services or his/her designee.

1.14 *Security Incident* means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

1.15 *Security Rule* shall mean the HIPAA Regulations that are codified at 45 C.F.R. Part 160 and Part 164, Subparts A and C, as amended by the HITECH Act and as may otherwise be amended from time to time.

1.16 *Unsecured PHI* shall mean PHI that is not secured through the use of a technology or methodology specified by the Secretary in guidance or as otherwise defined in 42 U.S.C. § 17932(h).

Scope of Agreement.

This Agreement applies to the PHI of Covered Entity to which Business Associate may be exposed as a result of the services that Business Associate will provide to Covered Entity pursuant to the Services Agreement. Business Associate shall abide by HIPAA, the HIPAA Regulations and the HITECH Act with respect to PHI of Covered Entity, as outlined below.

Obligations and Activities of Business Associate.

3.1 *Permitted Uses*. Except as otherwise limited in this Agreement, Business Associate may use PHI (i) for the proper management and administration of Business Associate, (ii) to carry out the legal responsibilities of Business Associate, or (iii) for Data Aggregation purposes for the Health Care Operations of Covered Entity. Business Associate may use PHI to provide services to Covered Entity under the Services Agreement provided that Business Associate shall not use PHI in any manner that would constitute a violation of the Privacy Rule or the HITECH Act if so used by Covered Entity.

3.2 *Permitted Disclosures*. Business Associate may disclose PHI (i) for the proper management and administration of Business Associate; (ii) to carry out the legal responsibilities of Business Associate; (iii) as Required By Law; or (iv) for Data Aggregation purposes for the Health Care Operations of Covered Entity. Business Associate may disclose PHI to provide services to Covered Entity under the Services Agreement, provided that Business Associate shall not disclose PHI in any manner that would constitute a violation of the Privacy Rule or the HITECH Act if so disclosed by Covered Entity.

3.2.1 In addition, if Business Associate discloses PHI to a third party, for Business Associate's management and administration purposes as specified in Section 3.2, Business Associate must obtain, prior to making any such disclosure, (i) reasonable written assurances from such third party that the PHI will be held as confidential as provided pursuant to this Agreement and only disclosed as Required By Law or for the purposes for which it was disclosed to such third party; and (ii) a written agreement from such third party to immediately notify Business Associate of any breaches of confidentiality of the PHI, to the extent such third party has obtained knowledge of such breach.

3.3 *Prohibited Uses and Disclosures*. Business Associate shall not use or disclose PHI for fundraising or marketing purposes. In accordance with 42 U.S.C. § 17935(a), Business Associate shall not disclose PHI to a health plan for payment or Health Care Operations purposes if the patient has requested this special restriction, and has paid out of pocket in full for the health care item or service to which the PHI solely relates. Business Associate shall not directly or indirectly receive remuneration in exchange for PHI, except with the prior written consent of Covered Entity and Individual and as permitted by 42 U.S.C. § 17935(d)(1) and (2); however, this prohibition shall not affect payment by Covered Entity to Business Associate for services provided pursuant to the Services Agreement.

3.4 *Other Business Associates.* As part of its providing functions, activities, and/or services to Covered Entity, Business Associate may disclose information, including PHI, to other business associates of Covered Entity, and Business Associate may use and disclose information, including PHI, received from other business associates of Covered Entity as if this information was received from, or originated with, Covered Entity.

3.5 *Safeguards for Protection of ePHI*. Business Associate agrees to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of Covered Entity. In accordance with 42 U.S.C. § 17931 of the HITECH Act, Business Associate shall be directly responsible for full compliance with the policies and procedures and documentation requirements of the HIPAA Security Rule, including, but not limited to, 45 C.F.R. §§ 164.308, 164.310, 164.312, and 164.316. Business Associate shall implement and at all times use all appropriate safeguards to prevent any use or disclosure of PHI not authorized under this Agreement.

3.6 *Reporting of Unauthorized Uses or Disclosures and Security Incidents*. Business Associate agrees to report to Covered Entity in writing any access, use or disclosure of the PHI not provided for or permitted by this Agreement and, any Security Incidents of which Business Associate (or Business Associate's employee, officer or agent) becomes aware. Business Associate shall so notify Covered Entity pursuant to this Section within twenty-four (24) hours after Business Associate becomes aware of such unauthorized use, disclosure or Security Incident. The notice to be provided pursuant to this Section shall be substantially in the same form as **Exhibit 1**, which is attached hereto.

3.7 *Reporting of Breach of Unsecured PHI*. Business Associate agrees to report to Covered Entity any Breach of Unsecured PHI of which Business Associate (or Business Associate's employee, officer or agent) becomes aware without unreasonable delay and in no case later than the next business day after Business Associate learns of such Breach, except where a law enforcement official determines that a notification would impede a criminal investigation or cause damage to national security. Business Associate's notification to Covered Entity hereunder shall be substantially in the same form as **Exhibit 1**.

3.8 *Agents and Subcontractors.* Business Associate agrees to ensure that any agent, including a subcontractor, to whom Business Associate provides PHI, agrees in writing to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such PHI, and implement the safeguards required by Section 3.5 above with respect to ePHI.

3.9 *Mitigation of Unauthorized Uses or Disclosures*. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate or one of its agents or subcontractors in violation of the requirements of this Agreement.

3.10 *Authorized Access to PHI*.

3.10.1 *Individual Requests for Access*. Business Associate shall cooperate with Covered Entity to fulfill all requests by Individuals for access to the Individual's PHI that are approved by Covered Entity. Business Associate shall cooperate with Covered Entity in all respects necessary for Covered Entity to comply with 45 C.F.R. §164.524 and applicable State law. If Business Associate receives a request from an Individual for access to PHI, Business Associate shall immediately forward such request to Covered Entity.

3.10.2 *Scope of Disclosure*. Covered Entity shall be solely responsible for determining the scope of PHI and/or Designated Record Set with respect to each request by an Individual for access to PHI. In the event that Covered Entity decides to charge a reasonable cost-based fee for the reproduction and delivery of PHI to an Individual, Covered Entity shall deliver a

portion of this fee to Business Associate in the event any such reproduction or delivery is made by Business Associate, and in proportion to the amount of work done by Business Associate in producing and delivering the PHI.

3.10.3 Designated Record Set. To the extent that Business Associate maintains PHI in a Designated Record Set and at the request of Covered Entity, Business Associate agrees to provide access to PHI in a Designated Record Set to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 C.F.R. § 164.524 and applicable State law. If Business Associate maintains PHI in a Designated Record Set, and maintains an Electronic Health Record, then Business Associate shall provide such Designated Record Set in electronic format to enable Covered Entity to fulfill its obligations under the HITECH Act, including, but not limited to, 42 U.S.C. § 17935(e).

3.10.4 Patient Right to Amend to PHI. A patient has the right to have Covered Entity amend his/her PHI, or a record in a Designated Record Set for as long as the PHI is maintained in the Designated Record Set, in accordance with 42 C.F.R. §164.526. To the extent that Business Associate maintains PHI in a Designated Record Set, Business Associate agrees to make any amendment(s) to PHI in a Designated Record Set at the request of Covered Entity in accordance with 45 C.F.R. § 164.526. Within fifteen (15) business days following Business Associate's amendment of PHI as directed by Covered Entity, Business Associate shall provide written notice to Covered Entity confirming that Business Associate has made the amendments or addenda to PHI as directed by Covered Entity and containing any other information as may be necessary for Covered Entity to provide adequate notice to the Individual in accordance with 45 C.F.R. §164.526.

3.11 Accounting for Disclosures.

3.11.1 Disclosures. In the event that Business Associate makes any disclosures of PHI that are subject to the accounting requirements of the Privacy Rule 45 C.F.R. §164.528 and/or the HITECH Act including, but not limited to, 42 U.S.C. § 17935(c))[1], Business Associate shall report such disclosures to Covered Entity within three (3) days of such disclosure. The notice by Business Associate to Covered Entity of the disclosure shall include the name of the Individual, the recipient, the reason for disclosure, and the date of the disclosure. Business Associate shall maintain a record of each such disclosure that shall include: (i) the date of the disclosure; (ii) the name and, if available, the address of the recipient of the PHI; (iii) a brief description of the PHI disclosed; and (iv) a brief description of the purpose of the disclosure. Business Associate shall maintain this record for a period of six (6) years and make it available to Covered Entity upon request in an electronic format so that Covered Entity may meet its disclosure accounting obligations under 45 C.F.R. §164.528. If Covered Entity provides a list of its business associates to an Individual in response to a request by an Individual for an accounting of disclosures, and the Individual thereafter specifically requests an accounting of disclosures from Business Associate, then Business Associate shall provide an accounting of disclosures to such Individual.

3.11.2 Electronic Health Record. Business Associate acknowledges that, to the extent Business Associate maintains an Electronic Health Record for Covered Entity, Business Associate is only required to provide an Individual with an accounting of disclosures related to treatment, payment or Health Care Operations for a period of three (3) years prior to such Individual's request. Therefore, upon request by an Individual to Covered Entity for an accounting of disclosures related to treatment, payment or Health Care Operations, Business Associate shall provide to Covered Entity, within three (3) days of Business

[1] The provisions of 42 U.S.C. § 17935(c) become effective on the following dates: (i) for users of electronic health records as of January 1, 2009, this section shall apply to disclosures made by the Covered Entity on and after January 1, 2014; (ii) for covered entities that acquire an electronic health record after January 1, 2009, this section shall apply to disclosures made by the Covered Entity after the later of January 1, 2011 or the date it acquires an electronic health record.

Associate's receipt of a written request from Covered Entity, an accounting of such disclosures for the three (3) year period prior to such request. Notwithstanding this Section, a record of disclosures pertaining to information disclosed by Business Associate for treatment, payment or Health Care Operations shall be maintained in accordance with Section 3.11.1, above.

3.12 *Secretary's Right to Audit*. Business Associate agrees to make its internal practices, books, and records relating to the use and disclosure of PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity, available to the Secretary for purposes of the Secretary determining Covered Entity's and/or Business Associate's compliance with HIPAA, the HIPAA Regulations and the HITECH Act. No attorney-client, or other legal privilege will be deemed to have been waived by Business Associate by virtue of this provision of the Agreement. Business Associate shall provide to Covered Entity a copy of any PHI and related documents that Business Associate provides to the Secretary concurrently with providing such documents to the Secretary.

3.13 *Data Ownership*. All PHI shall be deemed owned by Covered Entity unless otherwise agreed in writing.

3.14 *Compliance*. To the extent Business Associate is to carry out a Covered Entity's obligation under the HIPAA Privacy Regulations, Business Associate shall comply with the requirements of the Privacy Regulations that apply to Covered Entity in the performance of such obligation.

4 **Obligations of Covered Entity**.

4.1 *Notice of Privacy Practices*. Upon written request by Business Associate, Covered Entity shall provide Business Associate with Covered Entity's then current Notice of Privacy Practices.

4.2 *Revocation of Permitted Use or Disclosure of PHI*. Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by the patient to use or disclose PHI of Covered Entity, to the extent that such changes may affect Business Associate's use or disclosure of PHI of Covered Entity.

4.3 *Restrictions on Use or Disclosure of PHI*. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 C.F.R. § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

4.4 *Requested Uses or Disclosures of PHI*. Except for Data Aggregation or management and administrative activities of Business Associate, Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the HIPAA Regulations if done by Covered Entity.

5 **Term and Termination**.

5.1 *Term*. The term of this Agreement shall be coterminous with the Services Agreement. However, Business Associate shall have a continuing obligation to safeguard the confidentiality of PHI received from Covered Entity after the termination of the Services Agreement.

5.2 *Termination Without Cause*. Either party may terminate this Agreement without cause or penalty by the delivery of a written notice from the terminating party to the other party. Such termination is effective thirty (30) calendar days from the date that the other party receives such notice.

5.3 *Termination for Cause*. A breach of any provision of this Agreement by Business Associate shall constitute a material breach of this Agreement and shall provide grounds for immediate termination

of this Agreement by Covered Entity, any provision in this Agreement to the contrary notwithstanding.

5.4 *Judicial or Administrative Proceedings*. Either party may terminate the Agreement, effective immediately, if (i) the other party is named as a defendant in a criminal proceeding for a violation of HIPAA, the HIPAA Regulations, the HITECH Act, or other security or privacy laws or (ii) a finding or stipulation that the other party has violated any standard or requirement of HIPAA, the HIPAA Regulations, the HITECH Act or other security or privacy laws is made in any administrative or civil proceeding in which the party has been joined.

5.5 *Effect of Termination*.

5.5.1 Except as provided in Section 5.5.2, herein, upon termination of this Agreement for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity, including PHI in possession of any Business Associate's subcontractors and retain no copies or backup records of such PHI in any form or medium. Business Associate shall certify in writing to Covered Entity that such PHI has been destroyed.

5.5.2 In the event that Business Associate determines that returning or destroying the PHI is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction unfeasible. Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures to those purposes that make the return or destruction of the PHI unfeasible, for so long as Business Associate maintains such PHI.

6 **Breach Pattern or Practice**.

If either party (the "Non-Breaching Party") knows of a pattern of activity or practice of the other party (the "Breaching Party") that constitutes a material breach or violation of the Breaching Party's obligations under this Agreement, the Non-Breaching Party shall either (i) terminate this Agreement in accordance with Section 5 above, or (ii) take reasonable steps to cure the breach or end the violation. If the steps are unsuccessful, the Non-Breaching Party must terminate the Agreement if feasible. The Non-Breaching Party shall provide written notice to the Breaching Party of any pattern of activity or practice of the Breaching Party that the Non-Breaching Party believes constitutes a material breach or violation of the Breaching Party's obligations under this Agreement within three (3) days of discovery and shall meet with the Breaching Party's Privacy Coordinator to discuss and attempt to resolve the problem as one of the reasonable steps to cure the breach or end the violation.

7 **Disclaimer**.

Covered Entity makes no warranty or representation that compliance by Business Associate with this Agreement, HIPAA, the HIPAA Regulations, or the HITECH Act will be adequate or satisfactory for Business Associate's own purposes. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.

8 **Certification**.

To the extent that Covered Entity determines that such examination is necessary to comply with Covered Entity's legal obligation pursuant to HIPAA, the HIPAA Regulations, and the HITECH Act, Covered Entity or its authorized agents or contractors may, at Covered Entity's expense, examine Business Associate's facilities, systems, procedures (including but not limited to review of training procedures for Business Associate's staff) and records as may be necessary for such agents or contractors to certify to Covered Entity the extent to which Business Associate's security safeguards comply with HIPAA, the HIPAA Regulations, the HITECH Act, and this Agreement.

9 **Indemnification**.

Notwithstanding any contrary provision in the Services Agreement, Business Associate agrees to indemnify, defend and hold harmless Covered Entity, its shareholders, directors, officers, employees, affiliates, and agents ("Indemnified Party") against all actual and direct losses suffered by the Indemnified Party from any breach of this Agreement, negligence or wrongful acts or omissions, including, without limitation, failure to perform its obligations under this Agreement or Breach of Unsecured PHI, by Business Associate or its employees, directors, officers, subcontractors, agents or other members of its workforce. Accordingly, on demand, Business Associate shall reimburse the Indemnified Party for any and all actual and direct losses, liabilities, lost profits, fines, penalties, costs or expenses (including reasonable attorneys' fees) which may for any reason be incurred by Indemnified Party or imposed upon the Indemnified Party by reason of any suit, claim, action, proceeding or demand by any third party, as a result of the Business Associate's breach hereunder.

10 **Compliance With State Law**.

Business Associate acknowledges that Business Associate and Covered Entity may have confidentiality and privacy obligations under applicable State law. If any provisions of this Agreement or HIPAA/HIPAA Regulations/HITECH Act conflict with state law regarding the degree of protection provided for PHI and patient medical records, then Business Associate shall comply with the more restrictive requirements.

11 **Miscellaneous**.

11.1 *Amendment*. Business Associate and Covered Entity agree to take such action as is necessary to amend this Agreement from time to time to enable Covered Entity to comply with the requirements of HIPAA, the HIPAA Regulations and the HITECH Act. This Agreement may not be modified, nor shall any provision hereof be waived or amended, except in a writing duly signed and agreed to by Business Associate and Covered Entity.

