Hazel Hawkins
MEMORIAL HOSPITAL

SPECIAL AND REGULAR MEETING OF THE BOARD OF DIRECTORS SAN BENITO HEALTH CARE DISTRICT
911 SUNSET DRIVE, HOLLISTER, CALIFORNIA
THURSDAY, OCTOBER 26, 2023 – 5:00 P.M.
SUPPORT SERVICES BUILDING, 2ND-FLOOR, GREAT ROOM

Mission Statement - The San Benito Health Care District is a public agency that serves as a responsive, comprehensive health care resource for its patients, physicians, and the health care consumers of the community.

Vision Statement - San Benito Health Care District is committed to meeting community health care needs with quality care in a safe and compassionate environment.

San Benito Health Care District is a public agency that serves as a responsive, comprehensive health care resource for its patients, physicians and the community.

AGENDA

Presented By:

1. **Call to Order / Roll Call**

2. **Board Announcements**

3. **Public Comment**
   This opportunity is provided for members of the public to make a brief statement, not to exceed three (3) minutes, on matters within the jurisdiction of this District Board, which are not otherwise covered under an item on this agenda. This is the appropriate place to comment on items on the Consent Agenda. Board Members may not deliberate or take action on an item not on the duly posted agenda. Written comments for the Board should be provided to the Board clerk for the official record. Whenever possible, written correspondence should be submitted to the Board in advance of the meeting to provide adequate time for its consideration. Speaker cards are available.

4. **Consent Agenda – General Business** **(Pages 1 – 45)**
   The Consent Agenda deals with routine and non-controversial matters. The vote on the Consent Agenda shall apply to each item that has not been removed. A Board Member may pull an item from the Consent Agenda for discussion. One motion shall be made to adopt all non-removed items on the Consent Agenda.

   A. Consider and Approve Minutes of the Regular Meeting of the Board of Directors – September 28, 2023

   B. Consider and Approve Compliance Plan 2023

C. Receive Officer/Director Written Reports - No action required.

- Interim Chief Nursing Officer
- Provider Services & Clinic Operations
- Skilled Nursing Facilities Reports (Mabie Southside/Northside)
- Laboratory and Radiology
- Foundation Report
- Marketing/Public Relations

Recommended Action: Approval of Consent Agenda Items (A) through (C).

- Report
- Board Questions
- Motion/Second
- Action/Board Vote-Roll Call

5. Medical Executive Committee (Pages 46 – 54)

A. Consider and Approve Medical Staff Credentials: October 18, 2023

Recommended Action: Approval of Credentials.

- Report
- Board Questions
- Public Comment
- Motion/Second
- Action/Board Vote-Roll Call

B. Consider and Approve Amendments to the Application Form for Clinical Privileges/Obstetrics and Gynecology

Recommended Action: Approval of Privileges.

- Report
- Board Questions
- Public Comment
- Motion/Second
- Action/Board Vote-Roll Call

C. Consider and Approve Amendments to Ongoing Professional Practice Evaluation Policy

Recommended Action: Approval of Policy.

- Report
- Board Questions
- Public Comment
- Motion/Second
- Action/Board Vote-Roll Call

6. **Receive Informational Reports** **(Pages 55 – 92)**

A. Interim Chief Executive Officer

- Public Comment

B. Board Education

- Bankrupcy Litigation Update, Case No. 23-50544
- Presentation on Fair Market Value (Health & Safety Code Section 32121(p))

- Public Comment

C. Finance Committee **(Pages 93 – 106)**

1. Finance Committee Meeting Minutes – October 19, 2023

2. Review Financial Updates
   - Financial Statements –September 2023
   - Finance Dashboard – September 2023

- Public Comment

7. **Action Items** **(Pages 107 – 165)**

A. Consider Recommendation for Board Approval of Vendor Services Agreement - Interpol Private Security for a Two-Year Term, a 10-Day Termination Clause, and Fees 560,000 in Year One ($576,800 in Year Two). **(Pages 107 – 122)**

Recommended Action: Approval of Vendor Services Agreement

- Report
- Board Questions
- Public Comment
- Motion/Second
- Action/Board Vote-Roll Call

B. Consider Recommendation for Board Approval of Hospital Services Agreement - Imperial Health Plan of California, Inc. for a One-Year Term With Auto-Renewal for a One-Year Period, a 90-day Termination Clause, IP Pays 115% of DRG and OP Pays 135% of Fee Schedule. **(Pages 123 – 164)**

Recommended Action: Approval of Hospital Services Agreement

- Report
- Board Questions
- Public Comment
- Motion/Second
- Action/Board Vote-Roll Call

C. Consider Recommendation for Board Approval of Update to Affiliations with the California State Board of Pharmacy Disassociation of Affiliations with Former Employees and Board Members, and Addition of Affiliation with Interim CEO. **(Page 165)**

Recommended Action: Approval of Disassociation of Any Remaining Affiliations and Additions of Affiliations as Indicated

- Report
- Board Questions
- Public Comment
- Motion/Second
- Action/Board Vote-Roll Call

8. Public Comment

This opportunity is provided for members to comment on the closed session topics, not to exceed three (3) minutes.

9. Closed Session

(See Attached Closed Session Sheet Information)

10. Reconvene Open Session / Closed Session Report

11. Adjournment

The next Regular Meeting of the Board of Directors is scheduled for Thursday, November 16, 2023 at 5:00 p.m, Great Room.

The complete Board packet including subsequently distributed materials and presentations is available at the Board Meeting, in the Administrative Offices of the District, and posted on the District's website at https://www.hazelhawkins.com/news/categories/meeting-agendas/. All items appearing on the agenda are subject to action by the Board. Staff and Committee recommendations are subject to change by the Board.

Any public record distributed to the Board less than 72 hours prior to this meeting in connection with any agenda item shall be made available for public inspection at the District office. Public records distributed during the meeting, if prepared by the District, will be available for public inspection at the meeting. If the public record is prepared by a third party and distributed at the meeting, it will be made available for public inspection following the meeting at the District office.

Notes: Requests for a disability-related modification or accommodation, including auxiliary aids or services, to attend or participate in a meeting should be made to District Administration during regular business hours at 831-636-2673. Notification received 48 hours before the meeting will enable the District to make reasonable accommodations.

SAN BENITO HEALTH CARE DISTRICT BOARD OF DIRECTORS
OCTOBER 26, 2023

AGENDA FOR CLOSED SESSION

Pursuant to California Government Code Section 54954.2 and 54954.5, the board agenda may describe closed session agenda items as provided below. No legislative body or elected official shall be in violation of Section 54954.2 or 54956 if the closed session items are described in substantial compliance with Section 54954.5 of the Government Code.

