

## HILABS CARE, INC.

### ANCILLARY SERVICES AGREEMENT

This Ancillary Services Agreement ("Agreement") is made and entered into as of the first day of January 2021, by and between HILABS CARE, INC. doing business as **BRAND NEW DAY** ("Plan") and **ASCC LLC dba Riverwood Healthcare Center** ("Provider"), with reference to the following facts:

WHEREAS, Plan is a licensed health care services plan that has entered into or will enter into contracts with various government and private Payors under which the Plan has agreed to provide or arrange health care services and benefits to Plan Members under the Programs identified in Exhibit A hereto.

WHEREAS, Provider desires to participate in Plan's network of contracting providers by providing Ancillary Services to Members.

NOW THEREFORE, in consideration of the foregoing and for other good and valuable consideration, the parties hereto agree as follows:

#### ARTICLE I. DEFINITIONS

Whenever used in this Agreement, the following terms shall have the definitions contained in this Article I. Terms used in this Agreement which are defined by Law shall be interpreted consistent with such Laws.

- 1.1. Accreditation Organization. Accreditation Organization means any organization engaged in accrediting or certifying Plan or Provider.
- 1.2. Audit Protocol. Audit Protocol is the official procedure or system of rules governing affairs of how an Audit is conducted by a particular Regulatory Agency.
- 1.3. Ancillary Services. Ancillary Services are those Covered Services provided by Provider in accordance with its license. Ancillary Services may be further defined in Exhibit F hereto.
- 1.4. CMS. CMS is the Centers for Medicare and Medicaid Services, the agency of the United States government responsible for administering the Medicare program.
- 1.5. CMS Agreement. CMS Agreement is the Medicare contract between Plan and CMS.
- 1.6. Commencement Date. Commencement Date is the date this Agreement becomes effective, as specified in the first sentence to this Agreement or the date which the last party executes the agreement, whichever is later.
- 1.7. Complete Claim. Complete Claim shall have the meaning set forth in Title 28 of the California Code of Regulations, Section 1300.71 (a)(2) or as otherwise required by Law for the applicable Program.
- 1.8. Copayment. Copayment means an amount (whether expressed as either a percentage of cost or as a specific dollar amount) that a Member is obligated to pay directly to a provider for a specific service in accordance with the Program under which he or she is covered and in accordance with any applicable Membership Materials. For purposes of this Agreement, Copayments shall include, but not be limited to, those payments commonly referred to as "coinsurance," "copayments," and/or "deductibles."
- 1.9. Covered Services. Covered Services are those Medically Necessary health care services, supplies and benefits which are required by a Member pursuant to the coverage provisions of a Program, as further specified in the applicable Services Agreements and Membership Materials.
- 1.10. DHCS. DHCS is the State of California Department of Health Care Services, the agency responsible for administering the Medi-Cal program in California.

IN WITNESS WHEREOF, the undersigned have executed this Agreement effective as of the Commencement Date.

PLAN

**Hilabs Care, Inc. d.b.a. Brand New Day**

By: \_\_\_\_\_  
Name: John XYZ  
Title: CEO  
Date: 4.13.2021

Plan Address and/or Facsimile for Notices:

Street Address: 5455Abc Blvd #500  
City, State, Zip: XYZ CA 92845  
Facsimile Number: 666 / 4 00-1 2 09  
Email: ProviderContracting@hilaabscare.com

PROVIDER

**ASCC LLC dba  
Riverwood Healthcare Center**

By: \_\_\_\_\_  
Name: Smith XYZ  
Title: Associate  
Date: 4.13.2021

Provider Address and Facsimile Number for Notices:

Street Address: 5320 XYZ Circle  
City, State, Zip: ABC CA 95210  
Facsimile Number: 209-473-9999  
Tax ID #: 46-3055555  
NPI #: 1 6395 99999

## **EXHIBIT A**

### **SCHEDULE OF PROGRAMS**

Provider has been approved to provide Ancillary Services under the Programs defined below and pursuant to the applicable terms and conditions of the Agreement, including, without limitation, Exhibits B through E hereto.

**Medi-Cal Program:** A state and federally funded Program pursuant to a contract between the Plan or Payor and DHCS for coverage of Members who meet Medi-Cal eligibility requirements, as determined by DHCS.

**Medicare Program:** A Program sponsored by Plan or Payor pursuant to a contract with the federal Centers for Medicare and Medicaid Services ("CMS Contract") under the Medicare Advantage program.

**Commercial HMO Program:** The commercial health benefit program(s) offered and sold by Plan to Subscriber Groups, including, without limitation, the Plan's Health Benefit Off-Exchange Program.

**EXHIBIT E**  
**ANCILLARY SERVICES**

**Skilled Nursing Facility**

## EXHIBIT F COMPENSATION

The following shall constitute 100% payment for services when combined with any required co-payment and authorized.