11.2 *Interpretation*. The provisions of this Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HIPAA Regulations, the HITECH Act, the Privacy Rule and the Security Rule. The parties agree that any ambiguity in this Agreement shall be resolved in favor of a meaning that complies and is consistent with HIPAA, the HIPAA Regulations, the HITECH Act, the Privacy Rule and the Security Rule.

11.3 *No Third Party Beneficiaries*. Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than Business Associate and Covered Entity, and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.

11.4 *Notices*. All notices or other communications required or permitted hereunder shall be in writing and shall be deemed given or delivered (i) when delivered personally, against written receipt; (ii) if sent by registered or certified mail, return receipt requested, postage prepaid, when received; (iii) when received by facsimile transmission; or (iv) when delivered by a nationally recognized overnight courier service, prepaid, and shall be sent to the addresses set forth on the signature page of this Agreement or at such other address as each party may designate by written notice to the other by following this notice procedure.

11.5 *Regulatory References*. A reference in this Agreement to a section in the HIPAA Regulations or the HITECH Act means the section as in effect or as amended, and for which compliance is required.

11.6 *Assistance in Litigation or Administrative Proceedings*. Business Associate shall make itself, and any subcontractors, employees or agents, available to Covered Entity, at no cost to Covered Entity, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being

commenced against Covered Entity, its directors, officers or employees based upon a claimed violation of HIPAA, the HIPAA Regulations, the HITECH Act, the Privacy Rule, the Security Rule, or other laws relating to security and privacy, except where Business Associate or its subcontractor, employee or agent is a named adverse party.

11.7 *Subpoenas*. In the event that Business Associate receives a subpoena or similar notice or request from any judicial, administrative or other party arising out of or in connection with this Agreement, including, but not limited to, any unauthorized use or disclosure of PHI, Business Associate shall promptly forward a copy of such subpoena, notice or request to Covered Entity and afford Covered Entity the opportunity to exercise any rights it may have under law.

11.8 *Survival*. The respective rights and obligations of Business Associate under Section 3 et seq. of this Agreement shall survive the termination of this Agreement. In addition, Section 5.5 (Effect of Termination), Section 7 (Disclaimer), Section 9 (Indemnification), Section 10 (Compliance with State Law), Section 11.4 (Notices), Section 11.6 (Assistance in Litigation and Administrative Proceedings), Section 11.7 (Subpoenas), and Section 11.9 (Governing Law) shall survive the termination of this Agreement.

11.9 *Governing Law*. This Agreement shall be governed by and construed in accordance with the laws of the state in which the covered entity is principally located to the extent that the provisions of HIPAA, the HIPAA Regulations or the HITECH Act do not preempt the laws of that state.

11.10 *Independent Contractors*. Covered Entity and Business Associate shall be independent contractors and nothing in this Agreement is intended nor shall be construed to create an agency, partnership, employer-employee, or joint venture relationship between them.

[Signature Page to follow]

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

COVERED ENTITY: Orchard Prairie Healthcare LLC

Sign: 

Name: Brian Wayment

Title: Authorized Agent

Date: November 22, 2021

BUSINESS ASSOCIATE: Cornerstone Service Center, Inc.

Sign: 

Name: Lee Johnson

Title: Authorized Agent

Date: November 22, 2021

Exhibit 1

Notification to Orchard Prairie Healthcare LLC of
Unauthorized Use or Disclosure of PHI/Breach of Unsecured PHI

Attn: Privacy Officer
Orchard Prairie Healthcare LLC
Phone:
Fax:
Email: _____

This notification is made pursuant to Sections 3.6 and 3.7 of the Business Associate Agreement between Covered Entity and Business Associate.

Business Associate hereby notifies Covered Entity that there has been a breach of protected health information ("PHI") that Business Associate has used or has had access to under the terms of the Business Associate Agreement.

Description of the breach: _____
_____

Date of the breach: _____

Date of the discovery of the breach: _____

Number of individuals affected by the breach: _____

The types of PHI that were involved in the breach (e.g., full name, Social Security number, date of birth, home address, account number): _____
_____

Description of what Business Associate is doing to investigate the breach, mitigate losses, and protect against further breaches: _____
_____
_____
_____

Business Associate contact information: _____
_____
_____

DEREK BUNKER
CIO & SECRETARY
THE PENNANT GROUP, INC.

direct line (949) 540-1931
fax (208) 576-6909
dbunker@pennantservices.com

November 22, 2021

Wells Fargo Bank, N.A.
333 South Grand Avenue, 6th Floor
Los Angeles CA 90071

Re: Orchard Prairie Healthcare LLC
1675 E. Riverside Drive, Suite 150
Eagle, ID 83616
EIN: 87-3670377

Dear Sir or Madam:

The purpose of this letter is to certify that Orchard Prairie Healthcare LLC is a wholly-owned subsidiary of Cornerstone Healthcare, Inc., which is a wholly-owned subsidiary of The Pennant Group, Inc.

If you should have any questions regarding this matter, please feel free to contact Sara Kennedy at 208-401-1360.

Best Regards,

Derek Bunker
Chief Investment Officer & Secretary

EXHIBIT 9

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

FORM 10-Q

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

For the quarterly period ended March 31, 2023.

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

For the transition period from _____ to _____.

Commission file number: 001-38900

THE PENNANT GROUP, INC.

(Exact Name of Registrant as Specified in Its Charter)

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

1675 East Riverside Drive, Suite 150, Eagle, ID 83616
(Address of Principal Executive Offices and Zip Code)
(208) 506-6100
(Registrant's Telephone Number, Including Area Code)
None
(Former name, former address and former fiscal year, if changed since last report)

Securities registered pursuant to Section 12(b) of the Act:

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

Securities registered pursuant to Section 12(g) of the Act: None

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

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

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

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

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

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

As of May 3, 2023, 29,740,003 shares of the registrant's common stock were outstanding.

THE PENNANT GROUP, INC.
QUARTERLY REPORT ON FORM 10-Q
FOR THE THREE MONTHS ENDED MARCH 31, 2023
TABLE OF CONTENTS

PART I. FINANCIAL INFORMATION

Item I. *Financial Statements*

THE PENNANT GROUP, INC.
CONDENSED CONSOLIDATED BALANCE SHEETS
(unaudited, in thousands, except par value)

	March 31, 2023	December 31, 2022
Assets		
Current assets:		
Cash	$ 2,952	$ 2,079
Accounts receivable—less allowance for doubtful accounts of $573 and $592, respectively	50,660	53,420
Prepaid expenses and other current assets	13,140	18,323
Total current assets	66,752	73,822
Property and equipment, net	26,947	26,621
Right-of-use assets	264,109	260,868
Deferred tax assets, net	1,372	2,149
Restricted and other assets	10,652	10,545
Goodwill	79,497	79,497
Other indefinite-lived intangibles	58,827	58,617
Total assets	$ 508,156	$ 512,119
Liabilities and equity		
Current liabilities:		
Accounts payable	$ 12,161	$ 13,647
Accrued wages and related liabilities	20,495	23,283
Operating lease liabilities—current	16,856	16,633
Other accrued liabilities	16,116	16,684
Total current liabilities	65,628	70,247
Long-term operating lease liabilities—less current portion	250,041	247,042
Other long-term liabilities	6,240	6,281
Long-term debt, net	57,023	62,892
Total liabilities	378,932	386,462
Commitments and contingencies		
Equity:		
Common stock, $0.001 par value; 100,000 shares authorized; 30,203 and 29,729 shares issued and outstanding, respectively, at March 31, 2023; and 30,149 and 29,692 shares issued and outstanding, respectively, at December 31, 2022	29	29
Additional paid-in capital	101,334	99,764
Retained earnings	23,134	21,284
Treasury stock, at cost, 3 shares at March 31, 2023 and December 31, 2022	(65)	(65)
Total Pennant Group, Inc. stockholders' equity	124,432	121,012
Noncontrolling interest	4,792	4,645
Total equity	129,224	125,657
Total liabilities and equity	$ 508,156	$ 512,119

See accompanying notes to condensed consolidated financial statements.

THE PENNANT GROUP, INC.
CONDENSED CONSOLIDATED STATEMENTS OF INCOME
(unaudited, in thousands, except for per-share amounts)

	Three Months Ended March 31,	
	2023	2022
Revenue	$ 126,464	$ 113,910
Expense		
Cost of services	102,602	90,261
Rent—cost of services	9,597	10,051
General and administrative expense	8,705	10,033
Depreciation and amortization	1,280	1,147
Loss on asset dispositions and impairment, net	—	92
Total expenses	122,184	111,584
Income from operations	4,280	2,326
Other income (expense):		
Other income	30	3
Interest expense, net	(1,406)	(629)
Other (expense), net	(1,376)	(626)
Income before provision for income taxes	2,904	1,700
Provision for income taxes	907	542
Net income	1,997	1,158
Less: net income attributable to noncontrolling interest	147	144
Net income and other comprehensive income attributable to The Pennant Group, Inc.	$ 1,850	$ 1,014
Earnings per share:		
Basic	$ 0.06	$ 0.04
Diluted	$ 0.06	$ 0.03
Weighted average common shares outstanding:		
Basic	29,751	28,572
Diluted	30,147	30,143

See accompanying notes to condensed consolidated financial statements.

THE PENNANT GROUP, INC.
CONDENSED CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
(unaudited, in thousands)

	Common Stock		Additional Paid-In Capital	Retained Earnings	Treasury Stock		Non-controlling Interest	Total
	Shares	Amount			Shares	Amount		
Balance at December 31, 2022	30,149	$ 29	$ 99,764	$ 21,284	3	$ (65)	$ 4,645	$ 125,657
Net income attributable to The Pennant Group, Inc.	—	—	—	1,850	—	—	—	1,850
Net income attributable to noncontrolling interests	—	—	—	—	—	—	147	147
Share-based compensation	—	—	1,367	—	—	—	—	1,367
Issuance of common stock from the exercise of stock options	57	—	203	—	—	—	—	203
Net issuance of restricted stock	(3)	—	—	—	—	—	—	—
Balance at March 31, 2023	30,203	$ 29	$ 101,334	$ 23,134	3	$ (65)	$ 4,792	$ 129,224

	Common Stock		Additional Paid-In Capital	Retained Earnings	Treasury Stock		Non-controlling Interest	Total
	Shares	Amount			Shares	Amount		
Balance at December 31, 2021	28,826	$ 28	$ 95,595	$ 14,641	3	$ (65)	$ 4,045	$ 114,244
Net income attributable to The Pennant Group, Inc.	—	—	—	1,014	—	—	—	1,014
Net income attributable to noncontrolling interests	—	—	—	—	—	—	144	144
Share-based compensation	—	—	2,440	—	—	—	—	2,440
Issuance of common stock from the exercise of stock options	21	1	89	—	—	—	—	90
Net issuance of restricted stock	2	—	—	—	—	—	—	—
Balance at March 31, 2022	28,849	$ 29	$ 98,124	$ 15,655	3	$ (65)	$ 4,189	$ 117,932

See accompanying notes to condensed consolidated financial statements.

THE PENNANT GROUP, INC.
CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS
(unaudited, in thousands)

	Three Months Ended March 31,	
	2023	**2022**
Cash flows from operating activities:		
Net income	$ 1,997	$ 1,158
Adjustments to reconcile net income to net cash provided by (used in) operating activities:		
Depreciation and amortization	1,280	1,147
Amortization of deferred financing fees	130	129
Impairment of long-lived assets	—	97
Provision for doubtful accounts	151	184
Share-based compensation	1,367	2,440
Deferred income taxes	776	1,749
Change in operating assets and liabilities, net of acquisitions:		
Accounts receivable	3,166	(3,161)
Prepaid expenses and other assets	4,317	(4,665)
Operating lease obligations	(18)	120
Accounts payable	(772)	367
Accrued wages and related liabilities	(2,788)	(794)
Other accrued liabilities	(1,077)	1,635
Contract liabilities (CARES Act advance payments)	—	(4,722)
Other long-term liabilities	467	245
Net cash provided by (used in) operating activities	8,996	(4,071)
Cash flows from investing activities:		
Purchase of property and equipment	(2,314)	(2,392)
Other	(12)	(190)
Net cash used in investing activities	(2,326)	(2,582)
Cash flows from financing activities:		
Proceeds from Revolving Credit Facility	40,500	11,000
Payments on Revolving Credit Facility	(46,500)	(6,000)
Issuance of common stock upon the exercise of options	203	90
Net cash (used in) provided by financing activities	(5,797)	5,090
Net increase (decrease) in cash	873	(1,563)
Cash beginning of period	2,079	5,190
Cash end of period	$ 2,952	$ 3,627

See accompanying notes to condensed consolidated financial statements.

THE PENNANT GROUP, INC.
CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS - (Continued)
(unaudited, in thousands)

	Three Months Ended March 31,	
	2023	**2022**
Supplemental disclosures of cash flow information:		
Cash paid (received) during the period for:		
Interest	$ 1,536	$ 499
Income taxes	$ 30	$ (55)
Lease liabilities	$ 8,927	$ 9,516
Right-of-use assets obtained in exchange for new operating lease obligations	$ 7,489	$ 631
Non-cash adjustment to right-of-use assets and lease liabilities from lease modifications	$ —	$ 9,349
Non-cash adjustment to right-of-use assets and lease liabilities from lease terminations and assignments	$ —	$ (33,804)
Non-cash investing activity:		
Capital expenditures in accounts payable	$ 566	$ 720

See accompanying notes to condensed consolidated financial statements.

THE PENNANT GROUP INC.
NOTES TO THE CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(In thousands, except per share data and operational senior living units)

1. DESCRIPTION OF BUSINESS

The Pennant Group, Inc. (herein referred to as "Pennant," the "Company," "it," or "its"), is a holding company with no direct operating assets, employees or revenue. The Company, through its independent operating subsidiaries, provides healthcare services across the post-acute care continuum. As of March 31, 2023, the Company's subsidiaries operated 96 home health, hospice and home care agencies and 51 senior living communities located in Arizona, California, Colorado, Idaho, Iowa, Montana, Nevada, Oklahoma, Oregon, Texas, Utah, Washington, Wisconsin and Wyoming.

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

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

2. BASIS OF PRESENTATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation - The accompanying unaudited condensed consolidated financial statements of the Company (the "Interim Financial Statements") reflect the Company's financial position, results of operations and cash flows of the business. The Interim Financial Statements have been prepared in accordance with accounting principles generally accepted in the United States ("GAAP") and pursuant to the regulations of the Securities and Exchange Commission ("SEC"). Management believes that the Interim Financial Statements reflect, in all material respects, all adjustments which are of a normal and recurring nature necessary to present fairly the Company's financial position, results of operations, and cash flows for the periods presented in conformity with GAAP. The results reported in these Interim Financial Statements are not necessarily indicative of results that may be expected for the entire year.

The Condensed Consolidated Balance Sheet as of December 31, 2022 is derived from the Company's annual audited Consolidated Financial Statements for the fiscal year ended December 31, 2022, which should be read in conjunction with these Interim Financial Statements. Certain information in the accompanying footnote disclosures normally included in annual financial statements was condensed or omitted for the interim periods presented in accordance with GAAP.

All significant intercompany transactions and balances between the various legal entities comprising the Company have been eliminated in consolidation. The Company presents noncontrolling interests within the equity section of its Condensed Consolidated Balance Sheets and the amount of consolidated net income that is attributable to the Company and the noncontrolling interest in its Condensed Consolidated Statements of Income.

The Company consists of various limited liability companies and corporations established to operate home health, hospice, home care, and senior living operations. The Interim Financial Statements include the accounts of all entities controlled by the Company through its ownership of a majority voting interest.

Certain prior quarter amounts have been reclassified from cost of sales to loss on asset dispositions and impairment of assets, net for consistency with the current period presentation. These reclassifications had no effect on the reported results of operations in the current period or prior period.

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

CARES Act: The Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act") was enacted on March 27, 2020 in the United States. The CARES Act allowed for deferred payment of the employer-paid portion of social security taxes through the end of 2020, with 50% due on December 31, 2021 and the remainder due on December 31, 2022. The Company deferred approximately $7,836 of the employer-paid portion of social security taxes, all of which was repaid by December 31,

2022. The CARES Act also expanded the Centers for Medicare & Medicaid Services' ("CMS") ability to provide accelerated/advance payments intended to increase the cash flow of healthcare providers and suppliers impacted by COVID-19. During 2020, the Company applied for and received $27,997 in funds under the Accelerated and Advance Payment ("AAP") Program, all of which was recouped as of June 23, 2022.