CLOSED SESSION AGENDA ITEMS

[ ] LICENSE/PERMIT DETERMINATION
(Government Code §54956.7)

Applicant(s): (Specify number of applicants)_____

[ ] CONFERENCE WITH REAL PROPERTY NEGOTIATORS
(Government Code §54956.8)

[ ] CONFERENCE WITH LEGAL COUNSEL-EXISTING LITIGATION
(Government Code §54956.9(d)(1))

Name of case: (Specify by reference to claimant's name, names of parties, case or claim numbers):

Case name unspecified: (Specify whether disclosure would jeopardize service of process or existing settlement negotiations):_____

[ ] CONFERENCE WITH LEGAL COUNSEL-ANTICIPATED LITIGATION
(Government Code §54956.9)

Significant exposure to litigation pursuant to Section 54956.9(d)(2) or (3) (Number of potential cases):

Additional information required pursuant to Section 54956.9(e):_____

Initiation of litigation pursuant to Section 54956.9(d)(4) (Number of potential cases):____

[ ] LIABILITY CLAIMS
(Government Code §54956.95)

Claimant: (Specify name unless unspecified pursuant to Section 54961):
Agency claimed against: (Specify name):_____.

[ ] THREAT TO PUBLIC SERVICES OR FACILITIES
(Government Code §54957)

Consultation with: (Specify the name of law enforcement agency and title of officer):_____

[X] PUBLIC EMPLOYEE APPOINTMENT
(Government Code §54957)

Title: CEO

[ ] PUBLIC EMPLOYMENT
(Government Code §54957)

Title:

[ ] PUBLIC EMPLOYEE PERFORMANCE EVALUATION
(Government Code §54957)

Title: (Specify position title of the employee being reviewed):

[ ] PUBLIC EMPLOYEE DISCIPLINE/DISMISSAL/RELEASE
(Government Code §54957)

(No additional information is required in connection with a closed session to consider discipline, dismissal, or release of a public employee. Discipline includes potential reduction of compensation.)

[X] CONFERENCE WITH LABOR NEGOTIATOR
(Government Code §54957.6)

Agency designated representative:
Employee organization:
Unrepresented employee: Interim CEO/CEO

[ ] CASE REVIEW/PLANNING
(Government Code §54957.8)
(No additional information is required to consider case review or planning.)

[ ] REPORT INVOLVING TRADE SECRET
(Government Code §37606 & Health and Safety Code § 32106)

Discussion will concern: (Specify whether discussion will concern proposed new service, program, or facility):

1. Trade Secrets, Strategic Planning, Proposed New Programs, and Services.

Estimated date of public disclosure: (Specify month and year):

[ ] HEARINGS/REPORTS
(Government Code §37624.3 & Health and Safety Code §§1461, 32155)

Subject matter: (Specify whether testimony/deliberation will concern staff privileges, report of medical audit committee, or report of quality assurance committee):

[ ] CHARGE OR COMPLAINT INVOLVING INFORMATION PROTECTED BY FEDERAL LAW (Government Code §54956.86)

(No additional information is required to discuss a charge or complaint pursuant to Section 54956.86.)

ADJOURN TO OPEN SESSION

REGULAR MEETING OF THE BOARD OF DIRECTORS
SAN BENITO HEALTH CARE DISTRICT
SUPPORT SERVICES BUILDING, 2ND-FLOOR, GREAT ROOM

THURSDAY, SEPTEMBER 28, 2023
5:00 P.M.
MINUTES

HAZEL HAWKINS MEMORIAL HOSPITAL

Directors Present
Bill Johnson, Board Member
Devon Pack, Board Member
Josie Sanchez, Board Member
Rick Shelton, Board Member

Absent
Jeri Hernandez, Board Member

Also Present
Mary Casillas, Interim Chief Executive Officer
Mark Robinson, Chief Financial Officer
Michael Bogey, MD, Chief of Staff
Heidi A. Quinn, District Legal Counsel
Suzie Mays, Executive Assistant

1. **Call to Order**

Attendance was taken by roll call; Directors Pack, Sanchez, and Shelton were present. A quorum was present and Director Sanchez called the meeting to order at 5:01 p.m.

Director Sanchez announced Director Johnson as present at 5:15 p.m. Director Johnson presided over the meeting in the absence of Director Hernandez.

2. **Board Announcements**

None.

3. **Public Comment**

An opportunity was provided for public comment and individuals were given three minutes to address the Board Members and Administration.

4. **Consent Agenda - General Business**

A. Consider and Approve Minutes of the Special Meeting of the Board of Directors – August 16, 2023

B. Consider and Approve Minutes of the Regular and Special Meeting of the Board of Directors – August 23, 2023

C. Consider and Approve Risk Management & Patient Safety Plan 2023

D. Consider and Approve Plan for the Provision of Patient Care 2023 - 2024

E. Consider and Approve Policies

- New Employee Orientation Policy
- Dress Code Policy
- Drug-Free Workplace Policy
- Workplace Violence Prevention Policy
- Adverse Event Reporting Policy

F. Receive Officer/Director Written Reports - No action required.

- Interim Chief Nursing Officer
- Provider Services & Clinic Operations
- Skilled Nursing Facilities Reports (Mabie Southside/Northside)
- Laboratory and Radiology
- Foundation Report
- Marketing/Public Relations

Director Johnson presented the consent agenda items before the Board for action. This information was included in the Board packet.

MOTION: By Director Pack to approve Consent Agenda – General Business, Items (A) through ((F), as presented; Second by Director Shelton.

Moved/Seconded/Unanimously Carried. Ayes: Directors Johnson, Pack, Sanchez, and Shelton. Absent: Director Hernandez. Approved 4-0 by roll call.

5. **Report from the Medical Executive Committee Meeting on September 19, 2023 and Recommendations for Board Approval of the following:**

A. Medical Staff Credentials Report: Dr. Bogey, Chief of Staff, provided a review of the Credentials Report from September 19, 2023. The full written report can be found in the Board Packet.

Item: Proposed Approval of the Credentials Report; three (3) New Appointments, thirty-one (31) Reappointments, and six (6) Resignations/Retirements.

No public comment.

MOTION: By Director Pack to approve the Credentials Report as presented; Second by Director Sanchez.

Moved/Seconded/and Unanimously Carried: Ayes: Directors Johnson, Pack, Sanchez, and Shelton. Absent: Director Hernandez. Approved 4-0 by roll call.

B. Consider and Approve Revised Radiology Rules & Regulations: Dr. Bogey provided a review of the proposed revisions to the Radiology Rules & Regulations.

No public comment.

MOTION: By Director Pack to approve the revised Radiology Rules & Regulations as presented; Second by Director Sanchez.

Moved/Seconded/and Unanimously Carried: Ayes: Directors Johnson, Pack, Sanchez, and Shelton. Absent: Director Hernandez. Approved 4-0 by roll call.

C. Consider and Approve Revised Radiology Core Privileges: Dr. Bogey provided a review of the proposed revisions to the Radiology Core Privileges.

No public comment.

MOTION: Director Shelton to approve the revised Radiology Core Privileges, as presented; Second by Director Pack.