### **MEDICARE MEMBERS**

Skilled Nursing Services (SNF) and/or Sub-Acute Services shall be reimbursed at One Hundred Percent (100%) of the current year Medicare Rate

### **MEDI-CAL MEMBERS**

	Care Level	Revenue Code	Reimbursement Rate
<b>Level I services include, but are not limited to:</b>		<b>191</b>	<b>\$360</b>
<ul style="list-style-type: none"> <li>• Room and board</li> <li>• Twenty-four (24) hour nursing care</li> <li>• Prepared meals</li> <li>• Medication administration, oral, IM and subcutaneous (IV not included in this level)</li> <li>• Routine laboratory and radiology services</li> <li>• In and out catheter care</li> <li>• New and existing ostomy care, training and supplies</li> <li>• Medical/disposable supplies</li> <li>• Routine/standard DME (does not include bariatric, specialty mattress surfaces, Bi-Pap, C-Pap, wound vac, CPM, customized orthotics/prosthetics, customized wheelchairs)</li> <li>• Oxygen and supplies</li> <li>• New and existing tube feedings, (NG, gastrostomy, PEG) with nutritional supplements, and supplies</li> <li>• Medically stable but requires healthcare care needs to be assessed periodically 24 hours/day by licensed nurse or professional medical personnel</li> <li>• Medication administration (does not include antibiotics)</li> <li>• Restorative Nursing Care, Range of Motion</li> <li>• No rehab included in this level</li> <li>• Skilled care reflects minimal nursing intervention</li> <li>• Co-morbidities do not complicate treatment plan</li> <li>• Discharge planning/Social Services/Case Management</li> </ul>			
<b>Level II services include Level I services plus:</b>		<b>192</b>	<b>\$400</b>
<ul style="list-style-type: none"> <li>• IV fluids for hydration</li> <li>• Bowel and bladder training</li> <li>• Diabetic management</li> <li>• Assessment and management of chronic disease and co-morbidities that do not complicate the treatment plan</li> <li>• Nebulizer treatments, 1-2 treatments per day</li> <li>• Single dose IV medication administration, 1-2 times per 24 hours</li> <li>• Wound care stage I and II, superficial, or post-surgical dressing changes, not to exceed 1 treatment per day</li> <li>• Therapy: up to 60 minutes per day, up to 5 days per week, any combination of physical therapy (PT), occupational therapy (OT), speech therapy (ST), and/or respiratory therapy (RT)</li> <li>• IM pain management</li> <li>• Administration of antibiotics</li> <li>• Dialysis patients</li> <li>• Traction</li> <li>• Comprehensive care reflects moderate nursing intervention</li> <li>• Active treatment of co-morbidities with potential for co-morbidities to affect treatment plan</li> <li>• Pulse ox</li> <li>• RD consultation including patient education</li> </ul>			

Care Level	Revenue Code	Reimbursement Rate
<b>Level III services include Level I &amp; Level II plus:</b>	<b>193</b>	<b>\$500</b>
<ul style="list-style-type: none"> <li>• Subclavian, central and PICC lines, IV line maintenance and pushes</li> <li>• Behavioral symptoms that require frequent monitoring or direct supervision</li> <li>• Active medical care and treatment, assessment and management of chronic disease and co-morbidities that do complicate the treatment plan</li> <li>• High flow oxygen needs greater than 3 liters per minute or more continuous</li> <li>• Single IV medications 3 times in a 24 hour period or multiple IV medications</li> <li>• Nebulizer treatments, 3 or more treatments per day</li> <li>• Trach care, suctioning less than each/every shift</li> <li>• Total parental nutrition (TPN) and lipids</li> <li>• Neurological disorders (MS, ALS, Guillain Barre, Parkinson's, or other neuro-muscular diseases)</li> <li>• Pain pumps</li> <li>• Blood products/transfusion</li> <li>• Oxygen services to include Bi-Pap or C-Pap</li> <li>• Stage I/II decubitus requiring greater than 1 treatment per day, multiple Stage II, or Stage III and IV wound care and supplies, widespread skin disorder</li> <li>• Therapy: more than 60 minutes per day, less than 120 minutes per day, up to 5 days per week, any combination of physical therapy (PT), occupational therapy (OT), and speech therapy (ST), and respiratory therapy (RT)</li> <li>• Comfort measures/end of life care</li> </ul>		

Care Level	Revenue Code	Reimbursement Rate
<b>Level IV:</b>	<b>194</b>	<b>\$525</b>
<ul style="list-style-type: none"> <li>• Active medical care and treatment of co-morbidities is required, co-morbidities to affect treatment plan</li> <li>• RT needs instead of nursing for breathing/oxygen therapy</li> <li>• Therapy: more than 120 minutes per day, up to 5 days per week, any combination of physical therapy (PT), occupational therapy (OT), speech therapy (ST), and respiratory therapy (RT)</li> <li>• Trach care, suctioning each/every shift or greater</li> <li>• Continuous oxygen/humidification over trach site</li> </ul>		

#### **EXCLUDED SERVICES**

**Will be Reimbursed at invoice cost—invoice must be attached in order to receive reimbursement or at the rates listed by the service. Reimbursement will not exceed the Medi-Cal Allowable.**

- Any single dose medication greater than \$200/dose
- TPN & Lipids
- HIV/AIDs drugs
- Diagnostic Testing (lab/ x-ray greater than \$250/admission to be excluded and cost over \$250 paid by plan)
- Specialized DME, includes, but not limited to: CPM, c-pap, bi-pap, specialty mattresses, wound vac, bariatric)

**The following services are not included in the reimbursement and are to be provided by vendor and billed directly by vendor to health plan. SNF must utilize Health Plan's contracted vendors and must have prior authorization.**

- Physician coverage/visits (includes primary care and specialty services)
- Customized DME-wheelchairs, prosthetics/orthotics, splints
- Transportation
- Dialysis
- Chemotherapy
- Radiation
- CT Scan/MRI
- Psychiatric evaluation and treatment (**Covered for Medicare Members only and reimbursement will be at 100% of the current Medicare rate. For Medi-Cal Members this is a carve out to the county.**)

Provider Initials:\_\_\_\_\_