3. TRANSACTIONS WITH ENSIGN

On October 1, 2019, The Ensign Group, Inc. ("Ensign") completed the separation of Pennant (the "Spin-Off"). Pennant and Ensign continue to partner in the provision of services along the healthcare continuum.

The Company incurred costs of $273 for the three months ended March 31, 2023 and $643 for the three months ended March 31, 2022, that related primarily to shared services at proximate operations.

Expenses related to room and board charges at Ensign skilled nursing facilities for hospice patients were $940 for the three months ended March 31, 2023 and $574 for the three months ended March 31, 2022, and are included in cost of services.

The Company's independent operating subsidiaries leased 29 and 32 communities from subsidiaries of Ensign under a master lease arrangement as of March 31, 2023 and March 31, 2022, respectively. See further discussion below at Note 8, Leases.

On January 27, 2022, affiliates of the Company entered into certain operations transfer agreements (collectively, the "Transfer Agreements") with affiliates of Ensign, providing for the transfer of the operations of five senior living communities (the "Transaction"). The Transfer Agreements required one of the transferors to place $6,500 in escrow to cover post-closing capital expenditures and operating losses related to one of the communities, and such escrow was funded by an initial payment by the transferor at closing followed by eight equal monthly installments. The Transaction closed in April 2022.

4. NET INCOME PER COMMON SHARE

Basic net income per share is computed by dividing net income attributable to stockholders of the Company by the weighted average number of outstanding common shares for the period. The computation of diluted net income per share is similar to the computation of basic net income per share except that the denominator is increased to include the number of additional common shares that would have been outstanding if the dilutive potential common shares had been issued.

The following table sets forth the computation of basic and diluted net income per share for the periods presented:

	Three Months Ended March 31,	
	2023	2022
Numerator:		
Net income attributable to The Pennant Group, Inc.	$ 1,850	$ 1,014
Denominator:		
Weighted average shares outstanding for basic net income per share	29,751	28,572
Plus: assumed incremental shares from exercise of options and assumed conversion or vesting of restricted stock[(a)]	396	1,571
Adjusted weighted average common shares outstanding for diluted income per share	30,147	30,143
Earnings Per Share:		
Basic net income per common share	$ 0.06	$ 0.04
Diluted net income per common share	$ 0.06	$ 0.03

(a) The diluted per share amounts do not reflect common equivalent shares outstanding of 2,002 for the three months ended March 31, 2023 and 1,690 for the three months ended March 31, 2022, because of their anti-dilutive effect.

5. REVENUE AND ACCOUNTS RECEIVABLE

Revenue is recognized when services are provided to the patients at the amount that reflects the consideration to which the Company expects to be entitled from patients and third-party payors, including Medicaid, Medicare, Commercial and managed care programs (Medicare Advantage and Managed Medicaid plans), in exchange for providing patient care. The healthcare services in home health and hospice patient contracts include routine services in exchange for a contractual agreed-upon amount or rate. Routine services are treated as a single performance obligation satisfied over time as services are rendered. As such, patient care services represent a bundle of services that are not capable of being distinct within the context of the contract. Additionally, there may be ancillary services which are not included in the rates for routine services, but instead are treated as separate performance obligations satisfied at a point in time, if and when those services are rendered.

Revenue recognized from healthcare services are adjusted for estimates of variable consideration to arrive at the transaction price. The Company determines the transaction price based on contractually agreed-upon amounts or rate, adjusted for estimates of variable consideration. The Company uses the expected value method in determining the variable component that should be used to arrive at the transaction price, using contractual agreements and historical reimbursement experience within each payor type. The amount of variable consideration which is included in the transaction price may be constrained, and is included in the net revenue only to the extent that it is probable that a significant reversal in the amount of the cumulative revenue recognized will not occur in a future period. If actual amounts of consideration ultimately received differ from the Company's estimates, the Company adjusts these estimates, which would affect net service revenue in the period such variances become known.

Revenue from the Medicare and Medicaid programs accounted for 62.0% of the Company's revenue for the three months ended March 31, 2023, and 61.9% for the three months ended March 31, 2022. The Company records revenue from these governmental and managed care programs as services are performed at their expected net realizable amounts under these programs. The Company's revenue from governmental and managed care programs is subject to audit and retroactive adjustment by governmental and third-party agencies. Consistent with healthcare industry accounting practices, any changes to these governmental revenue estimates are recorded in the period the change or adjustment becomes known based on final settlement.

Disaggregation of Revenue

The Company disaggregates revenue from contracts with its patients by reportable operating segments and payors. The Company has determined that disaggregating revenue into these categories achieves the disclosure objectives to depict how the nature, amount, timing and uncertainty of revenue and cash flows are affected by economic factors.

The Company's service specific revenue recognition policies are as follows:

Home Health Revenue

Medicare Revenue

Net service revenue is recognized in accordance with the Patient Driven Groupings Model ("PDGM"). Under PDGM, Medicare provides agencies with payments for each 30-day payment period provided to beneficiaries. If a beneficiary is still eligible for care after the end of the first 30-day payment period, a second 30-day payment period can begin. There are no limits to the number of periods of care a beneficiary who remains eligible for the home health benefit can receive. While payment for each 30-day payment period is adjusted to reflect the beneficiary's health condition and needs, a special outlier provision exists to ensure appropriate payment for those beneficiaries that have the most expensive care needs. The payment under the Medicare program is also adjusted for certain variables including, but not limited to: (a) a low utilization payment adjustment if the number of visits is below an established threshold that varies based on the diagnosis of a beneficiary; (b) a partial payment if the patient transferred to another provider or the Company received a patient from another provider before completing the period of care; (c) adjustment to the admission source of claim if it is determined that the patient had a qualifying stay in a post-acute care setting within 14 days prior to the start of a 30-day payment period; (d) the timing of the 30-day payment period provided to a patient in relation to the admission date, regardless of whether the same home health provider provided care for the entire series of episodes; (e) changes to the acuity of the patient during the previous 30-day payment period; (f) changes in the base payments established by the Medicare program; (g) adjustments to the base payments for case mix and geographic wages; and (h) recoveries of overpayments.

The Company adjusts Medicare revenue on completed episodes to reflect differences between estimated and actual payment amounts, an inability to obtain appropriate billing documentation and other reasons unrelated to credit risk. Therefore, the Company believes that its reported net service revenue and patient accounts receivable will be the net amounts to be realized from Medicare for services rendered.

In addition to revenue recognized on completed episodes and periods, the Company also recognizes a portion of revenue associated with episodes and periods in progress. Episodes in progress are 30-day payment periods that begin during the reporting period but were not completed as of the end of the period. As such, the Company estimates revenue and recognizes it on a daily basis. The primary factors underlying this estimate are the number of episodes in progress at the end of the reporting period, expected Medicare revenue per period of care or episode of care and the Company's estimate of the average percentage complete based on the scheduled end of period and end of episode dates.

Non-Medicare Revenue

Episodic Based Revenue - The Company recognizes revenue in a similar manner as it recognizes Medicare revenue for episodic-based rates that are paid by other insurance carriers, including Medicare Advantage programs. These rates can vary based upon the negotiated terms.

Non-episodic Based Revenue - Revenue is recognized on an accrual basis based upon the date of service at amounts equal to its established or estimated per visit rates, as applicable.

Hospice Revenue

Revenue is recognized on an accrual basis based upon the date of service at amounts equal to the estimated payment rates. The estimated payment rates are calculated as daily rates for each of the levels of care the Company delivers. Revenue is adjusted for an inability to obtain appropriate billing documentation or authorizations acceptable to the payor and other reasons unrelated to credit risk. Additionally, as Medicare hospice revenue is subject to an inpatient cap and an overall payment cap, the Company monitors its provider numbers and estimates amounts due back to Medicare if a cap has been exceeded. The Company regularly evaluates and records these adjustments as a reduction to revenue and an increase to other accrued liabilities.

Senior Living Revenue

The Company has elected the lessor practical expedient within ASC Topic 842, *Leases* ("ASC 842") and therefore recognizes, measures, presents, and discloses the revenue for services rendered under the Company's senior living residency agreements based upon the predominant component, either the lease or non-lease component, of the contracts. The Company has determined that the services included under the Company's senior living residency agreements each have the same timing and pattern of transfer. The Company recognizes revenue under ASC Topic 606, *Revenue from Contracts with Customers* for its senior residency agreements, for which it has determined that the non-lease components of such residency agreements are the predominant component of each such contract.

The Company's senior living revenue consists of fees for basic housing and assisted living care. Accordingly, the Company records revenue when services are rendered on the date services are provided at amounts billable to individual residents. Residency agreements are generally for a term of 30 days, with resident fees billed monthly in advance. For residents under reimbursement arrangements with Medicaid, revenue is recorded based on contractually agreed-upon amounts or rates on a per resident, daily basis or as services are rendered.

Revenue By Payor

Revenue by payor for the three months ended March 31, 2023 and 2022, is summarized in the following tables:

	Three Months Ended March 31, 2023				
	Home Health and Hospice Services				
	Home Health Services	Hospice Services	Senior Living Services	Total Revenue	Revenue %
Medicare	$ 23,376	$ 37,380	$ —	$ 60,756	48.0 %
Medicaid	2,191	4,598	10,842	17,631	14.0
Subtotal	25,567	41,978	10,842	78,387	62.0
Managed care	15,932	1,194	—	17,126	13.5
Private and other[(a)]	6,291	117	24,543	30,951	24.5
Total revenue	$ 47,790	$ 43,289	$ 35,385	$ 126,464	100.0 %

(a) Private and other payors in the Company's home health and hospice services segment includes revenue from all payors generated in the Company's home care operations.

	Three Months Ended March 31, 2022				
	Home Health and Hospice Services				
	Home Health Services	Hospice Services	Senior Living Services	Total Revenue	Revenue %
Medicare	$ 21,357	$ 33,721	$ —	$ 55,078	48.4 %
Medicaid	2,506	3,265	9,623	15,394	13.5
Subtotal	23,863	36,986	9,623	70,472	61.9
Managed care	13,252	784	—	14,036	12.3
Private and other[(a)]	5,537	53	23,812	29,402	25.8
Total revenue	$ 42,652	$ 37,823	$ 33,435	$ 113,910	100.0 %

(a) Private and other payors in the Company's home health and hospice services segment includes revenue from all payors generated in the Company's home care operations.

Balance Sheet Impact

Included in the Company's Condensed Consolidated Balance Sheets are contract assets, comprised of billed accounts receivable and unbilled receivables, which are the result of the timing of revenue recognition, billings and cash collections, as well as, contract liabilities, which primarily represent payments the Company receives in advance of services provided.

Accounts receivable, net as of March 31, 2023 and December 31, 2022 is summarized in the following table:

	March 31, 2023	December 31, 2022
Medicare	$ 29,814	$ 31,321
Medicaid	9,603	10,700
Managed care	9,445	9,370
Private and other	2,371	2,621
Accounts receivable, gross	51,233	54,012
Less: allowance for doubtful accounts	(573)	(592)
Accounts receivable, net	$ 50,660	$ 53,420

Concentrations - Credit Risk

The Company has significant accounts receivable balances, the collectability of which is dependent on the availability of funds from certain governmental programs, primarily Medicare and Medicaid. These receivables represent the only significant concentration of credit risk for the Company. The Company does not believe there are significant credit risks associated with these governmental programs. The Company believes that an appropriate allowance has been recorded for the possibility of these receivables proving uncollectible, and continually monitors and adjusts these allowances as necessary. The Company's gross receivables from the Medicare and Medicaid programs accounted for approximately 76.9% and 77.8% of its total gross accounts receivable as of March 31, 2023 and December 31, 2022, respectively. Revenue from reimbursement under the Medicare and Medicaid programs accounted for 62.0% for the three months ended March 31, 2023, and 61.9% of the Company's revenue for the three months ended March 31, 2022.

Practical Expedients and Exemptions

As the Company's contracts have an original duration of one year or less, the Company uses the practical expedient applicable to its contracts and does not consider the time value of money. Further, because of the short duration of these contracts, the Company has not disclosed the transaction price for the remaining performance obligations as of the end of each reporting period or when the Company expects to recognize this revenue. In addition, the Company has applied the practical expedient provided by ASC 340, *Other Assets and Deferred Costs* ("ASC 340"), and all incremental customer contract acquisition costs are expensed as they are incurred because the amortization period would have been one year or less.

6. BUSINESS SEGMENTS

The Company classifies its operations into the following reportable operating segments: (1) home health and hospice services, which includes the Company's home health, hospice and home care businesses; and (2) senior living services, which includes the operation of assisted living, independent living and memory care communities. The reporting segments are business units that offer different services and are managed separately to provide greater visibility into those operations. The Company's Chief Executive Officer, who is the Company's Chief Operating Decision Maker ("CODM"), reviews financial information at the operating segment level. The Company also reports an "all other" category that includes general and administrative expense from the Company's Service Center.

As of March 31, 2023, the Company provided services through 96 affiliated home health, hospice and home care agencies, and 51 affiliated senior living operations. The Company evaluates performance and allocates capital resources to each segment based on an operating model that is designed to maximize the quality of care provided and profitability. The Company's Service Center provides various services to all lines of business. The Company does not review assets by segment and therefore assets by segment are not disclosed below.

The CODM uses Segment Adjusted EBITDAR from Operations as the primary measure of profit and loss for the Company's reportable segments and to compare the performance of its operations with those of its competitors. Segment Adjusted EBITDAR from Operations is net income attributable to the Company's reportable segments excluding interest expense, provision for income taxes, depreciation and amortization expense, rent, and, in order to view the operations performance on a comparable basis from period to period, certain adjustments including: (1) costs at start-up operations, (2) share-based compensation, (3) acquisition related costs and credit allowances, (4) the costs associated with transitioning operations, (5) unusual, non-recurring or redundant charges, and (6) net income attributable to noncontrolling interest. General

and administrative expenses are not allocated to the reportable segments, and are included as "All Other", accordingly the segment earnings measure reported is before allocation of corporate general and administrative expenses. The Company's segment measures may be different from the calculation methods used by other companies and, therefore, comparability may be limited.

The following tables present certain financial information regarding the Company's reportable segments, general and administrative expenses are not allocated to the reportable segments and are included in "All Other" for the three months ended March 31, 2023 and 2022:

	Home Health and Hospice Services	Senior Living Services	All Other	Total
Three Months Ended March 31, 2023				
Revenue	$ 91,079	$ 35,385	$ —	$ 126,464
Segment Adjusted EBITDAR from Operations	$ 14,412	$ 10,241	$ (7,514)	$ 17,139
Three Months Ended March 31, 2022				
Revenue	$ 80,475	$ 33,435	$ —	$ 113,910
Segment Adjusted EBITDAR from Operations	$ 13,948	$ 9,432	$ (8,146)	$ 15,234

This following table provides a reconciliation of Segment Adjusted EBITDAR from Operations to income from operations:

	Three Months Ended March 31,	
	2023	2022
Segment Adjusted EBITDAR from Operations	$ 17,139	$ 15,234
Less: Depreciation and amortization	1,280	1,147
Rent—cost of services	9,597	10,051
Other expense	30	3
Adjustments to Segment EBITDAR from Operations:		
Less: Costs at start-up operations[(a)]	203	131
Share-based compensation expense and related taxes[(b)]	1,419	2,440
Acquisition related costs and credit allowances[(c)]	32	—
Costs associated with transitioning operations[(d)]	47	(757)
Unusual, non-recurring or redundant charges[(e)]	398	37
Add: Net income attributable to noncontrolling interest	147	144
Condensed Consolidated Income from Operations	$ 4,280	$ 2,326

(a) Represents results related to start-up operations. This amount excludes rent and depreciation and amortization expense related to such operations.

(b) Share-based compensation expense and related payroll taxes incurred. Share-based compensation expense and related payroll taxes are included in cost of services and general and administrative expense.

(c) Non-capitalizable costs associated with acquisitions and credit allowances for amounts in dispute with the prior owners of certain acquired operations.

(d) During the three months ended March 31, 2023, an affiliate of the Company placed its memory care units into transition and is actively seeking to sublease the units to an unrelated third party. The amount above represents the net operating impact attributable to the units in transition. The amounts reported exclude rent and depreciation and amortization expense related to such operations.