Moved/Seconded/and Unanimously Carried: Ayes: Directors Johnson, Pack, Sanchez, and Shelton. Absent: Director Hernandez. Approved 4-0 by roll call.

6. **Receive Informational Reports**

A. Interim Chief Executive Officer

Ms. Casillas provided highlights of the Interim CEO Report, which can be found in the Board packet.

- On August 31 several members of the Administrative Team and the Board conducted site visits to American Advanced Management (AAM) hospitals, including Orchard Hospital and Colusa Medical Center.
- The District hosted a site visit for representatives from San Benito County (County), Salinas Valley Health, and ECG Management Consultants on September 13th as part of the due diligence process.
- The District hosted a site visit for an additional interested party this past week. Further information will be provided as it becomes available.
- B. Riley continues to communicate with all interested parties.
- The interim CNO position has been filled.
- A meeting was attended with the County Behavioral Health Team to understand processes and discuss holds in the emergency room, reimbursement, and coverage. The County will be starting a mobile program in January for behavioral health and may attend a future Board meeting to provide more information.
- Representatives of Hazel Hawkins were invited by Benitolink to observe a meeting with other community leaders to learn more about community concerns regarding healthcare.
- The District will be working with the high school for a new four-year healthcare project for students. Hazel Hawkins will be teaming with them to provide speakers and possibly have students tour clinics.
- The Board Ad Hoc Committee has had several meetings this past month and Ms. Casillas asked Director Pack to provide an update.

Director Pack reported:

- B. Riley continues communications with AAM.
- One of the forthcoming matters will be to approve a contract for an independent appraisal of the fair market value of Hazel Hawkins Memorial Hospital. The Ad Hoc Committee gave approval to a bring contract forward for review, which is still being negotiated.
- There is a short-term window to add a vote to the ballot for the March 2024 primary, which would require all due diligence be completed by December 8, 2023. If the December 8, 2023 deadline is not met, a special independent election would need to be held and consideration given from the

interested party for financing of the special election. Alternatively, the vote would need to wait to the November 2024 general election.

Ms. Casillas noted the Ad Hoc Committee recommended Administration proceed to consult with a pollster and Administration will be working through that process.

An opportunity was provided for public comment and individuals were given three minutes to address the Board Members and Administration.

B. Financial Report

1. Review Finance Updates - Mr. Robinson provided an overview of the financial report for September 21, 2023, as well as the Financial Statements and Finance Dashboard for August 2023, included in the Board packet.

   Highlights include:

   - HCAI confirmed the Treasury has received the second installment of $150M for the AB112 Distressed Hospital Loan Program. It is anticipated the loan documents will be received by the District for review over the next several weeks. The District is scheduled to receive funding from the second installment; the first installment has yet to be distributed to selected facilities.
   - Census continues to be lower at the acute facility, exceeding at SNFs, and the ER is slower than budgeted. The District has flexed down for labor and expenses, but is not able to build reserve or put funding away at this time.
   - Expenses have been reduced and benefits changed to reduce costs. The District is still exposed as self-insured and there is a sense of urgency to move as quickly as possible to establish a strategic partner.

2. Mr. Robinson reviewed highlights of the SBHCD Pension Plan – January 1, 2023 Actuarial Funding Valuation Report, which was included in the Board packet. The report will be provided annually.

   During discussion, it was noted Innova would attend a future Board meeting to provide an overview of the findings of the revenue cycle audit.

An opportunity was provided for public comment and individuals were given three minutes to address the Board Members and Administration.

7. **Action Items**

A. Consider Recommendation for Board Approval of the Professional Services Agreement Between the County of San Benito and Hazel Hawkins Memorial Hospital for County Eligibility Specialist Worker Effective July 1, 2023 through June 30, 2026 and Not to Exceed $90,000 Annually

Staff reviewed the proposed Professional Services Agreement, which was included in the Board packet. It was noted there was a misprint and the contract is not to exceed $92,000 annually - versus $90,000 annually.

There was no public comment.

MOTION: By Director Pack to approve the Professional Services Agreement Between the County of San Benito and Hazel Hawkins Memorial Hospital for County Eligibility Specialist Worker Effective July 1, 2023 through June 30, 2026 and Not to Exceed $92,000 Annually; Second by Director Shelton.

Moved/Seconded/and Unanimously Carried: Ayes: Directors Johnson, Pack, Sanchez, and Shelton. Absent: Director Hernandez. Approved 4-0 by roll call vote.

8. **Closed Session**

Vice-President Johnson announced the items to be discussed in Closed Session as listed on the posted Agenda are (1) Conference with Legal Counsel-Existing Litigation, Government Code §54956.9(d)(1); (2) Hearings/Reports, Government Code §37624.3 & Health and Safety Code §§1461, 32155.

The meeting was recessed into Closed Session at 6:23 p.m.

9. **Reconvene Open Session/Closed Session Report**

The Board of Directors reconvened Open Session at 7:10p.m. District Counsel Quinn reported that in Closed Session the Board discussed: (1) Conference with Legal Counsel-Existing Litigation, Government Code §54956.9(d)(1); (2) Hearings/Reports, Government Code §37624.3 & Health and Safety Code §§1461, 32155.

No reportable action was taken.

10. **Adjournment:**

There being no further regular business or actions, the meeting was adjourned at 7:10 p.m.

The next Regular Meeting of the Board of Directors is scheduled for Thursday, October 26, 2023 at 5:00 p.m., and will be conducted in person.

/tr

Compliance Plan 2023
Hazel Hawkins Memorial Hospital

Draft Letter from CEO

Dear Colleague:

Hazel Hawkins has developed a Compliance Program reflecting our ongoing commitment to provide high quality care in a safe environment, in compliance with ethical and legal business practices.

Every team member has a role in ensuring we are faithful to our mission and in full compliance with the applicable laws and ethical standards through their daily conduct. This Compliance Program will assist you in understanding the myriad of regulations and standards that govern our work. Please take the time to read the document in its entirety and familiarize yourself with its content.

If you have any questions about this Compliance Program or need assistance in addressing a specific compliance-related issue, you are encouraged to discuss the situation with your supervisor. If you would rather speak to our Chief Compliance Officer directly, you can call 831-635-1149. Alternatively, you may call the compliance hotline at (800) 216-1288 (Spanish) or (855) 222-2500 (English). You are highly encouraged to ask questions and to bring all potential compliance issues forward.

Compliance is doing the right thing. Thank you for your personal commitment to compliance as we fulfill our mission and serve our patients.

Sincerely,

Mary Casillas
Chief Executive Officer

Compliance Program

Hazel Hawkins is dedicated to maintaining excellence and integrity in all aspects of its operations and its professional and business conduct. The Hospital is committed to conformance with high ethical standards and compliance with all governing laws and regulations, not only in the delivery of health care but in its business affairs and its dealings with all of its associates. It is the personal responsibility of all who are associated with Hazel Hawkins to honor this commitment in accordance with the terms of the Code of Conduct and related policies and procedures developed by Hazel Hawkins in connection with the Compliance Program.