During January 2022, affiliates of the Company entered into Transfer Agreements with affiliates of Ensign, providing for the transfer of the operations of certain senior living communities (the "Transaction") from affiliates of the Company to affiliates of Ensign. The closing of the Transaction was completed in two phases with the transfer of two operations on March 1, 2022 and the remainder transferred on April 1, 2022. The amount above represents the net impact on revenue and cost of service attributable to all of the transferred entities. The amounts reported exclude rent and depreciation and amortization expense related to such operations.

(e) Represents unusual or non-recurring charges for legal services, implementation costs, integration costs, and consulting fees in general and administrative expenses.

Costs identified as redundant or non-recurring incurred by the Company for additional services provided by Ensign. All amounts are included in general and administrative expense. Fees incurred were $273 for the three months ended March 31, 2023, and $643 for the three months ended March 31, 2022.

7. ACQUISITIONS

The Company's is focused on acquiring operations that are complementary to the Company's current businesses, accretive to the Company's business or otherwise advance the Company's strategy. The results of all the Company's independent operating subsidiaries are included in the Interim Financial Statements subsequent to the date of acquisition. Acquisitions are accounted for using the acquisition method of accounting.

2023 Acquisitions

During the three months ended March 31, 2023, the Company expanded its operations with the addition of one home health agency as well as two senior living communities. In connection with the addition of the two senior living communities, the Company entered into a new long-term "triple-net" lease. A subsidiary of the Company entered into a separate operations transfer agreement with the prior operator of each acquired operation as part of each transaction.

The one home health agency acquired was a Medicare license and is considered an asset acquisition. The fair value of the home health license acquired was $210 and was allocated to indefinite-lived intangible assets.

Subsequent Events

On May 1, 2023, the Company closed on the purchase of one home health agency that expands the Company's footprint in Colorado. The purchase of the home health agency was $875. A subsidiary of the Company entered into an operations transfer agreement with the prior operator.

8. PROPERTY AND EQUIPMENT—NET

Property and equipment, net consist of the following:

	March 31, 2023	December 31, 2022
Land	$ 96	$ 96
Building	1,890	1,890
Leasehold improvements	19,106	18,759
Equipment	26,659	25,532
Furniture and fixtures	1,223	1,151
	48,974	47,428
Less: accumulated depreciation	(22,027)	(20,807)
Property and equipment, net	$ 26,947	$ 26,621

Depreciation expense was 1,275 for the three months ended March 31, 2023 and $1,114 for the three months ended March 31, 2022.

The Company measures certain assets at fair value on a non-recurring basis, including long-lived assets, which are evaluated for impairment. Long-lived assets include assets such as property and equipment, operating lease assets and certain intangible assets. The inputs used to determine the fair value of long-lived assets and a reporting unit are considered Level 3 measurements due to their subjective nature. Management has evaluated its long-lived assets and determined there were immaterial impairments recorded during the three months ended March 31, 2023 and 2022.

9. GOODWILL AND OTHER INDEFINITE-LIVED INTANGIBLE ASSETS

The following table represents activity in goodwill by segment for the three months ended March 31, 2023:

	Home Health and Hospice Services	Senior Living Services	Total
December 31, 2022	$ 75,855	$ 3,642	$ 79,497
Additions	—	—	—
March 31, 2023	$ 75,855	$ 3,642	$ 79,497

Other indefinite-lived intangible assets consist of the following:

	March 31, 2023	December 31, 2022
Trade name	$ 1,385	$ 1,385
Medicare and Medicaid licenses	57,442	57,232
Total	$ 58,827	$ 58,617

No goodwill or intangible asset impairments were recorded during the three months ended March 31, 2023 and 2022.

10. OTHER ACCRUED LIABILITIES

Other accrued liabilities consist of the following:

	March 31, 2023	December 31, 2022
Refunds payable	$ 2,017	$ 2,244
Deferred revenue	1,609	1,592
Resident deposits	3,663	4,315
Property taxes	1,129	1,027
Deferred state relief funds	909	1,479
Accrued self-insurance liabilities	4,076	3,546
Other	2,713	2,481
Other accrued liabilities	$ 16,116	$ 16,684

Refunds payable includes payables related to overpayments, duplicate payments and credit balances from various payor sources. Deferred revenue occurs when the Company receives payments in advance of services provided. Resident deposits include refundable deposits to residents.

11. DEBT

Long-term debt, net consists of the following:

	March 31, 2023	December 31, 2022
Revolving Credit Facility	$ 58,500	$ 64,500
Less: unamortized debt issuance costs[(a)]	(1,477)	(1,608)
Long-term debt, net	$ 57,023	$ 62,892

(a) Amortization expense for debt issuance costs was $130 for three months ended March 31, 2023 and $129 for the three months ended March 31, 2022, and is recorded in interest expense, net on the Condensed Consolidated Statements of Income.

On February 23, 2021, Pennant entered into an amendment to its existing credit agreement (as amended, the “Credit Agreement”), which provides for an increased revolving credit facility with a syndicate of banks with a borrowing capacity of $150,000 (the “Revolving Credit Facility”). The interest rates applicable to loans under the Revolving Credit Facility are, at the

Company's election, either (i) Adjusted LIBOR (as defined in the Credit Agreement) plus a margin ranging from 2.3% to 3.3% per annum or (ii) Base Rate plus a margin ranging from 1.3% to 2.3% per annum, in each case, based on the ratio of Consolidated Total Net Debt to Consolidated EBITDA (each, as defined in the Credit Agreement). In addition, Pennant pays a commitment fee on the undrawn portion of the commitments under the Revolving Credit Facility which ranges from 0.35% to 0.50% per annum, depending on the Consolidated Total Net Debt to Consolidated EBITDA ratio of the Company and its subsidiaries. The Company is not required to repay any loans under the Credit Agreement prior to maturity in 2026, other than to the extent the outstanding borrowings exceed the aggregate commitments under the Credit Agreement. As of March 31, 2023, the Company's weighted average interest rate on its outstanding debt was 7.53%. As of March 31, 2023, the Company had available borrowing on the Revolving Credit Facility of $87,314, which is net of outstanding letters of credit of $4,186.

The fair value of the Revolving Credit Facility approximates carrying value, due to the short-term nature and variable interest rates. The fair value of this debt is categorized within Level 2 of the fair value hierarchy based on the observable market borrowing rates.

The Credit Agreement is guaranteed, jointly and severally, by certain of the Company's independent operating subsidiaries, and is secured by a pledge of stock of the Company's material independent operating subsidiaries as well as a first lien on substantially all of each material operating subsidiary's personal property. The Credit Agreement contains customary covenants that, among other things, restrict, subject to certain exceptions, the ability of the Company and its independent operating subsidiaries to grant liens on their assets, incur indebtedness, sell assets, make investments, engage in acquisitions, mergers or consolidations, amend certain material agreements and pay certain dividends and other restricted payments. Financial covenants require compliance with certain levels of leverage ratios that impact the amount of interest. As of March 31, 2023, the Company was compliant with all such financial covenants.

12. OPTIONS AND AWARDS

Outstanding options and restricted stock awards of the Company were granted under the 2019 Omnibus Incentive Plan (the "OIP") and Long-Term Incentive Plan (the "LTIP", and together with the OIP, the "Pennant Plans").

Under the Pennant Plans, stock-based payment awards, including employee stock options, restricted stock awards ("RSA"), and restricted stock units ("RSU" and together with RSA, "Restricted Stock") are issued based on estimated fair value. The following disclosures represent share-based compensation expense relating to employees of the Company's subsidiaries and non-employee directors who have awards under the Pennant Plans.

Total share-based compensation expense for all Plans for the three months ended March 31, 2023 and 2022 was:

	Three Months Ended March 31,	
	2023	2022
Share-based compensation expense related to stock options	$ 850	$ 842
Share-based compensation expense related to Restricted Stock	177	1,519
Share-based compensation expense related to Restricted Stock to non-employee directors	340	79
Total share-based compensation	$ 1,367	$ 2,440

In future periods, the Company estimates it will recognize the following share-based compensation expense for unvested stock options and unvested Restricted Stock as of March 31, 2023:

	Unrecognized Compensation Expense	Weighted Average Recognition Period (in years)
Unvested Stock Options	$ 12,339	3.5
Unvested Restricted Stock	2,931	4.2
Total unrecognized share-based compensation expense	$ 15,270	

On July 25, 2022 the Company modified certain outstanding RSUs granted to the former chief executive officer of the Company in connection with the Spin-off. All the RSUs had an original vesting date of October 1, 2022. The modification resulted in the forfeiture of 250 outstanding RSUs and accelerated the vesting on the remaining 943 RSUs from October 1, 2022 to July 31, 2022. The modification of the award resulted in a net reduction of share-based compensation expense related to the awards of $3,812 recorded in general and administrative expense in the third quarter of 2022.

Stock Options

Under the Pennant Plans, options granted to employees of the subsidiaries of Pennant generally vest over five years at 20% per year on the anniversary of the grant date. Options expire ten years after the date of grant.

The Company uses the Black-Scholes option-pricing model to recognize the value of stock-based compensation expense for share-based payment awards under the Plans. Determining the appropriate fair-value model and calculating the fair value of stock-based awards at the grant date requires considerable judgment, including estimating stock price volatility and expected option life. The Company develops estimates based on historical data and market information, which can change significantly over time.

The fair value of each option is estimated on the grant date using a Black-Scholes option-pricing model with the following weighted average assumptions for stock options granted as of March 31:

Grant Year	Options Granted	Risk-Free Interest Rate	Expected Life[a]	Expected Volatility[b]	Dividend Yield	Weighted Average Fair Value of Options
2023	467	4.1 %	6.5	41.5 %	— %	$ 7.25
2022	213	1.9 %	6.5	40.0 %	— %	$ 6.03

(a) Under the midpoint method, the expected option life is the midpoint between the contractual option life and the average vesting period for the options being granted. This resulted in an expected option life of 6.5 years for the options granted.

(b) Because the Company's equity shares have been traded for a relatively short period of time, expected volatility assumption was based on the volatility of related industry stocks.

The following table represents the employee stock option activity during the three months ended March 31, 2023:

	Number of Options Outstanding	Weighted Average Exercise Price	Number of Options Vested	Weighted Average Exercise Price of Options Vested
December 31, 2022	2,219	20.76	973	$ 16.90
Granted	467	15.02		
Exercised	(25)	7.95		
Forfeited	(24)	21.67		
Expired	(24)	19.58		
March 31, 2023	2,613	$ 19.70	1,008	$ 17.31

Restricted Stock

A summary of the status of Pennant's non-vested Restricted Stock, and changes during the three months ended March 31, 2023, is presented below:

	Non-Vested Restricted Stock	Weighted Average Grant Date Fair Value
December 31, 2022	418	$ 14.26
Granted	32	10.80
Vested	(38)	11.12
Forfeited	(3)	15.63
March 31, 2023	409	$ 14.28

13. LEASES

The Company's independent operating subsidiaries lease 51 senior living communities and its administrative offices under non-cancelable operating leases, most of which have initial lease terms ranging from 15 to 25 years. Most of these leases contain renewal options, most involve rent increases and none contain purchase options. The lease term excludes lease renewals because the renewal rents are not at a bargain, there are no economic penalties for the Company to renew the lease, and it is not reasonably certain that the Company will exercise the extension options. The Company's independent operating subsidiaries leased 29 and 32 communities from subsidiaries of Ensign (the "Ensign Leases") under a master lease arrangement as of March 31, 2023 and March 31, 2022, respectively. Each of the leases have an initial term of between 14 and 20 years from the lease commencement date. The total amount of rent expense included in rent - cost of services paid to subsidiaries of Ensign was $3,416 for the three months ended March 31, 2023 and $3,484 for the three months ended March 31, 2022. In addition to rent, each of the operating companies are required to pay the following: (1) all impositions and taxes levied on or with respect to the leased properties (other than taxes on the income of the lessor); (2) all utilities and other services necessary or appropriate for the leased properties and the business conducted on the leased properties; (3) all insurance required in connection with the leased properties and the business conducted on the leased properties; (4) all community maintenance and repair costs; and (5) all fees in connection with any licenses or authorizations necessary or appropriate for the leased properties and the business conducted on the leased properties.

Fourteen of the Company's affiliated senior living communities, excluding the communities that are operated under the Ensign Leases (as defined herein), are operated under three separate master lease arrangements. Under these master leases, a breach at a single community could subject one or more of the other communities covered by the same master lease to the same default risk. Failure to comply with Medicare and Medicaid provider requirements is a default under several of the Company's leases and master leases. With an indivisible lease, it is difficult to restructure the composition of the portfolio or economic terms of the master lease without the consent of the landlord.

As further described in Note 3, on January 27, 2022, affiliates of the Company entered into Transfer Agreements with affiliates of Ensign, providing for the transfer of the operations of five senior living communities. The closing of the Transaction was completed in two phases with the transfer of two operations on March 1, 2022 and the remainder transferred on April 1, 2022. As a result of the lease terminations, the Company reduced both the right of use assets and the lease liabilities by $33,804. One of the terminated leases was part of a master lease agreement. As a result of the transferred leases being removed from master lease arrangement, the remaining lease components under the master lease arrangement was modified which resulted in a net increase to the lease liability and ROU asset balance of $9,349 for the three months ended March 31, 2022.

The components of operating lease cost, are as follows:

	Three Months Ended March 31,	
	2023	2022
Operating Lease Costs:		
Community Rent—cost of services	$ 8,274	$ 8,789
Office Rent—cost of services	1,323	1,262
Rent—cost of services	$ 9,597	$ 10,051
General and administrative expense	$ 93	$ 81
Variable lease cost [(a)]	$ 1,730	$ 1,575

(a) Represents variable lease cost for operating leases, which costs include property taxes and insurance, common area maintenance, and consumer price index increases, incurred as part of the Company's triple net lease, and which is included in cost of services for the three months ended March 31, 2023 and 2022.

The following table shows the lease maturity analysis for all leases as of March 31, 2023, for the years ended December 31:

Year	Amount
2023 (Remainder)	$ 27,102
2024	35,658
2025	34,302
2026	33,249
2027	32,662
Thereafter	253,638
Total lease payments	416,611
Less: present value adjustments	(149,714)
Present value of total lease liabilities	266,897
Less: current lease liabilities	(16,856)
Long-term operating lease liabilities	$ 250,041

Operating lease liabilities are based on the net present value of the remaining lease payments over the remaining lease term. In determining the present value of lease payments, the Company used its incremental borrowing rate based on the information available at each lease's commencement date to determine each lease's operating lease liability. As of March 31, 2023, the weighted average remaining lease term is 12.5 years and the weighted average discount rate is 7.6%.

14. INCOME TAXES

The Company recorded income tax expense of $907 and $542, or 31.2% and 31.9% of earnings before income taxes for the three months ended March 31, 2023 and 2022, respectively. The decrease in effective tax is primarily due to a decrease in non-deductible equity compensation.

15. COMMITMENTS AND CONTINGENCIES

Regulatory Matters - The Company provides services in complex and highly regulated industries. The Company's compliance with applicable U.S. federal, state and local laws and regulations governing these industries may be subject to governmental review and adverse findings may result in significant regulatory action, which could include sanctions, damages, fines, penalties (many of which may not be covered by insurance), and even exclusion from government programs. The Company is a party to various regulatory and other governmental audits and investigations in the ordinary course of business and cannot predict the ultimate outcome of any federal or state regulatory survey, audit or investigation. While governmental audits and investigations are the subject of administrative appeals, the appeals process, even if successful, may take several years to resolve and penalties subject to appeal may remain in place during such appeals, which may include suspension, termination, or revocation of participation in governmental programs for the payment of the services the Company provides. The Department of Justice, CMS, or other federal and state enforcement and regulatory agencies may conduct additional investigations related to the Company's businesses. The Company believes it is presently in compliance in all material respects with all applicable laws and regulations.

Cost-Containment Measures - Government and third-party payors have instituted cost-containment measures designed to limit payments made to providers of healthcare services, may propose future cost-containment measures, and there can be no assurance that future measures designed to limit payments made to providers will not adversely affect the Company.

Indemnities - From time to time, the Company enters into certain types of contracts that contingently require the Company to indemnify parties against third-party claims. These contracts primarily include (i) certain real estate leases, under which the Company may be required to indemnify property owners or prior operators for post-transfer environmental or other liabilities and other claims arising from the Company's use of the applicable premises, (ii) operations transfer agreements, in which the Company agrees to indemnify past operators of agencies and communities the Company acquires against certain liabilities arising from the transfer of the operation and/or the operation thereof after the transfer, (iii) certain Ensign lending agreements, and (iv) certain agreements with management, directors and employees, under which the subsidiaries of the Company may be required to indemnify such persons for liabilities arising out of their employment relationships. The terms of such obligations vary by contract and, in most instances, a specific or maximum dollar amount is not explicitly stated therein. Generally, amounts under these contracts cannot be reasonably estimated until a specific claim is asserted. Consequently, because no claims have been asserted, no liabilities have been recorded for these obligations on the Company's Condensed Consolidated Balance Sheets for any of the periods presented.

Litigation - The Company's businesses involve a significant risk of liability given the age and health of the patients and residents served by its independent operating subsidiaries. The Company, its operating companies, and others in the industry may be subject to a number of claims and lawsuits, including professional liability claims, alleging that services provided have resulted in personal injury, elder abuse, wrongful death or other related claims. Healthcare litigation (including class action litigation) is common and is filed based upon a wide variety of claims and theories, and the Company is routinely subjected to these claims in the ordinary course of business, including potential claims related to patient care and treatment, and professional negligence, as well as employment-related claims. If there were a significant increase in the number of these claims or an increase in amounts owing should plaintiffs be successful in their prosecution of these claims, this could materially adversely affect the Company's business, financial condition, results of operations and cash flows. In addition, the defense of these lawsuits may result in significant legal costs, regardless of the outcome, and may result in large settlement amounts or damage awards.

In addition to the potential lawsuits and claims described above, the Company is also subject to potential lawsuits under the False Claims Act (the "FCA") and comparable state laws alleging submission of fraudulent claims for services to any governmental healthcare program (such as Medicare) or commercial payor. A violation may provide the basis for exclusion from federally funded healthcare programs. Such exclusions could have a correlative negative impact on the Company's financial performance. Some states, including California, Arizona and Texas, have enacted similar whistleblower and false claims laws and regulations. In addition, the Deficit Reduction Act of 2005 created incentives for states to enact anti-fraud legislation modeled on the FCA, for which 18 states have qualified, including California and Texas, where we conduct business. As such, the Company could face increased scrutiny, potential liability and legal expenses and costs based on claims under state false claims acts in markets in which it conducts business.

Under the Fraud Enforcement and Recovery Act ("FERA") and its associated rules, healthcare providers face significant penalties for the knowing retention of government overpayments, even if no false claim was involved. Providers have an obligation to proactively exercise "reasonable diligence" to identify overpayments and return those overpayments to

CMS within 60 days of "identification" or the date any corresponding cost report is due, whichever is later. Retention of overpayments beyond this period may create liability under the FCA. In addition, FERA protects whistleblowers (including employees, contractors, and agents) from retaliation.

The Company cannot predict or provide any assurance as to the possible outcome of any litigation. If any litigation were to proceed, and the Company and its operating companies are subjected to, alleged to be liable for, or agree to a settlement of, claims or obligations under federal Medicare statutes, the FCA, or similar state and federal statutes and related regulations, the Company's business, financial condition and results of operations and cash flows could be materially and adversely affected. Among other things, any settlement or litigation could involve the payment of substantial sums to settle any alleged civil violations, and may also include the assumption of specific procedural and financial obligations by the Company or its independent operating subsidiaries going forward under a corporate integrity agreement and/or other arrangement with the government.

Medicare Revenue Recoupments - The Company is subject to probe reviews relating to Medicare services, billings and potential overpayments by Unified Program Integrity Contractors ("UPIC"), Recovery Audit Contractors ("RAC"), Zone Program Integrity Contractors ("ZPIC"), Program Safeguard Contractors ("PSC"), Supplemental Medical Review Contractors ("SMRC") and Medicaid Integrity Contributors ("MIC") programs, each of the foregoing collectively referred to as "Reviews."

As of March 31, 2023, nine of the Company's independent operating subsidiaries had Reviews scheduled, on appeal or in dispute resolution process, both pre- and post-payment. If an operation fails an initial or subsequent Review, the operation could then be subject to extended Review, suspension of payment, or extrapolation of the identified error rate to all billing in the same time period. The Company, from time to time, receives record requests in reviews which have resulted in claim denials on paid claims. The Company has appealed substantially all denials arising from these reviews using the applicable appeals process. As of March 31, 2023, and through the filing of this Quarterly Report on Form 10-Q, the Company's independent operating subsidiaries have responded to the Reviews that are currently ongoing, on appeal or in dispute resolution process. The Company cannot predict the ultimate outcome of any regulatory and other governmental reviews. While such reviews are the subject of administrative appeals, the appeals process, even if successful, may take several years to resolve. The costs to respond to and defend such reviews may be significant and an adverse determination in such reviews may subject the Company to sanctions, damages, extrapolation of damage findings, additional recoupments, fines, other penalties (some of which may not be covered by insurance), and termination from Medicare programs which may, either individually or in the aggregate, have a material adverse effect on the Company's business and financial condition.

From June 2021 to May 2022, one hospice provider number was subject to a Medicare payment suspension imposed by a UPIC. As of March 31, 2023, the total amount due from the government payor impacted by the suspension was $5,134 and was recorded in long-term other assets. The amounts suspended represent all Medicare payments due to the provider number during the suspension.

In May 2022, the Company received communication that the Medicare payment suspension was terminated and the UPIC's review was complete. The UPIC reviewed 107 patient records covering a 10-month period to determine whether, in its view, a Medicare overpayment was made. Based on the results of the review, the UPIC has alleged sampled and extrapolated overpayments of $5,134, and has withheld that amount through continued recoupment of Medicare payments. The Company is pursuing its appeal rights through the administrative appeals process, including contesting the methodology used by the UPIC to perform statistical extrapolation. At this stage of the review, based on the information currently available to the Company, the Company cannot predict the timing or the ultimate outcome of this review. As of March 31, 2023, we have an accrued liability that is immaterial for this review which was recorded as an offset to revenue.

Insurance - The Company retains risk for a substantial portion of potential claims for general and professional liability, workers' compensation and automobile liability. The Company recognizes obligations associated with these costs, up to specified deductible limits in the period in which a claim is incurred, including with respect to both reported claims and claims incurred but not reported. The general and professional liability insurance has a retention limit of $150 per claim with a $500 corridor as an additional out-of-pocket retention we must satisfy for claims within the policy year before the carrier will reimburse losses. The workers' compensation insurance has a retention limit of $250 per claim, except for policies held in Texas and Washington which are subject to state insurance and possess their own limits.

The Company is self-insured for claims related to employee health, dental, and vision care. To protect itself against loss exposure, the Company has purchased individual stop-loss insurance coverage that insures individual health claims that exceed $350 for each covered person for fiscal year 2023 and fiscal year 2022.

16. COMMON STOCK REPURCHASE PROGRAM

On December 12, 2022, the Board of the Directors of the Company approved a share repurchase program under which the Company may repurchase up to $1,000 of its common stock. Under the share repurchase program, the Company may repurchase shares from time to time through open market purchases, including through the use of trading plans intended to comply with Rule 10b5-1 under the Securities Exchange Act of 1934. The timing and total amount of stock repurchases will depend upon business, economic and market conditions, corporate and regulatory requirements, prevailing stock prices, and other considerations. The authorization expires on December 12, 2023, and may be suspended or discontinued at any time and does not obligate the company to acquire any amount of common stock. No shares were repurchased during the three months ended March 31, 2023.

Item 2. ***Management's Discussion and Analysis of Financial Condition and Results of Operations***

You should read the following discussion and analysis in conjunction with the Interim Financial Statements and the related notes thereto contained in Part I, Item 1 of this Quarterly Report on Form 10-Q (this "Quarterly Report"). The information contained in this Quarterly Report is not a complete description of our business or the risks associated with an investment in our common stock. We urge you to carefully review and consider the various disclosures made by us in this Quarterly Report and in our other reports filed with the Securities and Exchange Commission ("SEC"), including our Annual Report on Form 10-K for the year ended December 31, 2022 (the "2022 Annual Report"), which discusses our business and related risks in greater detail, as well as subsequent reports we may file from time to time on Form 10-K, Form 10-Q and 8-K, for additional information. The section entitled "Risk Factors" filed within our 2022 Annual Report describes some of the important risk factors that may affect our business, financial condition, results of operations and/or liquidity. You should carefully consider those risks, in addition to the other information in this Quarterly Report and in our other filings with the SEC, before deciding to purchase, hold or sell our common stock.

Special Note About Forward-Looking Statements

This Quarterly Report contains "forward-looking statements" within the meaning of the safe harbor provisions of the U.S. Private Securities Litigation Reform Act of 1995, that are based on our management's beliefs and assumptions and on information currently available to our management. Forward-looking statements include all statements that are not historical facts and can be identified by the use of forward-looking terminology such as the words "outlook," "believes," "expects," "potential," "continues," "may," "might," "will," "should," "could," "seeks," "approximately," "goals," "future," "projects," "predicts," "guidance," "target," "intends," "plans," "estimates," "anticipates", the negative version of these words or other comparable words. Forward-looking statements include, but are not limited to, statements related to our expectations regarding the performance of our business, our financial results, our liquidity and capital resources, the effects of competition and the effects of future legislation or regulations and other non-historical statements.

The risk factors discussed in this Quarterly Report and the 2022 Annual Report under the heading "Risk Factors," could cause our results to differ materially from those expressed in forward-looking statements. Factors that could cause actual results to differ materially from those in the forward-looking statements include, but are not limited to:

- federal and state changes to, or delays receiving, reimbursement and other aspects of Medicaid and Medicare;
- changes in, and compliance with, the laws and regulations affecting the U.S. healthcare industry;
- proposed changes to payment models and reimbursement amounts within the Medicare and Medicaid fee schedules for future calendar years;
- future cost containment measures undertaken by payors;
- government reviews, audits and investigations of our business;
- potential additional regulation affecting the transparency, ownership, operating standards, and staffing of businesses in our industry;
- increased competition and increased cost of acquisition or retention for, or a shortage of, skilled personnel;
- achievement and maintenance of competitive quality of care ratings and referrals from referral sources;
- changes in, and compliance with, state and federal employment, fair housing, safety, licensing and other laws;
- competition from other healthcare providers, state efforts to regulate or deregulate the healthcare services industry, or the construction or expansion of the number of home health, hospice or senior living operations;
- actions of labor unions;
- costs associated with litigation or any future litigation settlements;
- the leases of our affiliated senior living communities;
- inability to complete future acquisitions at attractive prices or at all, and failure to successfully or efficiently new acquisitions into our existing operations and operating subsidiaries;
- general economic conditions, including a housing downturn, which could affect seniors' ability to afford resident fees, or inflation and increasing interest rates, which raise the costs of goods and borrowing capital, which may affect the delivery and affordability of our services;

- security breaches and other cyber security incidents;
- the performance of the financial and credit markets and uncertainties related to our ability to obtain financing or the terms of such financing; and
- uncertainties related to the lingering effect of the COVID-19 pandemic, including new regulatory risks impacting our operations, potential litigation, and vaccination mandates.

Forward-looking statements involve risks, uncertainties and assumptions. Actual results may differ materially from those expressed in these forward-looking statements. You should not place undue reliance on any forward-looking statements in this Quarterly Report. Although we may from time to time voluntarily update our prior forward-looking statements, we disclaim any commitment to do so except as required by applicable securities laws.

Overview

We are a leading provider of high-quality healthcare services to patients of all ages, including the growing senior population, in the United States. We strive to be the provider of choice in the communities we serve through our innovative operating model. We operate in multiple lines of businesses including home health, hospice and senior living services across Arizona, California, Colorado, Idaho, Iowa, Montana, Nevada, Oklahoma, Oregon, Texas, Utah, Washington, Wisconsin and Wyoming. As of March 31, 2023, our home health and hospice business provided home health, hospice and home care services from 96 agencies operating across these 14 states, and our senior living business operated 51 senior living communities throughout six states.

The following table summarizes our affiliated home health and hospice agencies and senior living communities as of:

	December 31,								March 31,
	2015	2016	2017	2018	2019	2020	2021	2022	2023
Home health and hospice agencies	32	39	46	54	63	76	88	95	96
Senior living communities	36	36	43	50	52	54	54	49	51
Senior living units	3,184	3,184	3,434	3,820	3,963	4,127	4,127	3,500	3,588
Total number of home health, hospice, and senior living operations	68	75	89	104	115	130	142	144	147

Recent Activities

Acquisitions. During the three months ended March 31, 2023, we expanded our operations with the addition of one home health agency, as well as two senior living communities. A subsidiary of the Company entered into a separate operations transfer agreement with the prior operator of the acquired operation as part of each transaction.

Trends

We have experienced modest senior living occupancy improvement through the first quarter of 2023, partly as a result of improving COVID-19 case trends and renewed consideration of senior living communities as a home-based care setting. Though we have seen steady improvements in occupancy throughout 2022 and the first quarter of 2023, we cannot be sure when the occupancy levels in our senior living communities will return to pre-pandemic levels.

When we acquire turnaround or start-up operations, we expect that our combined metrics may be impacted. We expect these metrics to vary from period to period based upon the maturity of the operations within our portfolio. We have generally experienced lower occupancy rates and higher costs at our senior living communities and lower census and higher costs at our home health and hospice agencies for recently acquired operations; as a result, we generally anticipate lower and/or fluctuating consolidated and segment margins during years of acquisition growth.

Government Regulation

We have disclosed under the heading “Government Regulation” in the 2022 Annual Report a summary of regulations that we believe materially affect our business, financial condition or results of operations. Since the time of the filing of the 2022 Annual Report, the following regulations have been updated.

On March 31, 2023, CMS issued the 2024 Hospice Payment Rate Update proposed rule (the "Hospice Payment Proposed Rule"). The Hospice Payment Proposed Rule requests information regarding increased levels of transparency regarding ownership of hospice agencies, seeks to make permanent the Hospice Quality Reporting program ("HQRP") data submission threshold policy adopted in the 2016 Hospice Payment Rule Update final rule, and identified concerns about fraud, waste, and abuse in the hospice space. This proposed rule's hospice payment update percentage is 2.8%, which is an estimated increase of $720 million in payments from fiscal year 2023. The payment update percentage of 2.8% is based on a 3.0% market basket percentage increase, which is reduced by a 0.2% productivity adjustment. Additionally, hospices that fail to meet quality reporting requirements will receive a 4% reduction to the annual hospice payment update percentage increase for that year, which would more than negate the payment update percentage for fiscal year 2024 contained in the Hospice Payment Proposed Rule for hospices that fail to submit required quality reporting data to CMS. The Hospice Payment Proposed Rule's HQRP provisions discuss how the data to be collected can be used to evaluate outcomes and patient evaluation, inform CMS's quality measures for hospice providers, and measure health equity efforts. As this is a proposed rule, the final rule that is expected later in 2023 may contain significant changes, or even remove, the provisions contained within the Hospice Payment Proposed Rule.

On October 31, 2022, CMS issued the 2023 Home Health Prospective Payment System Rate Update Final Rule ("Home Health Payment Final Rule"). The rule implements a 3.9% decrease to the home health 30-day period standard payment rate in 2023, half of the 7.9% permanent decrease which CMS proposes to fully implement by 2024. This decrease is based on assumed behavior changes resulting from implementation of the Patient Driven Grouping Model ("PDGM"). Low Utilization Payment Adjustments ("LUPAs") are excluded. Aside from these adjustments, CMS finalized a 2.9% basket increase for the home health payment update in calendar year 2023. CMS also recalibrated case-mix weights and low utilization payment adjustment thresholds using 2021 data. Additionally, the rule applies a permanent 5.0% cap on decreases in the wage index, meaning an agency's wage index for any future year will not be less than 95.0% of the final wage index for the preceding year. For home health agencies that do not report required quality reporting data to CMS, their increase in payment will be 0.9%, rather than the full 2.9% contemplated in the rule. Overall, the Home Health Payment Final Rule estimates that Medicare payments to all home health agencies will increase in the aggregate by 0.7%, or $125.0 million, based on its contents. The rule is effective beginning January 1, 2023. A proposed rule for the 2024 Home Health Prospective Payment System Rate Update is expected later this year, and its finalization is anticipated in the fourth quarter. Any changes to CMS's payment for home health services in 2024 may be based upon behavioral data gathered and analyzed by CMS for the purposes of rate development, as explained in materials published by CMS on March 29, 2023.