An effective Compliance Program will ensure that Hazel Hawkins is:

- Operating in accordance with applicable laws and regulations
- Maintaining a culture of honesty and integrity
- Meeting high ethical and professional standards
- Preventing compliance issues before they occur
- Detecting compliance issues at earlier stages
- Assuring prompt corrective action
- Creating a culture of ethical and compliant behavior
- Building team member and public trust and confidence

Purpose of Compliance Program

The Compliance Program is intended to provide reasonable assurance that Hazel Hawkins:

1. complies in all material respects with all federal, state and local laws and regulations that are applicable to its operations;
2. satisfies the conditions of participation in health care programs funded by the state and federal governments and the terms of its other contractual arrangements;
3. detects and deters criminal conduct or other forms of misconduct by trustees, officers, employees, medical staff, agents and contractors that might expose Hazel Hawkins to significant civil liability;
4. promotes self-auditing and self-policing, and provides for, in appropriate circumstances, voluntary disclosure of violations of laws and regulations;
5. establishes, monitors and enforces high professional and ethical standards.

Compliance Program Elements

The Board of Directors of Hazel Hawkins has directed the development and implementation of an effective compliance program which includes the following elements recommended in the Office of Inspector General's Compliance Guideline for Hospitals:

Compliance Program

1. Chief Compliance Officer and Compliance Committee designations
2. Education and training program development and implementation:
    a. Provide general compliance information to the broad-based population.
    b. Provide focused technical training to functional areas with the potential to subject Hazel Hawkins to significant compliance exposure.
3. Hotline process maintenance:
    a. Receive complaints confidentially and provide retaliation protection to all individuals who report concerns via the Compliance Hotline.
4. Sanction or Disciplinary Action enforcement:
    a. Enforce the appropriate sanctions or disciplinary actions against individuals who violate compliance policies, applicable laws or regulations or governmental health program requirements.
5. Monitoring:
    a. Perform audits and risk assessments to identify problems.
    b. Conduct ongoing compliance monitoring of identified problem areas.
6. Investigation and Remediation:
    a. Investigate and remediate identified systemic problems.
    b. Develop appropriate corrective action plans.
7. Code of Conduct:
    a. Develop and distribute a Code of Conduct.
    b. Develop or revise written policies and procedures that further promote the Hospital's commitment to compliance.

Chief Compliance Officer

The Chief Compliance Officer is the primary leader of the Compliance Program. The Hospital's Chief Compliance Officer occupies a high-level position within the organization and has the necessary authority to carry out all Compliance Program responsibilities. The Chief Compliance Officer is responsible for assuring that the Compliance Program is implemented, ensuring that the Hospital is at all times maintaining business integrity and that all applicable statutes, regulations and policies are followed.

The Chief Compliance Officer provides regular and frequent reports to the Board of Directors about the Compliance Program and compliance issues. The Board of Directors is ultimately responsible for supervising the work of the Chief Compliance Officer, and maintaining the standards of conduct set forth in the Compliance Program. The Board oversees all of the Hospital's compliance efforts and takes any necessary actions to ensure that the Hospital conducts its activities in compliance with the law and ethical business practices.

The Chief Compliance Officer has direct access to the Board of Directors, Chief Executive Officer, other senior management and legal counsel. The Chief Compliance Officer has the authority to retain outside legal counsel as necessary.

Compliance Program

Responsibilities of the Chief Compliance Officer

The Chief Compliance Officer's responsibilities primarily include:

1. overseeing and monitoring the implementation of the Compliance Program;
2. developing an annual Compliance Work Plan to guide implementation of the Compliance Program;
3. Reporting to the Chief Executive Officer and the Board of Directors on the progress of Compliance Program implementation;
4. Advising Hospital associates in establishing methods to reduce Hazel Hawkins' vulnerability to fraud, abuse and waste;
5. Obtaining the required commitment of resources to perform compliance review and monitoring activities;
6. Revising the Compliance Program periodically to reflect changes in the needs of the organization, and in the laws and regulations under which the Hospital operates;
7. Developing, coordinating, and participating in an educational and training program that focuses on the elements of the Compliance Program, and ensures that all associates are appropriately knowledgeable of pertinent laws, rules, regulations, and ethical standards;
8. Ensuring that independent contractors and agents who furnish services to Hazel Hawkins are aware of the applicable requirements of the Compliance Program;
9. Coordinating internal compliance review and monitoring activities, including periodic reviews of departments or functions that have the potential to become involved in compliance issues;
10. Independently investigating and acting on matters related to compliance, including the design and coordination of internal investigations that respond to reports of potential compliance issues;
11. Ensuring disciplinary action is enforced as appropriate;
12. Implementing processes to investigate, resolve, and document all issues reported via the Compliance Hotline;
13. Monitoring Compliance Work Plan progress, reporting status and relevant information to the Board of Directors;
14. Responding, in conjunction with legal counsel when appropriate to external agency requests regarding compliance issues.

Compliance Committee

Hazel Hawkins has established a Compliance Committee to advise the Chief Compliance Officer and assist in monitoring the Compliance Program. The Compliance Committee provides the perspectives of individuals with diverse knowledge and responsibilities throughout the organization.

Members of the Committee

The Compliance Committee consists of the following representatives. The members include those individuals designated below and other members who may be chosen by the Hospital's Chief Executive Officer in consultation with the Chief Compliance Officer:

- Chief Compliance Officer
- Chief Financial Officer
- Chief Nursing Officer
- Information Security Officer
- Privacy Officer
- Medical Staff Representative
- Human Resources Executive
- Risk Manager
- Quality Director
- Health Information Director
- Business Office Manager
- As appropriate, Directors of Emergency Department, Laboratory, Pharmacy, Imaging, and Purchasing
- Others as appropriate

Functions of the Committee

The Chief Compliance Officer serves as the chairperson of the Compliance Committee. The Compliance Committee serves in an advisory role.

The Compliance Committee's functions include the following:

- Assessing existing and proposed compliance policies for modification or possible incorporation into the Compliance Program;
- Working with the Chief Compliance Officer to develop further standards of conduct and policies to promote compliance;
- Recommending and monitoring, in conjunction with the Chief Compliance Officer, the development of internal systems and controls to implement the standards and policies of the Compliance Program;
- Reviewing and proposing strategies to promote compliance and detection of potential violations;
- Assisting the Chief Compliance Officer in the development and ongoing monitoring of systems to solicit, evaluate and respond to complaints and problems related to compliance;
- Assisting the Chief Compliance Officer in coordinating compliance training, education and other compliance-related activities in the departments and functions in which the members of the Committee work;

- Consulting with vendors of the Hospital on a periodic basis to promote adherence to this Compliance Program.

The items listed above are not intended to be exhaustive. The Compliance Committee may address other compliance-related matters as determined by the Chief Compliance Officer.