Segments

We have two reportable segments: (1) home health and hospice services, which includes our home health, home care and hospice businesses; and (2) senior living services, which includes the operation of assisted living, independent living and memory care communities. Our Chief Executive Officer, who is our Chief Operating Decision Maker ("CODM"), reviews financial information at the operating segment level. We also report an "all other" category that includes general and administrative expense from our Service Center.

Common Stock Repurchase Program

On December 12, 2022, the Board of the Directors of the Company approved a share repurchase program under which the Company may repurchase up to $1.0 million of its common stock. Under the share repurchase program, the Company may repurchase shares from time to time through open market purchases, including through the use of trading plans intended to comply with Rule 10b5-1 under the Securities Exchange Act of 1934, as amended. The timing and total amount of stock repurchases will depend upon business, economic and market conditions, corporate and regulatory requirements, prevailing stock prices, and other considerations. The authorization expires on December 12, 2023, and may be suspended or discontinued at any time and does not obligate the company to acquire any amount of common stock. No shares were repurchased during the three months ended March 31, 2023.

Key Performance Indicators

We manage the fiscal aspects of our business by monitoring key performance indicators that affect our financial performance. These indicators and their definitions include the following:

Home Health and Hospice Services

- ***Total home health admissions***. The total admissions of home health patients, including new acquisitions, new admissions and readmissions.
- ***Total Medicare home health admissions***. Total admissions of home health patients, who are receiving care under Medicare reimbursement programs, including new acquisitions, new admissions and readmissions.
- ***Average Medicare revenue per completed 60-day home health episode***. The average amount of revenue for each completed 60-day home health episode generated from patients who are receiving care under Medicare reimbursement programs.
- ***Total hospice admissions***. Total admissions of hospice patients, including new acquisitions, new admissions and recertifications.
- ***Average hospice daily census***. The average number of patients who are receiving hospice care during any measurement period divided by the number of days during such measurement period.
- ***Hospice Medicare revenue per day***. The average daily Medicare revenue recorded during any measurement period for services provided to hospice patients.

The following table summarizes our overall home health and hospice statistics for the periods indicated:

	Three Months Ended March 31,	
	2023	2022
Home health services:		
Total home health admissions	10,910	10,182
Total Medicare home health admissions	4,948	4,633
Average Medicare revenue per 60-day completed episode[(a)]	$ 3,504	$ 3,495
Hospice services:		
Total hospice admissions	2,451	2,409
Average hospice daily census	2,439	2,232
Hospice Medicare revenue per day	$ 183	$ 179

(a) The year-to-date average Medicare revenue per 60-day completed episode includes post period claim adjustments for prior quarters.

Senior Living Services

- ***Occupancy***. The ratio of actual number of days our units are occupied during any measurement period to the number of days units are available for occupancy during such measurement period.
- ***Average monthly revenue per occupied unit***. The room and board revenue for senior living services during any measurement period divided by actual occupied senior living units for such measurement period divided by the number of months for such measurement period.

The following table summarizes our senior living statistics for the periods indicated:

	Three Months Ended March 31,	
	2023	2022
Occupancy	78.1 %	72.6 %
Average monthly revenue per occupied unit	$ 3,846	$ 3,371

Revenue Sources

Home Health and Hospice Services

Home Health. We derive the majority of our home health revenue from Medicare and managed care. The Medicare payment is adjusted for differences between estimated and actual payment amounts, an inability to obtain appropriate billing documentation or authorizations acceptable to the payor and other reasons unrelated to credit risk. Net service revenue is recognized in accordance with the under the PDGM methodology. Under PDGM, Medicare provides agencies with payments for each 30-day period of care provided to beneficiaries. If a beneficiary is still eligible for care after the end of the first 30-day payment period, a second 30-day payment period can begin. There are no limits to the number of periods of care a beneficiary who remains eligible for the home health benefit can receive. While payment for each 30-day period of care is adjusted to reflect the beneficiary's health condition and needs, a special outlier provision exists to ensure appropriate payment for those beneficiaries that have the most expensive care needs. The payment under the Medicare program is also adjusted for certain variables including, but not limited to: (a) a low utilization payment adjustment if the number of visits is below an established threshold that varies based on the diagnosis of a beneficiary; (b) a partial payment if the patient transferred to another provider or the Company received a patient from another provider before completing the period of care; (c) adjustment to the admission source of claim if it is determined that the patient had a qualifying stay in a post-acute care setting within 14 days prior to the start of a 30-day payment period; (d) the timing of the 30-day payment period provided to a patient in relation to the admission date, regardless of whether the same home health provider provided care for the entire series of episodes; (e) changes to the acuity of the patient during the previous 30-day period of care; (f) changes in the base payments established by the Medicare program; (g) adjustments to the base payments for case mix and geographic wages; and (h) recoveries of overpayments. For further detail regarding PDGM see the *Government Regulation* section of our 2022 Annual Report.

Hospice. We derive the majority of our hospice business revenue from Medicare reimbursement. The estimated payment rates are calculated as daily rates for each of the levels of care we deliver. Rates are set based on specific levels of care, are adjusted by a wage index to reflect healthcare labor costs across the country and are established annually through federal legislation. The following are the four levels of care provided under the hospice benefit:

- ***Routine Home Care ("RHC").*** Care that is not classified under any of the other levels of care, such as the work of nurses, social workers or home health aides.
- ***General Inpatient Care.*** Pain control or acute or chronic symptom management that cannot be managed in a setting other than an inpatient Medicare-certified facility, such as a hospital, skilled nursing facility or hospice inpatient facility.
- ***Continuous Home Care.*** Care for patients experiencing a medical crisis that requires nursing services to achieve palliation and symptom control, if the agency provides a minimum of eight hours of care within a 24-hour period.
- ***Inpatient Respite Care.*** Short-term, inpatient care to give temporary relief to the caregiver who regularly provides care to the patient.

CMS has established a two-tiered payment system for RHC. Hospices are reimbursed at a higher rate for RHC services provided from days of service one through 60 and a lower rate for all subsequent days of service. CMS also provides for a Service Intensity Add-On, which increases payments for certain RHC services provided by registered nurses and social workers to hospice patients during the final seven days of life.

Medicare reimbursement is adjusted for an inability to obtain appropriate billing documentation or authorizations acceptable to the payor and other reasons unrelated to credit risk. Additionally, as Medicare hospice revenue is subject to an inpatient cap limit and an overall payment cap, we monitor our provider numbers and estimate amounts due back to Medicare to the extent that the cap has been exceeded.

Senior Living Services. As of March 31, 2023, we provided assisted living, independent living and memory care services in 51 communities. Within our senior living operations, we generate revenue primarily from private pay sources, with a portion earned from Medicaid or other state-specific programs.

Primary Components of Expense

Cost of Services (excluding rent, general and administrative expense and depreciation and amortization). Our cost of services represents the costs of operating our independent operating subsidiaries, which primarily consists of payroll and related benefits, supplies, purchased services, and ancillary expenses such as the cost of pharmacy and therapy services provided to patients. Cost of services also includes the cost of general and professional liability insurance and other general cost of services specifically attributable to our operations.

Rent—Cost of Services. Rent—cost of services consists solely of base minimum rent amounts payable under lease agreements to our landlords. Our subsidiaries lease and operate but do not own the underlying real estate at our operations, and these amounts do not include taxes, insurance, impounds, capital reserves or other charges payable under the applicable lease agreements.

General and Administrative Expense. General and administrative expense consists primarily of payroll and related benefits and travel expenses for our Service Center personnel, including training and other operational support. General and administrative expense also includes professional fees (including accounting and legal fees), costs relating to information systems, stock-based compensation and rent for our Service Center offices.

Depreciation and Amortization. Property and equipment are recorded at their original historical cost. Depreciation is computed using the straight-line method over the estimated useful lives of the depreciable assets (ranging from one to 40 years). Leasehold improvements are amortized on a straight-line basis over the shorter of their estimated useful lives or the remaining lease term.

Critical Accounting Policies and Estimates

Our discussion and analysis of our financial condition and results of operations are based on Interim Financial Statements, which have been prepared in accordance with U.S. generally accepted accounting principles (“GAAP”). The preparation of the Interim Financial Statements and related disclosures requires us to make judgments, estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. On an ongoing basis we review our judgments and estimates, including but not limited to those related to self-insurance reserves, revenue, leases, intangible assets, goodwill, and income taxes. We base our estimates and judgments upon our historical experience, knowledge of current conditions and our belief of what could occur in the future considering available information, including assumptions that we believe to be reasonable under the circumstances. By their nature, these estimates and judgments are subject to an inherent degree of uncertainty, and actual results could differ materially from the amounts reported. While we believe that our estimates, assumptions, and judgments are reasonable, they are based on information available when the estimate was made. Refer to Note 2, *Basis of Presentation and Summary of Significant Accounting Policies*, within the 2022 Annual Report for further information on our critical accounting estimates and policies, which are as follows:

- ***Self-insurance reserves*** - The valuation methods and assumptions used in estimating costs up to retention amounts to settle open claims of insureds and an estimate of the cost of insured claims up to retention amounts that have been incurred but not reported;
- ***Revenue recognition*** - The estimate of variable considerations to arrive at the transaction price, including methods and assumptions used to determine settlements with Medicare and Medicaid payors or retroactive adjustments due to audits and reviews;
- ***Leases*** - We use our estimated incremental borrowing rate based on the information available at lease commencement date in determining the present value of future lease payments;
- ***Acquisition accounting*** - The assumptions used to allocate the purchase price paid for assets acquired and liabilities assumed in connection with our acquisitions; and
- ***Income taxes*** - The estimation of valuation allowance or the need for and magnitude of liabilities for uncertain tax position.

Recent Accounting Pronouncements

Information concerning recently issued accounting pronouncements are included in Note 2, *Basis of Presentation and Summary of Significant Accounting Policies* in the Interim Financial Statements.

Results of Operations

The following table sets forth details of our revenue, expenses and earnings as a percentage of total revenue for the periods indicated:

	Three Months Ended March 31,	
	2023	2022
Total revenue	100.0 %	100.0 %
Expense:		
Cost of services	81.1	79.3
Rent—cost of services	7.6	8.8
General and administrative expense	6.9	8.8
Depreciation and amortization	1.0	1.0
Total expenses	96.6	97.9
Income from operations	3.4	2.1
Other (expense):		
Interest expense, net	(1.1)	(0.6)
Other expense, net	(1.1)	(0.6)
Income before provision for income taxes	2.3	1.5
Provision for income taxes	0.7	0.5
Net income	1.6	1.0
Less: net income attributable to noncontrolling interest	0.1	0.1
Net income attributable to Pennant	1.5 %	0.9 %

The following table presents our consolidated GAAP Financial measures for the three months ended March 31, 2023 and 2022:

	Three Months Ended March 31,	
	2023	2022
	(In thousands)	
Consolidated GAAP Financial Measures:		
Total revenue	$ 126,464	$ 113,910
Total expenses	$ 122,184	$ 111,584
Income from operations	$ 4,280	$ 2,326

The following tables present certain financial information regarding our reportable segments. General and administrative expenses are not allocated to the reportable segments and are included in “All Other”:

	Home Health and Hospice Services	Senior Living Services	All Other	Total
		(In thousands)		
Segment GAAP Financial Measures:				
Three Months Ended March 31, 2023				
Revenue	$ 91,079	$ 35,385	$ —	$ 126,464
Segment Adjusted EBITDAR from Operations	$ 14,412	$ 10,241	$ (7,514)	$ 17,139
Three Months Ended March 31, 2022				
Revenue	$ 80,475	$ 33,435	$ —	$ 113,910
Segment Adjusted EBITDAR from Operations	$ 13,948	$ 9,432	$ (8,146)	$ 15,234

The table below provides a reconciliation of Segment Adjusted EBITDAR from Operations to Condensed Consolidated Income from operations:

	Three Months Ended March 31,	
	2023	2022
	(In thousands)	
Segment Adjusted EBITDAR from Operations[(a)]	$ 17,139	$ 15,234
Less: Depreciation and amortization	1,280	1,147
Rent—cost of services	9,597	10,051
Other Expense	30	3
Adjustments to Segment EBITDAR from Operations:		
Less: Costs at start-up operations[(b)]	203	131
Share-based compensation expense[(c)]	1,419	2,440
Acquisition related costs and credit allowances[(d)]	32	—
Costs associated with transitioning operations[(e)]	47	(757)
Unusual, non-recurring or redundant charges[(f)]	398	37
Add: Net income attributable to noncontrolling interest	147	144
Condensed Consolidated Income from Operations	$ 4,280	$ 2,326

(a) Segment Adjusted EBITDAR from Operations is net income attributable to the Company's reportable segments excluding interest expense, provision for income taxes, depreciation and amortization expense, rent, and, in order to view the operations performance on a comparable basis from period to period, certain adjustments including: (1) costs at start-up operations, (2) share-based compensation, (3) acquisition related costs and credit allowances, (4) the costs associated with transitioning operations, (5) unusual, non-recurring or redundant charges, and (6) net income attributable to noncontrolling interest. General and administrative expenses are not allocated to the reportable segments, and are included as “All Other”, accordingly the segment earnings measure reported is before allocation of corporate general and administrative expenses. The Company's segment measures may be different from the calculation methods used by other companies and, therefore, comparability may be limited.

(b) Represents results related to start-up operations. This amount excludes rent and depreciation and amortization expense related to such operations.

(c) Share-based compensation expense and related payroll taxes incurred. Share-based compensation expense and related payroll taxes are included in cost of services and general and administrative expense.

(d) Non-capitalizable costs associated with acquisitions and credit allowances for amounts in dispute with the prior owners of certain acquired operations.

(e) During the three months ended March 31, 2023, an affiliate of the Company placed its memory care units into transition and is actively seeking to sublease the units to an unrelated third party. The amount above represents the net operating impact attributable to the units in transition. The amounts reported exclude rent and depreciation and amortization expense related to such operations.

During January 2022, affiliates of the Company entered into Transfer Agreements with affiliates of Ensign, providing for the transfer of the operations of certain senior living communities (the "Transaction") from affiliates of the Company to affiliates of Ensign. The closing of the Transaction was completed in two phases with the transfer of two operations on March 1, 2022 and the remainder transferred on April 1, 2022. The amount above represents the net impact on revenue and cost of service attributable to all of the transferred entities. The amounts reported exclude rent and depreciation and amortization expense related to such operations.

(f) Represents unusual or non-recurring charges for legal services, implementation costs, integration costs, and consulting fees in general and administrative expenses.

Costs identified as redundant or non-recurring incurred by the Company for additional services provided by Ensign. All amounts are included in general and administrative expense. Fees incurred were $273 for the three months ended March 31, 2023, and $643 for the three months ended March 31, 2022.

Performance and Valuation Measures:

	Three Months Ended March 31,	
	2023	2022
	(In thousands)	
Consolidated Non-GAAP Financial Measures:		
Performance Metrics		
Consolidated EBITDA	$ 5,443	$ 3,332
Consolidated Adjusted EBITDA	$ 7,916	$ 6,145
Valuation Metric		
Consolidated Adjusted EBITDAR	$ 17,139	

	Three Months Ended March 31,	
	2023	2022
	(In thousands)	
Segment Non-GAAP Measures:[(a)]		
Segment Adjusted EBITDA from Operations		
Home health and hospice services	$ 13,182	$ 12,710
Senior living services	$ 2,248	$ 1,581

(a) General and administrative expenses are not allocated to any segment for purposes of determining segment profit or loss.

The tables below reconcile Consolidated Net Income to the consolidated Non-GAAP financial measures, Consolidated EBITDA and Consolidated Adjusted EBITDA, and to the Non-GAAP valuation measure, Consolidated Adjusted EBITDAR, for the periods presented:

	Three Months Ended March 31,	
	2023	2022
	(In thousands)	
Consolidated Net income	$ 1,997	$ 1,158
Less: Net income attributable to noncontrolling interest	147	144
Add: Provision for income taxes	907	542
Interest expense, net	1,406	629
Depreciation and amortization	1,280	1,147
Consolidated EBITDA	5,443	3,332
Adjustments to Consolidated EBITDA		
Add: Costs at start-up operations[(a)]	203	131
Share-based compensation expense[(b)]	1,419	2,440
Acquisition related costs and credit allowances[(c)]	32	—
Costs associated with transitioning operations[(d)]	47	(757)
Unusual, non-recurring or redundant charges[(e)]	398	37
Rent related to items (a) and (d) above	374	962
Consolidated Adjusted EBITDA	7,916	6,145
Rent—cost of services	9,597	10,051
Rent related to items (a) and (d) above	(374)	(962)
Adjusted rent—cost of services	9,223	9,089
Consolidated Adjusted EBITDAR	$ 17,139	

(a) Represents results related to start-up operations. This amount excludes rent and depreciation and amortization expense related to such operations.

(b) Share-based compensation expense and related payroll taxes incurred. Share-based compensation expense and related payroll taxes are included in cost of services and general and administrative expense.

(c) Non-capitalizable costs associated with acquisitions and credit allowances for amounts in dispute with the prior owners of certain acquired operations.

(d) During the three months ended March 31, 2023, an affiliate of the Company placed its memory care units into transition and is actively seeking to sublease the units to an unrelated third party. The amount above represents the net operating impact attributable to the units in transition. The amounts reported exclude rent and depreciation and amortization expense related to such operations.

During January 2022, affiliates of the Company entered into Transfer Agreements with affiliates of Ensign, providing for the transfer of the operations of certain senior living communities (the “Transaction”) from affiliates of the Company to affiliates of Ensign. The closing of the Transaction was completed in two phases with the transfer of two operations on March 1, 2022 and the remainder transferred on April 1, 2022. The amount above represents the net impact on revenue and cost of service attributable to all of the transferred entities. The amounts reported exclude rent and depreciation and amortization expense related to such operations.

(e) Represents unusual or non-recurring charges for legal services, implementation costs, integration costs, and consulting fees in general and administrative expenses.

Costs identified as redundant or non-recurring incurred by the Company for additional services provided by Ensign. All amounts are included in general and administrative expense. Fees incurred were $273 for the three months ended March 31, 2023, and $643 for the three months ended March 31, 2022.

The table below reconciles Segment Adjusted EBITDAR from Operations to Segment Adjusted EBITDA from Operations for the periods presented:

	Three Months Ended March 31,			
	Home Health and Hospice		Senior Living	
	2023	2022	2023	2022
	(In thousands)			
Segment Adjusted EBITDAR from Operations	$ 14,412	$ 13,948	$ 10,241	$ 9,432
Less: Rent—cost of services	1,323	1,262	8,274	8,789
Rent related to start-up and transitioning operations	(93)	(24)	(281)	(938)
Segment Adjusted EBITDA from Operations	$ 13,182	$ 12,710	$ 2,248	$ 1,581

The following discussion includes references to certain performance and valuation measures, which are non-GAAP financial measures, including Consolidated EBITDA, Consolidated Adjusted EBITDA, Segment Adjusted EBITDA from Operations, and Consolidated Adjusted EBITDAR (collectively, “Non-GAAP Financial Measures”). Non-GAAP Financial Measures are used in addition to, and in conjunction with, results presented in accordance with GAAP and should not be relied upon to the exclusion of GAAP financial measures. Non-GAAP Financial Measures reflect an additional way of viewing aspects of our operations and company that, when viewed with our GAAP results and the accompanying reconciliations to corresponding GAAP financial measures, we believe can provide a more comprehensive understanding of factors and trends affecting our business.

We believe these Non-GAAP Financial Measures are useful to investors and other external users of our financial statements regarding our results of operations because:

- they are widely used by investors and analysts in our industry as a supplemental measure to evaluate the overall performance of companies in our industry without regard to items such as interest expense, rent expense and depreciation and amortization, which can vary substantially from company to company depending on the book value of assets, the method by which assets were acquired, and differences in capital structures;
- they help investors evaluate and compare the results of our operations from period to period by removing the impact of our asset base and capital structure from our operating results; and
- Consolidated Adjusted EBITDAR is used by investors and analysts in our industry to value the companies in our industry without regard to capital structures.

We use Non-GAAP Financial Measures:

- as measurements of our operating performance to assist us in comparing our operating performance on a consistent basis from period to period;
- to allocate resources to enhance the financial performance of our business;
- to assess the value of a potential acquisition;
- to assess the value of a transformed operation’s performance;
- to evaluate the effectiveness of our operational strategies; and
- to compare our operating performance to that of our competitors.

We typically use Non-GAAP Financial Measures to compare the operating performance of each operation from period to period. We find that Non-GAAP Financial Measures are useful for this purpose because they do not include such costs as interest expense, income taxes, depreciation and amortization expense, which may vary from period-to-period depending upon various factors, including the method used to finance operations, the date of acquisition of a community or business, and the tax law of the state in which a business unit operates.

We also establish compensation programs and bonuses for our leaders that are partially based upon the achievement of Consolidated Adjusted EBITDAR targets.

Non-GAAP Financial Measures have no standardized meaning defined by GAAP. Therefore, our Non-GAAP Financial Measures have limitations as analytical tools, and they should not be considered in isolation, or as a substitute for analysis of our results as reported in accordance with GAAP. Some of these limitations are:

- they do not reflect our current or future cash requirements for capital expenditures or contractual commitments;
- they do not reflect changes in, or cash requirements for, our working capital needs;
- they do not reflect the net interest expense, or the cash requirements necessary to service interest or principal payments, on our debt;
- in the case of Consolidated Adjusted EBITDAR, it does not reflect rent expenses, which are normal and recurring operating expenses that are necessary to operate our leased operations;
- they do not reflect any income tax payments we may be required to make;
- although depreciation and amortization are non-cash charges, the assets being depreciated and amortized will often have to be replaced in the future, and do not reflect any cash requirements for such replacements; and
- other companies in our industry may calculate the same Non-GAAP Financial Measures differently than we do, which may limit their usefulness as comparative measures.

We compensate for these limitations by using Non-GAAP Financial Measures only to supplement net income on a basis prepared in accordance with GAAP in order to provide a more complete understanding of the factors and trends affecting our business.

We strongly encourage investors to review the Interim Financial Statements, included in this Quarterly Report in their entirety and to not rely on any single financial measure. Because these Non-GAAP Financial Measures are not standardized, it may not be possible to compare these financial measures with other companies' non-GAAP financial measures having the same or similar names. These Non-GAAP Financial Measures should not be considered a substitute for, nor superior to, financial results and measures determined or calculated in accordance with GAAP. We strongly urge you to review the reconciliation of income from operations to the Non-GAAP Financial Measures in the table presented above, along with the Interim Financial Statements and related notes included elsewhere in this Quarterly Report.

We believe the following Non-GAAP Financial Measures are useful to investors as key operating performance measures and valuation measures:

Performance Measures:

Consolidated EBITDA

We believe Consolidated EBITDA is useful to investors in evaluating our operating performance because it helps investors evaluate and compare the results of our operations from period to period by removing the impact of our asset base (depreciation and amortization expense) from our operating results.

We calculate Consolidated EBITDA as net income, adjusted for net income attributable to noncontrolling interest prior to the Spin-Off, before (a) interest expense (b) provision for income taxes and (c) depreciation and amortization.

Consolidated Adjusted EBITDA

We adjust Consolidated EBITDA when evaluating our performance because we believe that the exclusion of certain additional items described below provides useful supplemental information to investors regarding our ongoing operating performance. We believe that the presentation of Consolidated Adjusted EBITDA, when considered with Consolidated EBITDA and GAAP net income is beneficial to an investor's complete understanding of our operating performance.

We calculate Consolidated Adjusted EBITDA by adjusting Consolidated EBITDA to exclude the effects of non-core business items, which for the reported periods includes, to the extent applicable:

- costs at start-up operations;
- share-based compensation expense;
- acquisition related costs and credit allowances;

- Costs associated with transitioning operations; and
- unusual, non-recurring, or redundant charges.

Segment Adjusted EBITDA from Operations

We calculate Segment Adjusted EBITDA from Operations by adjusting Segment Adjusted EBITDAR from Operations to include rent-cost of services. We believe that the inclusion of rent-cost of services provides useful supplemental information to investors regarding our ongoing operating performance for each segment.

***Valuation Measure*:**

Consolidated Adjusted EBITDAR

We use Consolidated Adjusted EBITDAR as one measure in determining the value of prospective acquisitions. It is also a measure commonly used by us, research analysts and investors to compare the enterprise value of different companies in the healthcare industry, without regard to differences in capital structures. Additionally, we believe the use of Consolidated Adjusted EBITDAR allows us, research analysts and investors to compare operational results of companies with operating and finance leases. A significant portion of finance lease expenditures are recorded in interest, whereas operating lease expenditures are recorded in rent expense.

This measure is not displayed as a performance measure as it excludes rent expense, which is a normal and recurring operating expense and, as such, does not reflect our cash requirements for leasing commitments. Our presentation of Consolidated Adjusted EBITDAR should not be construed as a financial performance measure.

The adjustments made and previously described in the computation of Consolidated Adjusted EBITDA are also made when computing Consolidated Adjusted EBITDAR. We calculate Consolidated Adjusted EBITDAR by excluding rent-cost of services and rent related to start up operations from Consolidated Adjusted EBITDA.

Three Months Ended March 31, 2023 Compared to the Three Months Ended March 31, 2022

Revenue

	Three Months Ended March 31,			
	2023		2022	
	Revenue Dollars	Revenue Percentage	Revenue Dollars	Revenue Percentage
	(In thousands)			
Home health and hospice services				
Home health	$ 41,780	33.0 %	$ 37,420	32.9 %
Hospice	43,289	34.2	37,823	33.2
Home care and other[(a)]	6,010	4.8	5,232	4.5
Total home health and hospice services	91,079	72.0	80,475	70.6
Senior living services	35,385	28.0	33,435	29.4
Total revenue	$ 126,464	100.0 %	$ 113,910	100.0 %

(a) Home care and other revenue is included with home health revenue in other disclosures in this Quarterly Report.

Our total revenue increased $12.6 million, or 11.0%, during the three months ended March 31, 2023. The increase in revenue was driven by increases in all key metrics for home health and hospice and senior living, including hospice admissions, hospice revenue per day, hospice average daily census, senior living occupancy, and senior living revenue per occupied room.

Home Health and Hospice Services

	Three Months Ended March 31,			
	2023	2022	Change	% Change
	(In thousands)			
Home health and hospice revenue				
Home health services	$ 41,780	$ 37,420	$ 4,360	11.7 %
Hospice services	43,289	37,823	5,466	14.5
Home care and other	6,010	5,232	778	14.9
Total home health and hospice revenue	$ 91,079	$ 80,475	$ 10,604	13.2 %

	Three Months Ended March 31,			
	2023	2022	Change	% Change
Home health services:				
Total home health admissions	10,910	10,182	728	7.1 %
Total Medicare home health admissions	4,948	4,633	315	6.8
Average Medicare revenue per 60-day completed episode[(a)]	$ 3,504	$ 3,495	$ 9	0.3
Hospice services:				
Total hospice admissions	2,451	2,409	42	1.7
Average daily census	2,439	2,232	207	9.3
Hospice Medicare revenue per day	$ 183	$ 179	$ 4	2.2
Number of home health and hospice agencies at period end	96	88	8	9.1

(a) The year-to-date average for Medicare revenue per 60-day completed episode includes post period claim adjustments for prior periods.

Home health and hospice revenue increased $10.6 million, or 13.2% during the three months ended March 31, 2023. Segment revenue grew primarily due to an increase in hospice average daily census of 9.3%, as well as an increase of 7.1% in home health admissions, inclusive of an increase in total Medicare home health admissions of 6.8%.

Senior Living Services

	Three Months Ended March 31,			
	2023	2022	Change	% Change
Revenue (in thousands)	$ 35,385	$ 33,435	$ 1,950	5.8 %
Number of communities at period end	51	52	(1)	(1.9)
Occupancy	78.1 %	72.6 %	5.5 %	
Average monthly revenue per occupied unit	$ 3,846	$ 3,371	$ 475	14.1

Senior living revenue increased $2.0 million, or 5.8%, for the three months ended March 31, 2023 compared to the same period in the prior year primarily due to an increase of 14.1% in average monthly revenue per occupied unit and an addition of 5.5% in the occupancy rate between March 31, 2022 and March 31, 2023.

Cost of Services

	Three Months Ended March 31,			
	2023	2022	Change	% Change
	(In thousands)			
Home Health and Hospice	$ 77,406	$ 66,937	$ 10,469	15.6 %
Senior Living	25,196	23,324	1,872	8.0
Total cost of services	$ 102,602	$ 90,261	$ 12,341	13.7 %

Consolidated cost of services increased $12.3 million or 13.7% during the three months ended March 31, 2023. Cost of services as a percentage of revenue for the three months ended March 31, 2023 increased by 1.8% to 81.1% from 79.3% compared to the three months ended March 31, 2022.

Home Health and Hospice Services

	Three Months Ended March 31,			
	2023	2022	Change	% Change
Cost of service (in thousands)	$ 77,406	$ 66,937	$ 10,469	15.6 %
Cost of services as a percentage of revenue	85.0 %	83.2 %	1.8 %	

Cost of services related to our Home Health and Hospice services segment increased $10.5 million, or 15.6%, primarily due to the increased volume of services from growth in admissions and census. Cost of services as a percentage of revenue for the three months ended March 31, 2023 increased by 1.8% compared to the three months ended March 31, 2022 primarily due to increased wage rates, benefits, and contract labor cost.

Senior Living Services

	Three Months Ended March 31,			
	2023	2022	Change	% Change
Cost of service (in thousands)	$ 25,196	$ 23,324	$ 1,872	8.0 %
Cost of services as a percentage of revenue	71.2 %	69.8 %	1.4 %	

Cost of services related to our Senior Living services segment increased $1.9 million, or 8.0% during the three months ended March 31, 2023 in response to higher occupancy and wage rate increases. As a percentage of revenue, costs of service increased by 1.4% from 69.8% to 71.2% during the three months ended March 31, 2023 when compared to the three months ended March 31, 2022, due primarily to increased wage rates and benefits.

Rent—Cost of Services. Rent decreased 4.5% from $10.1 million to $9.6 million during the three months ended March 31, 2023 compared to the same period in the prior year, primarily as a result of the transfer of senior living communities to Ensign. As a percentage of revenue, rent—cost of services decreased 1.2% when compared to the three months ended March 31, 2022.

General and Administrative Expense. Our general and administrative expense decreased $1.3 million or 13.2% from $10.0 million to $8.7 million for the three months ended March 31, 2023 when compared to the three months ended March 31, 2022. The decrease in general and administrative expense was due to a decrease of $1.1 million in share-based compensation, for the three months ended March 31, 2023 when compared to the three months ended March 31, 2022.

Depreciation and Amortization. Depreciation and amortization expense increased by $0.1 million and remained flat as a percentage of revenue for three months ended March 31, 2023 as compared to the three months ended March 31, 2022.

Loss on asset dispositions and impairment, net. Loss on asset dispositions and impairment, net decreased $0.1 million for the three months ended March 31, 2023 when compared to the three months ended March 31, 2022.

Provision for Income Taxes. We recorded income tax expense of $0.9 million and $0.5 million, or 31.2% and 31.9% of earnings before income taxes, for the three months ended March 31, 2023 and 2022, respectively. The decrease in effective tax is primarily due to a decrease in non-deductible equity compensation.

Liquidity and Capital Resources

Our primary sources of liquidity are net cash provided by operating activities and borrowings under our revolving credit facility.

Revolving Credit Facility

On February 23, 2021, Pennant entered into an amendment to its existing credit agreement (as amended, the "Credit Agreement"), which provides for an increased revolving credit facility with a syndicate of banks with a borrowing capacity of $150.0 million (the "Revolving Credit Facility"). The Revolving Credit Facility is not subject to interim amortization and the Company will not be required to repay any loans under the Revolving Credit Facility prior to maturity in 2026. The Company is permitted to prepay all or any portion of the loans under the Revolving Credit Facility prior to maturity without premium or penalty, subject to reimbursement of any LIBOR breakage costs of the lenders.

The Credit Agreement contains customary covenants that, among other things, restrict, subject to certain exceptions, the ability of the Company and its independent operating subsidiaries to grant liens on their assets, incur indebtedness, sell assets, make investments, engage in acquisitions, mergers or consolidations, amend certain material agreements and pay certain dividends and other restricted payments. Financial covenants require compliance with certain levels of leverage ratios that impact the amount of interest. As of March 31, 2023, the Company was compliant with all such financial covenants.