Education and Training

The Compliance Program will be effective only if it is communicated and explained to associates on a routine basis and in a manner that clearly explains its requirements. For this reason, the Hospital will establish mandatory, ongoing training requirements for its departments and associates based on the needs and requirements of each department and associate. Training programs will include appropriate education in federal and state statutes, regulations, guidelines, the policies described in this Compliance Program, and corporate ethics.

All formal training undertaken as part of the Compliance Program will be documented. Documentation includes at a minimum the identification of the individuals participating in the training, the subject matter of the training, the length of the training, the time and date of the training, the training materials used, and any other relevant information.

The Chief Compliance Officer will evaluate the content of the training program at least annually to ensure that the subject content is current, appropriate and sufficient to cover the range of issues confronting the Hospital's associates. The training program will be modified as necessary to keep up-to-date with any changes in federal and state health care program requirements, and to address the results of the Hospital's audits and investigations; results from previous training and education programs, trends in confidential Compliance Hotline reports; and guidance from applicable federal and state agencies.

The Chief Compliance Officer will seek feedback to identify shortcomings in the training program, and administer post-training tests as appropriate to ensure understanding and retention of the subject matter delivered.

The members of the Board of Directors will be provided with periodic compliance training, not less than annually.

Attendance and participation in compliance training programs is a condition of continued employment. Failure to comply with training requirements may result in disciplinary action.

Written Policies and Procedures

Written policies and procedures should outline compliance program expectations. It is best practice that all compliance plans and related documents including compliance-related policies

be approved by the Board of Directors. Policies and procedures should be reviewed and revised annually with past versions archived.

It is also best practice to ensure that the approved compliance policies are easily available to staff. At a minimum, the Compliance Program and the Code of Conduct should be posted on an external website, as well as on an intranet location that all associates can easily find.

Some of the policies the Hospital should consider establishing and implementing are listed below:

Compliance Reporting

- Confidential Reporting System
- Non-Retaliation for Reporting
- Documenting Reports Received by Compliance Officer

Compliance Enforcement

- Screening for Ineligible Persons
- Investigating Reports of Noncompliance
- Enforcement of Compliance Program
- Auditing of Compliance Program
- Conflicts of Interest

Fraud and Abuse

- Federal and State False Claims Laws
- Anti-Kickback Laws
- Self-Referral Laws
- Physician Recruitment
- Corporate Practice of Medicine
- Inducement to Lower Utilization
- Inducements to Patients
- Waivers of Coinsurance
- Vendor Contracts

Patient Care and Rights

- Patient Rights and Responsibilities
- Informed Consent
- Patient Freedom of Choice / Disclosures of Financial Interests
- Patient Privacy – HIPAA
- Advance Beneficiary Notice
- EMTALA
- Independent Contractor Credentialing

Compliance Program

Billing

- Claim Development and Submission
- Medical Necessity
- Outpatient Billing Prior to Inpatient Stay
- Patient Transfer Versus Discharge
- Provider-Based Rules
- Bad Debts
- Credit Balances
- Billing and Coding for Medicare OPPS
- NCCI Edits
- Charge Description Master
- Same Day Discharges and Readmissions
- Outlier Claims
- Reporting Billing Errors
- Biller Education and Resources
- Charity and Discounted Care

Health Information Services

- Inpatient Coding
- Outpatient Coding
- Coding Education and Resources
- Patient Record Documentation
- Record Retention

Reimbursement

- Cost Report Documentation
- Reporting Cost Report Errors
- Independent Review of Cost Reports
- Medicare Contractor Audits of Cost Reports
- Treatment of Non-Allowable Costs
- Treatment of Protested Items

External Investigations

- Responding to Audits
- Responding to Government Investigations

Compliance Program

Compliance Reporting and Communication

Open Communication

The Hospital recognizes that clear and open lines of communication between the Compliance Department and Hospital associates are important to the success of this Compliance Program. Hazel Hawkins maintains an open door policy with regard to all Compliance Program-related matters. Hospital associates are encouraged to seek clarification from the Compliance Department in the event of any confusion or question about a statute, regulation, or policy discussed in this Compliance Program.

Submitting Questions or Complaints

The Hospital has established a confidential Compliance Hotline for use by Hospital associates to report concerns or possible wrongdoing regarding compliance issues. The confidential Compliance Hotline numbers are:

Phone: 800-216-1288 (Spanish) or 855-222-2599 (English)
Fax: 215-689-3885

Calls to the confidential Compliance Hotline are answered by an independent contractor, not by Hospital employees. All calls are treated confidentially and are not traced. The caller need not provide his or her name. The Hospital's Chief Compliance Officer or designee investigates all calls and letters and initiates follow-up actions as appropriate.

Communications via the confidential Compliance Hotline and any correspondence sent to the Chief Compliance Officer are treated as privileged to the extent permitted by applicable law.

Matters reported through the confidential Compliance Hotline, or in writing, that suggest violations of compliance policies, statutes or regulations, are documented and investigated promptly. A log is maintained by the Chief Compliance Officer of all calls or communications, including the nature of any investigation and subsequent results. A summary of this information is included in reports by the Chief Compliance Officer to the Hospital's Board of Directors and Chief Executive Officer.

Non-Retaliation Policy

Associates who, in good faith, report possible compliance violations will not be subjected to retaliation or harassment as a result of their reports. Retribution related to reporting of compliance concerns is prohibited and anyone who engages in such prohibited activity will be subject to disciplinary action. Concerns about possible retaliation should be reported to Human Resources or the Chief Compliance Officer. All such communications will be kept as

confidential as possible but there may be occasions when the reporting individual's identity may become known or may have to be revealed as required by applicable law.

When appropriate, the Chief Compliance Officer will seek advice directly from legal counsel to assist in the investigation of compliance concerns.

Enforcing Standards and Policies

It is the Hospital's policy to appropriately discipline Hospital employees who fail to comply with the Code of Conduct or the associated policies of the Compliance Program. The Hospital takes compliance seriously, and will respond appropriately to compliance-related misconduct.

All violators of the Compliance Program will be subject to disciplinary action. The seriousness of the offense and frequency of the violation will inform the precise discipline utilized including any or all of the following disciplinary actions:

- Written warning
- Written reprimand
- Suspension
- Termination and/or
- Restitution

Auditing and Monitoring

The Hospital conducts periodic monitoring of this Compliance Program. Compliance reports created as a result of this monitoring, including reports of suspected noncompliance, will be reviewed and maintained by the Chief Compliance Officer.

The Chief Compliance Officer will develop and implement a Compliance Work Plan. The plan will be reviewed at least annually and updated to ensure it addresses the relevant areas of concern.

Periodic compliance audits are used to promote and ensure compliance. These audits are designed to address, at a minimum, compliance with laws governing kickback arrangements, physician self-referrals, claims development and submission, reimbursement and marketing. All individuals are expected to cooperate fully with auditors during this process by providing information and answering questions.