As of March 31, 2023, we had $3.0 million of cash and $87.3 million of available borrowing capacity on our Revolving Credit Facility.

We believe that our existing cash, cash generated through operations, and access to available borrowing capacity under our existing Credit Agreement, will be sufficient to provide adequate liquidity for the next twelve months for both our operating activities and opportunities for acquisition growth.

The following table presents selected data from our Condensed Consolidated Statement of Cash Flows for the periods presented:

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	Three Months Ended March 31,	
	2023	2022
	(In thousands)	
Net cash provided by (used in) operating activities	$ 8,996	$ (4,071)
Net cash used in investing activities	(2,326)	(2,582)
Net cash (used in) provided by financing activities	(5,797)	5,090
Net increase (decrease) in cash	873	(1,563)
Cash at beginning of period	2,079	5,190
Cash at end of period	$ 2,952	$ 3,627

Three Months Ended March 31, 2023 Compared to the Three Months Ended March 31, 2022

Our net cash flow from operating activities for the three months ended March 31, 2023 increased by $13.1 million when compared to the three months ended March 31, 2022. The primary driver of this difference can be attributed to a $0.8 million increase in Net income, a $6.3 million increase in cash flows from improved cash collections of accounts receivable and a decrease in CARES fund repayments.

Our net cash used in investing activities for the three months ended March 31, 2023 decreased by $0.3 million compared to the three months ended March 31, 2022, primarily driven by $0.2 million less in cash used for restricted and other assets during the three months ended March 31, 2023 compared to the three months ended March 31, 2022.

Our net cash used in financing activities increased by approximately $10.9 million for the three months ended March 31, 2023 compared to the three months ended March 31, 2022. The increase was primarily due to a net reduction in the balance on our line of credit during the three months ended March 31, 2023 compared to the three months ended March 31, 2022.

Contractual Obligations, Commitments and Contingencies

We continue to make draws and payments on our Revolving Credit Facility, as described in Note 11, *Debt*, to the Interim Financial Statements in Part I of this Quarterly Report. Additionally, we have right-of-use assets obtained in exchange for new operating lease obligations, as described in the supplemental disclosures of cash flow information in the Condensed Consolidated Statement of Cash Flows and in Note 13, *Leases*, to the Interim Financial Statements in Part I of this Quarterly Report.

Besides those transactions there have been no other material changes to our total obligations during the period covered by this Quarterly Report outside of the normal course of our business.

Item 3. ***Quantitative and Qualitative Disclosures About Market Risk***

Interest Rate Risk. We are exposed to risks associated with market changes in interest rates. Our Revolving Credit Facility exposes us to variability in interest payments due to changes in LIBOR (and any benchmark replacement rate chosen after the completion of the phase-out of LIBOR in June 2023). A 1.0% interest rate change would cause interest expense to change by approximately $0.6 million annually based upon our outstanding long-term debt as of March 31, 2023. We manage our exposure to this market risk by monitoring available financing alternatives.

LIBOR Phase-Out. LIBOR is in the process of being wound down and will be phased out by June 30, 2023. As of March 31, 2023 all CHF and EUR LIBOR settings, the 1 Week and 2 Months USD LIBOR settings, and the Overnight/Spot Next, 1 Week, 2 Months and 12 Months GBP and JPY LIBOR settings have ceased to be published. However, the Overnight and the 1-, 3-, 6- and 12-Months USD LIBOR settings will continue until June 2023. We are required to pay interest on borrowings under our Credit Facility at floating rates based on the 1-month LIBOR and thus, we do not expect to transition from the LIBOR benchmark until June 2023.

Future debt that we may incur may also require that we pay interest based upon LIBOR, or a "synthetic" benchmark equivalent such as the Standard Overnight Financing Rate or ("SOFR"). Our Credit Agreement provides a mechanism by which, when LIBOR is no longer published and available, the Administrative Agent and the Company may amend the Credit Agreement to replace LIBOR with a benchmark replacement rate (which may include term SOFR). We currently expect that the benchmark rate used to determine the interest rate applicable to borrowings under our Credit Agreement would be revised as provided under the agreement or amended as necessary to provide for an interest rate that approximates the existing interest rate as calculated in accordance with LIBOR for similar types of loans. Despite our current expectations, we cannot be sure that, when LIBOR is phased out, the changes to the benchmark rate used to determine the interest rate applicable to borrowings under our Credit Agreement would approximate the current calculation in accordance with LIBOR.

Item 4. ***Controls and Procedures***

Evaluation of Disclosure Controls and Procedures

Under the supervision and with the participation of our management, including the Chief Executive Officer and Chief Financial Officer, we have evaluated the effectiveness of our disclosure controls and procedures (as such term is defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended (the "Exchange Act")), as of the end of the period covered by this Quarterly Report. Based on that evaluation, the Chief Executive Officer and Chief Financial Officer have concluded that these disclosure controls and procedures were effective to provide reasonable assurance that information we are required to disclose in reports that we file or submit under the Exchange Act is recorded, processed, summarized, and reported within the time periods specified in SEC rules and forms, and that such information is accumulated and communicated to our management, including our Chief Executive Officer and Chief Financial Officer, as appropriate, to allow timely decisions regarding required disclosure.

Changes in Internal Control over Financial Reporting

There were no material changes in our internal control over financial reporting (as such term is defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act) that occurred during our most recent fiscal quarter that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

PART II. OTHER INFORMATION

Item 1. ***Legal Proceedings***

We are involved in various claims and lawsuits arising in the ordinary course of business, none of which, in the opinion of management, is expected to have a material adverse effect on our results of operations or financial condition. However, the results of such matters cannot be predicted with certainty and we cannot assure you that the ultimate resolution of any legal or administrative proceeding or dispute will not have a material adverse effect on our business, financial condition, results of operations and cash flows. See Note 15, *Commitments and Contingencies*, to the Interim Financial Statements for a description of claims and legal actions arising in the ordinary course of our business.

Item 1A. ***Risk Factors***

We have disclosed under the heading “Risk Factors” in the 2022 Annual Report risk factors that materially affect our business, financial condition or results of operations. You should carefully consider the risk factors set forth in the 2022 Annual Report and the other information set forth elsewhere in this Quarterly Report. You should be aware that these risk factors and other information may not describe every risk facing our Company. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial also may materially adversely affect our business, financial condition and/or operating results.

Item 6. Exhibits

EXHIBIT INDEX

Exhibit	Description
3.1	Amended and Restated Certificate of Incorporation of The Pennant Group, Inc., effective as of September 27, 2019 (incorporated by reference to Exhibit 3.1 to The Pennant Group, Inc.'s Current Report on Form 8-K (File No. 001-38900) filed with the SEC on October 3, 2019).
3.2	Second Amended and Restated Bylaws of The Pennant Group, Inc., effective as of February 21, 2022 (incorporated by reference to Exhibit 3.1 to The Pennant Group, Inc.'s Current Report on Form 8-K (File No. 001-38900) filed with the SEC February 22, 2022).
31.1	Certification of Chief Executive Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
31.2	Certification of Chief Financial Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1	Certification of Chief Executive Officer pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
32.2	Certification of Chief Financial Officer pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
101.INS	XBRL Instance Document - the instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document.
101.SCH	Inline XBRL Taxonomy Extension Schema Document
101.CAL	Inline XBRL Taxonomy Extension Calculation Linkbase Document
101.DEF	Inline XBRL Taxonomy Extension Definition Linkbase Document
101.LAB	Inline XBRL Taxonomy Extension Label Linkbase Document
101.PRE	Inline XBRL Taxonomy Extension Presentation Linkbase Document
104	Cover Page Interactive Data File (embedded within the Inline XBRL document)

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

The Pennant Group, Inc.

Dated: May 4, 2023

BY: /s/ JENNIFER L. FREEMAN

Jennifer L. Freeman

Interim Chief Financial Officer (Principal Financial Officer and Duly Authorized Officer)

EXHIBIT 31.1

I, Brent Guerisoli, certify that:

1. I have reviewed this annual report on Form 10-Q of The Pennant Group, Inc;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) for the registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: May 4, 2023

/s/ BRENT GUERISOLI

Name:	Brent Guerisoli
Title:	Chief Executive Officer (Principal Executive Officer)

EXHIBIT 31.2

I, Jennifer L. Freeman, certify that:

1. I have reviewed this annual report on Form 10-Q of The Pennant Group, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) for the registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: May 4, 2023

/s/ JENNIFER L. FREEMAN

Name: Jennifer L. Freeman

Title: *Interim Chief Financial Officer (Principal Financial Officer, Principal Accounting Officer and Duly Authorized Officer)*

EXHIBIT 32.1

CERTIFICATION PURSUANT TO
18 U.S.C. §1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Annual Report of The Pennant Group, Inc. (the Company) on Form 10-Q for the period ended March 31, 2023, as filed with the Securities and Exchange Commission on the date hereof (the Report), I, Brent Guerisoli, Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that to my knowledge:

1 The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

2 The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ BRENT GUERISOLI

Name: Brent Guerisoli

Title: Chief Executive Officer (Principal Executive Officer)

May 4, 2023

A signed original of this written statement required by 18 U.S.C. Section 1350 has been provided to the Company and will be retained by the Company and furnished to the Securities and Exchange Commission or its staff upon request.

EXHIBIT 32.2

CERTIFICATION PURSUANT TO
18 U.S.C. §1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Annual Report of The Pennant Group, Inc. (the Company) on Form 10-Q for the period ended March 31, 2023, as filed with the Securities and Exchange Commission on the date hereof (the Report), I, Jennifer L. Freeman, Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that to my knowledge:

1 The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

2 The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ JENNIFER L. FREEMAN

Name: Jennifer L. Freeman

Title: *Interim Chief Financial Officer (Principal Financial Officer, Principal Accounting Officer and Duly Authorized Officer)*

May 4, 2023

A signed original of this written statement required by 18 U.S.C. Section 1350 has been provided to the Company and will be retained by the Company and furnished to the Securities and Exchange Commission or its staff upon request.

EXHIBIT 11

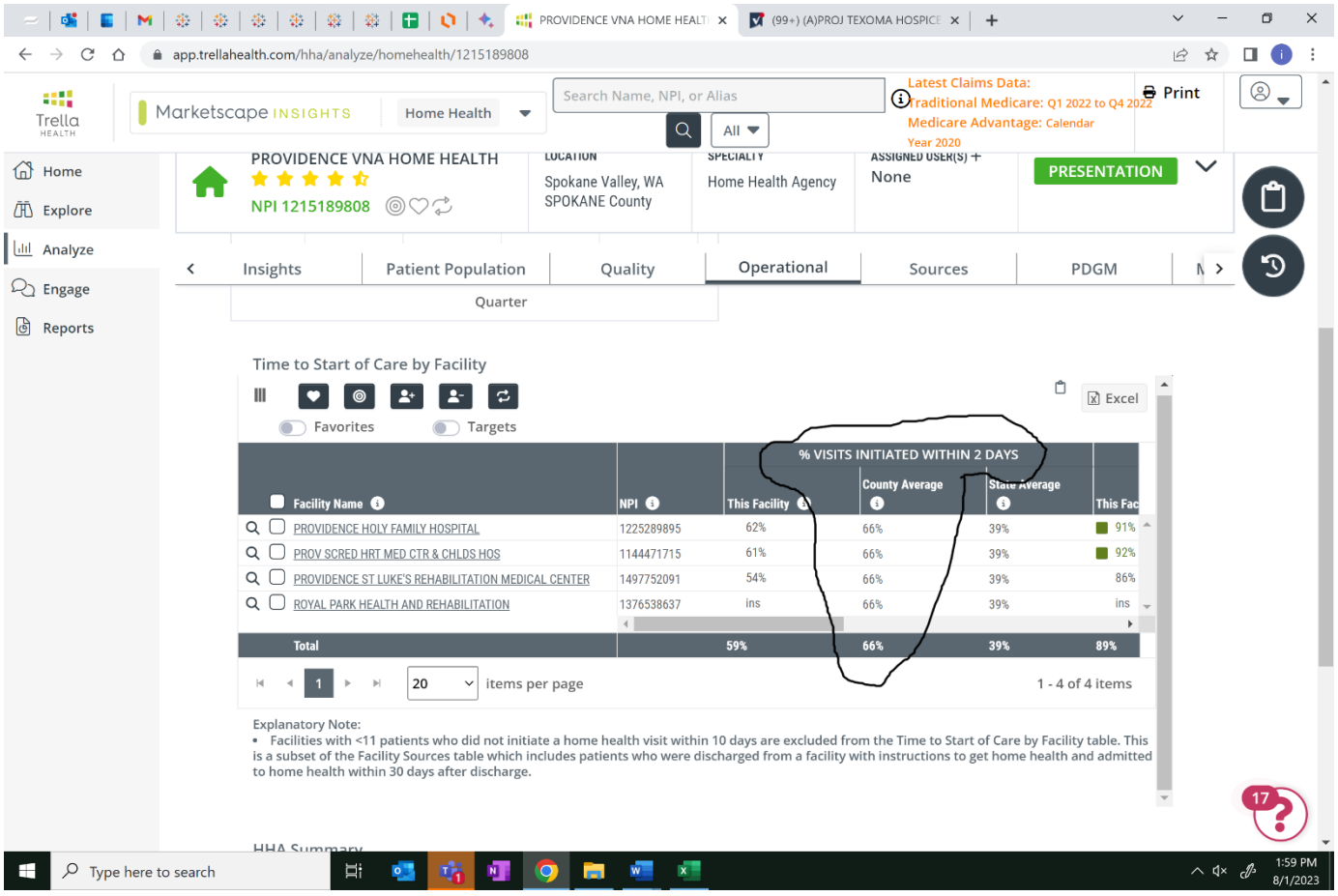
PROVIDENCE VNA HOME HEALT
(99+) (A)PROJ TEXOMA HOSPICE
app.trellahealth.com/hha/analyze/homehealth/1215189808
Trella HEALTH
Marketscape INSIGHTS
Home Health
Search Name, NPI, or Alias
All
Latest Claims Data:
Traditional Medicare: Q1 2022 to Q4 2022
Medicare Advantage: Calendar Year 2020
Print
Home
Explore
Analyze
Engage
Reports
PROVIDENCE VNA HOME HEALTH
NPI 1215189808
LOCATION
Spokane Valley, WA
SPOKANE County
SPECIALTY
Home Health Agency
ASSIGNED USER(S)
None
PRESENTATION
Insights
Patient Population
Quality
Operational
Sources
PDGM
Quarter
Time to Start of Care by Facility
Excel
Favorites
Targets
% VISITS INITIATED WITHIN 2 DAYS
Facility Name
NPI
This Facility
County Average
State Average
This Fac
PROVIDENCE HOLY FAMILY HOSPITAL 1225289895 62% 66% 39% 91%
PROV SCRED HRT MED CTR & CHLDS HOS 1144471715 61% 66% 39% 92%
PROVIDENCE ST LUKE'S REHABILITATION MEDICAL CENTER 1497752091 54% 66% 39% 86%
ROYAL PARK HEALTH AND REHABILITATION 1376538637 ins 66% 39% ins
Total 59% 66% 39% 89%
1
20
items per page
1 - 4 of 4 items
Explanatory Note:
• Facilities with <11 patients who did not initiate a home health visit within 10 days are excluded from the Time to Start of Care by Facility table. This is a subset of the Facility Sources table which includes patients who were discharged from a facility with instructions to get home health and admitted to home health within 30 days after discharge.
17
HHA Summary
Type here to search
1:59 PM
8/1/2023

EXHIBIT 12

PENNANT

April 10, 2023

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

Dear Mr. Hernandez,

As the Corporate Controller for The Pennant Group, Inc., the ultimate parent company of **Orchard Prairie Healthcare LLC**, I am writing to affirm a commitment to fully finance the establishment of **Manito Home Health** in Spokane County, Washington. As the ultimate parent of **Orchard Prairie Healthcare LLC** we have provided a copy of Pennant's 10-Q in conjunction with this filing that demonstrates the necessary capital reserves to meet the funding requirements.

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

Sincerely,

Mike Magette

Mike Magette
Corporate Controller
The Pennant Group, Inc.
1675 E. Riverside Dr., Ste 150
Eagle, ID 83616