The Hospital shall conduct periodic reviews to determine whether the elements of this Compliance Program have been satisfied. Appropriate modifications will be implemented when monitoring discloses deficiencies in the Compliance Program.

Investigation and Remediation

Hazel Hawkins is committed to investigating all reported concerns promptly and confidentially to the extent possible. The Chief Compliance Officer and Privacy Officer will coordinate findings from investigations and immediately recommend changes to be implemented and/or corrective action. The Hospital expects all associates to cooperate with investigation efforts. Employees giving false or misleading information during an investigation may lead to disciplinary action, up to and including termination.

Where an internal investigation substantiates a reported violation, the Hospital will initiate corrective action, including, as appropriate, making prompt restitution of any overpayments received, notifying the appropriate governmental agency, instituting disciplinary action as necessary and implementing system changes to prevent a similar violation from recurring in the future.

Compliance Program

Code of Conduct

Purpose

Along with its medical staff, Hazel Hawkins Memorial Hospital serves as a responsive, comprehensive health care resource for its community by providing quality care in a safe and compassionate environment.

The Hospital's Board of Directors adopted the Compliance Program, including this Code of Conduct, to provide guidance to all Hazel Hawkins' employees and partners carrying out their daily duties to fulfill the Hospital's mission. These standards and obligations protect and promote the Hospital's integrity and enhance the Hospital's ability to achieve its mission.

Although intended to be comprehensive in nature, this Code of Conduct likely does not capture every scenario or circumstance that may arise. The Hospital expects you to consider not only the words written in this Code of Conduct, but the meaning and purpose of those words as well. You are expected to read this Code of Conduct and exercise good judgment ("do the right thing").

You are encouraged to talk to your supervisor or the Chief Compliance Officer if you have any questions about this Code of Conduct or what is expected of you.

Applicability

This Code of Conduct applies to all individuals conducting business on behalf of Hazel Hawkins including employees, affiliated providers, subcontractors, independent contractors, vendors, volunteers and consultants.

Hazel Hawkins requires all employees to attest in an acknowledgment confirming they have received the Code of Conduct, understand it represents mandatory policies of Hazel Hawkins and agree to abide by it. New employees are required to sign an acknowledgement as a condition of employment.

Personal Conduct

The Hospital's integrity and reputation rest on all of us as individuals exercising good judgment and acting in accordance with this Code of Conduct and the law. The Hospital's basic belief in the importance of respect for the individual has led to a strict regard for privacy and dignity. In the event it is determined that your personal conduct affects your performance, or that of other team members, or the legitimate interests of the Hospital, the Hospital may be required to take action.

Compliance Program

Compliance with Laws and Regulations

Hazel Hawkins provides healthcare services pursuant to federal, state, and local laws and regulations. All individuals conducting business on behalf of Hazel Hawkins are expected to comply with all applicable laws. When the application of a law or regulation is uncertain, the Hospital will seek appropriate legal counsel.

Obligation to Report

You have the responsibility to report any activity that appears to violate applicable laws, rules, regulations, accreditation standards, medical practice standards, Conditions of Participation or any other legal or ethical standard. If you feel comfortable, you should first contact your supervisor with the concern. You can also contact the Chief Compliance Officer or call the confidential Compliance Hotline to disclose your concern. All reports of unlawful or unethical conduct will be investigated promptly. The Hospital does not tolerate threats or acts of retaliation or retribution for reporting compliance concerns.

Work Environment

Health and Safety

The Hospital complies with all applicable workplace health, safety and environmental laws and regulations. Hospital associates may be required to handle hazardous chemicals, infectious agents, and medical waste as part of their normal duties. You are expected to handle materials according to established procedures for control, storage and disposal. If you are not aware of these procedures or have questions about them, contact your supervisor or the Safety Officer at (831) 313-3670.

You should immediately report to your supervisor any situations that may cause falls, shocks, burns or other harm to patients, visitors or fellow team members.

Diversity and Equal Employment Opportunity

The Hospital strives to create and maintain a work environment where all are treated with respect and diversity is valued. Hazel Hawkins prohibits discrimination in any work-related decision on the basis of race, creed, sexual orientation, gender identity, age, disability status, national origin, or any other illegal basis.

If you believe an inequitable or unfair practice is occurring in the workplace, you should contact the Human Resources Department. If the matter is not resolved to your satisfaction, you may contact the Chief Compliance Officer or call the confidential Compliance Hotline.

Harassment

The Hospital is committed to providing a work environment that is free of harassment, and abusive, intimidating, threatening or disruptive behavior. The Hospital will not tolerate sexual advances, actions, comments, racial or religious slurs, or any other conduct that creates an intimidating or otherwise offensive environment.

Harassment can also take the form of workplace violence. Workplace violence includes robbery, stalking, violence towards the employer, terrorism, and hate crimes.

If you observe or experience any form of harassment or violence, you should report the incident to your supervisor, the Human Resources Department, the Chief Compliance Officer or the confidential Compliance Hotline. The Hospital considers all reports of such perceived conduct to be serious, and will ensure investigations are conducted expeditiously.

Conflicts of Interest

A conflict of interest may occur if a Hospital team member's outside activities, personal financial interests, or other personal interests influence or appear to influence his or her ability to fulfill job responsibilities. A conflict of interest may also exist if the demands of any outside activities hinder or distract one from the performance of his is or her job duties or cause the individual to use Hospital resources for other than Hospital business. Situations of actual or potential conflicts of interest are to be avoided at all times.

A good rule of thumb is that a conflict of interest may exist any time an objective observer may wonder if your actions are significantly influenced by your personal or financial activities or interests. If you have any question about whether an outside activity or personal interest might constitute a conflict of interest, you must obtain the approval of the Chief Compliance Officer before pursuing the activity, or obtaining or retaining the interest.

Gifts and Entertainment

It is the general policy of the Hospital that neither you nor any member of your family may solicit, receive, offer or pay any money or gift that is, or could reasonably be construed to be an inducement in exchange for influence or assistance in conducting Hospital business. It is the intent of the Hospital that this policy be construed broadly such that all business transactions with vendors, contractors and other third parties are transacted to avoid even the appearance of improper activity.

Additionally, you are prohibited from making any expenditures of Hospital or personal funds for gifts, dining or entertainment in any way related to Hospital business, unless such expenditures are made in strict accordance with Hospital policies.

Sanctioned/Excluded Individuals and Entities

The Hospital does not knowingly contract with, employ, or bill for services rendered by an individual or entity that is excluded or ineligible to participate in government healthcare programs, or has been convicted of a criminal offense related to the provision of healthcare items or services. We routinely search the Department of Health and Human Services' Office of Inspector General and General Services Administration's lists of such excluded and ineligible persons.

Employees, vendors, and privileged practitioners at Hazel Hawkins are required to immediately report to the Hospital if they become excluded, debarred or ineligible to participate in government healthcare programs; or have been convicted of a criminal offense related to the provision of healthcare items or services.

License and Certification Renewals

Employees, individuals retained as independent contractors, and privileged practitioners in positions which require professional licenses, certifications, or other credentials are responsible for maintaining the current status of their credentials and shall comply at all times with federal and state requirements applicable to their respective disciplines. To assure compliance, the Hospital may require evidence of the individual having a current license or credential status.

Hazel Hawkins does not allow any employee, independent contractor or privileged practitioner to work in a position that requires a license or certification without valid, current licenses or credentials.

Substance Use

Hazel Hawkins is committed to an alcohol and drug-free work environment. All associates conducting Hospital business must report for work free of the influence of alcohol and illegal drugs. Failure to do so may result in termination. The Hospital may use drug testing to enforce this policy.

The Hospital further recognizes that individuals may be taking prescription or over-the-counter medications which could impair their judgment or job performance. Should you have questions about the effect of such medications or should you observe a team member who appears impaired, you are required to immediately report it following your department's protocol. Please ensure you are aware of your department's reporting protocol, and should you have questions regarding this matter, please discuss them with your supervisor.

Compliance Program

Privacy

Patient Information

In providing healthcare services, the Hospital collects and maintains patients' and guarantors' personal, sensitive information. Individuals conducting business on behalf of Hazel Hawkins are prohibited from using or disclosing this information in a manner that violates the privacy rights of our patients.

The Hospital has developed access and privacy policies and procedures consistent with state and federal privacy requirements. You are expected to adhere to these policies and procedures at all times. You have no right to access any patient information unless it is deemed necessary to perform your job duties.

Employee Information

The Hospital collects and maintains personal information that relates to your employment, including medical and benefit information. Access to personal information is restricted solely to people with a need to know this information. Personal information is released outside the Hospital or to its agents only with employee approval, except in response to appropriate investigatory or legal requirements, or in accordance with other applicable law. All individuals responsible for maintaining personal information and those who are provided access to such information must ensure it is not disclosed in violation of the Hospital's policies and practices.

Hospital Property

Hospital property is made available to team members exclusively for authorized business purposes and should not be used for personal reasons. Property as used in this document refers to physical assets such as office equipment, computers, software, supplies, company records, patient information and proprietary business information. Hospital property must not be removed from the premises unless it is necessary to do so to fulfill your job responsibilities. If property is removed from the premises, you must maintain it in your possession at all times and return it when no longer needed.

Hospital team members are expected to maintain and properly care for Hazel Hawkins property. If you become aware of any damaged or malfunctioning property, you should report it to the appropriate personnel. If you become aware of anyone intentionally or negligently damaging Hospital property, you should report it to your supervisor.

Information Security

You should exercise due care and diligence in maintaining the confidentiality, availability and integrity of information. It is essential that each team member protect our computer systems

and the information contained in them by not sharing passwords and by reviewing and adhering to the Hospital's information security policies and guidance.

Electronic Media

All communications systems, including but not limited to electronic mail, intranet, internet access, telephones, and voice mail, are the property of Hazel Hawkins and are to be used primarily for business purposes in accordance with electronic communications policies and standards.

Users of computer and telephonic systems should presume no expectation of privacy in anything they create, store, send, or receive on the computer and telephonic systems. Hazel Hawkins reserves the right to monitor and/or access electronic media usage and content consistent with policies and procedures.

Team members may not use internal communication channels or access the internet at work to post, store, transmit, download or distribute any threatening materials, maliciously false materials, obscene materials, or anything constituting or encouraging a violation of any law.

Social Media

When using social media, avoid talking about patients even in general terms. Remember that an unintentional disclosure of PHI (protected health information) is still a violation of HIPAA. You should avoid posting photos of patients or anything that could be used to identify them such as notes, lab results, etc.

Political Activities

Hazel Hawkins complies with all federal, state and local laws governing participation in governmental relations and political activities. Hospital funds or resources may not be contributed directly to individual political campaigns, political parties, or other organizations which intend to use the funds primarily for political objectives. Hazel Hawkins engages in public policy debate only in a limited number of instances where it has special expertise that can inform the public with relevant factual information. The Hospital encourages trade associations with which it is associated with to do the same.

Personal and corporate political activities must be kept separate in order to comply with the appropriate rules and regulations related to lobbying or attempting to influence government officials. No use of Hospital resources, including electronic mail is appropriate for personally engaging in political activity. An associate may, of course, participate in the political process on his or her own time at his or her own expense. While doing so, it is important that he or she not give the impression of speaking on behalf of or representing Hazel Hawkins in these activities.

Recording, Reporting and Retaining Information

Each Hospital team member is responsible for the integrity and accuracy of our organization's documents, not only to comply with regulatory and legal requirements but also to ensure records are available to support our business practices and actions. You may not alter or falsify information on any record or document. Records relevant to government or other investigations must never be destroyed.

Medical and business documents and records are retained in accordance with the law and the Hospital's record retention policy. It is important to retain and destroy records only according to our policy.

Use of Proprietary Information

Proprietary Information

Proprietary information is generally confidential information that is developed by the Hospital as part of its business and operations. Such information includes, but is not limited to, the business, financial, marketing and contract arrangements associated with Hospital services. It also includes computer access passwords, procedures used in producing computer or data processing records, personnel and medical records, and payroll data. Proprietary information also includes management know-how and processes, Hospital business and service plans; a variety of internal databases, and any copyrighted material such as software.

The Hospital alone, except for complying with specific legal requirements, is entitled to determine who may possess its proprietary information and what use may be made of it. You should not use or disclose proprietary information except as authorized by the Hospital.

Inadvertent Disclosure

The unintentional disclosure of proprietary information can be just as harmful as intentional disclosure. To avoid unintentional disclosure, never discuss proprietary information that has not been made public by the Hospital with any unauthorized person. This information includes unannounced products or services, prices, earnings, procurement plans, business volumes, capital requirements, confidential financial information, marketing and service strategies, business plans, and other confidential information.

You should not discuss confidential information even with authorized Hospital employees if you are in the presence of others who are not authorized. This also applies to discussions with family members or friends, who might inadvertently pass the information on.

Direct Requests for Information

If someone outside the Hospital asks you questions about the Hospital or its business activities, either directly or through another person, do not attempt to answer them unless you are certain you are authorized to do so. If you are not authorized, refer the person to the appropriate source within the Hospital. If you receive a request for information or to conduct an interview from an attorney, investigator, or any law enforcement officer, and it concerns the Hospital's business, you should refer the request to the office of the Hospital's Chief Executive Officer.

Marketing

The Hospital has expended significant efforts and resources in developing its services and reputation for providing high-quality patient care, including efforts involving marketing, advertising and other promotional activities. While such activities are important to the success of the Hospital, they are also potential sources of legal liability as a result of laws that regulate the marketing of health care services. It is therefore important that the Hospital closely monitor and regulate advertising, marketing, and other promotional activities to ensure that all such activities are performed in accordance with Hospital objectives and applicable law.

It is the general policy of the Hospital that no individual engage in any advertising, marketing or other promotional activities on behalf of the Hospital unless such activities are approved in advance by the appropriate Hospital representative.

APPENDICES

Charter Compliance Committee of Board of Directors

Organization

This charter governs the operations of the Compliance Committee of the Board of Directors of San Benito Healthcare District. The Compliance Committee shall periodically review and reassess the adequacy of this charter and recommend any proposed changes to the charter to the Board for approval. The Board's Governance Committee, in consultation with the Chairman of the Board, shall recommend members to the Board for approval for appointment to the Compliance Committee. The Compliance Committee shall be comprised of at least two directors, each of whom is independent of management and the Hospital. The Compliance Committee shall maintain minutes of its meetings and report to the Board.

Policy

The Compliance Committee shall: (1) oversee and monitor matters relating to Hazel Hawkins' compliance with applicable laws and regulations other than those relating to matters reserved for the Audit Committee, and (2) oversee matters relating to sustainability, corporate social responsibilities and corporate citizenship. The Compliance Committee shall have the authority to retain special legal, accounting or other consultants to advise the Compliance Committee. The Compliance Committee may request any associates of the Hospital, including outside counsel to attend a meeting of the Compliance Committee or to meet with any members of, or consultants to, the Compliance Committee.

Areas of Oversight

The Compliance Committee shall:

1. Provide oversight and monitoring of compliance matters.
2. Provide oversight and monitoring of implementation and ongoing execution of the Compliance Program.
3. Provide oversight of the Hospital's sustainability, corporate social responsibility and corporate citizenship policies, programs and initiatives.
4. Provide oversight of the Hospital's political activities, including the periodic review of any related policies.
5. Monitor the Hospital's efforts to implement programs, policies and procedures relating to compliance matters, and the training of employees and others on such matters.
6. Review the results of internal and external compliance-related audits.

7. Request or oversee the investigation of any significant instances or potential instances of noncompliance with the Compliance Program.
8. Review on a regular basis litigation matters filed against the Hospital related to alleged violations of laws and regulations.
9. Review on a regular basis the Hospital's Compliance Risk Assessment and Compliance Work Plan.
10. Identify and investigate emerging compliance issues, trends and risks.
11. Periodically review the Hospital's compliance oversight structure and the allocation of resources to the compliance function.
12. In consultation with the Governance Committee, conduct an annual evaluation of the performance and effectiveness of the Compliance Committee and report the results of that evaluation to the Board.
13. Have such other duties and oversight and monitoring responsibilities as may be assigned to the Compliance Committee by the Board.

While the Compliance Committee has the oversight and monitoring responsibilities and powers set forth in this charter, it is not the duty of the Compliance Committee to conduct investigations to assure compliance with laws and regulations and the Hospital's Code of Conduct.

Compliance Program Appendices

Education and Training Considerations

The purpose of conducting an education and training program is to ensure that each individual that functions on behalf of the Hospital is fully capable of executing his or her role in compliance with the laws, regulations, rules and standards under which the Hospital is governed.

An effective training program considers the following factors:

- Qualifications of trainers
- Training general and relevant to individuals' responsibilities
    - Ensure Coding and Billing staff receive ongoing, comprehensive focused training
- Training appropriate and adequate to cover the range of issues confronting the Hospital's associates
- Incorporation of recent changes in laws, rules, regulations and standards
- Incorporation of:
    - Key learnings from results of audits and investigations
    - Results from previous education and training programs
    - Trends from confidential Corporate Hotline reports
    - OIG, CMS or other agency guidance or advisories
- Collecting feedback from training attendees to continually improve content
- Documentation of who attended required training
- Disciplinary mechanisms for individuals failing to attend required training

Topics that should be considered for the education and training content include, but are not limited to:

- Compliance Program
- Code of Conduct
- Conflict of Interests
- Anti-Kickback Statute
- Physician Self-Referral (Stark) Law
- Exclusion Statute
- Fraud, Waste and Abuse
- Patient Privacy
    - Privacy Rule
    - Security Rule
    - Breach Notification Rule
- Record Retention
- EMTALA
- Medical Record Documentation
- Accurate Coding and Billing
- Policies Recently Implemented

Conflict of Interest Policy and Procedures

Policy Statement

Hazel Hawkins expects that all employees, volunteers, and Board members (collectively referred to herein as "associates") exercise the utmost integrity in all transactions related to their duties at the Hospital and its property. Hazel Hawkins maintains a policy of full disclosure when a potential conflict of interest exists.

A conflict of interest is any situation in which financial or other personal considerations may compromise or appear to compromise an individual's business judgment, delivery of patient care, or ability to perform one's job responsibilities. You should avoid situations in which a conflict of interest exists or is perceived to exist.

Required Standards

All decisions and transactions undertaken by an associate in the conduct of the Hospital's business must be made in a manner that promotes the best interests of the Hospital, free from the possible influence of any conflict of interest of such associate or the associate's family or friends. Associates have an obligation to address both actual conflicts of interest and the appearance of a conflict of interest. You must always disclose and seek resolution of any actual or potential conflict of interest, whether or not you consider it an actual conflict, before taking a potentially improper action.

No set of principles or standards can cover every type of conflict of interest. The following standards address conduct required of all associates and provide some examples of potential conflict of interest situations in addition to those discussed above.

1. You may not make or influence business decisions, including executing purchasing agreements or other types of contracts, from which you, a family member, or a friend may benefit.

2. You must disclose your "significant" (as defined below) financial interests in any entity you know to have current or prospective business, directly or indirectly, with the Hospital. There are two types of significant financial interests:

    a. Receipt of anything of monetary value from a single source in excess of $### annually. Examples include salary, royalties, gifts and payments for services including consulting fees and honoraria; and

    b. Ownership of an equity interest exceeding 5 percent in any single entity, excluding stocks, bonds and other securities sold on a national exchange;

certificates of deposit; mutual funds; and brokerage accounts managed by third parties.

3. You must disclose any activity, relationship or interest that may be perceived to be a conflict of interest so that these activities, relationships and interests can be evaluated and managed properly.

4. You must disclose any outside activities that interfere, or may be perceived to interfere, with your capacity to satisfy your job or responsibilities at the Hospital. Such outside activities include leadership participation (such as serving an officer or member of the Board of Directors) in professional, community or charitable activities; self-employment; participation in business partnerships; and employment or consulting arrangements.

5. You may not solicit personal gifts or favors from vendors, contractors, or other third parties that have current or prospective business with the Hospital. You may not accept cash gifts or any value, or non-monetary gifts including meals, transportation or entertainment valued in excess of $## annually from vendors, contractors or other third parties that have current or prospective business with the Hospital. Questions regarding the gift limitations should be directed to the Chief Compliance Officer.

6. Any involvement in a personal business venture shall be conducted outside the Hospital work environment and shall be kept separate and distinct from the Hospital's business in every respect.

7. You should not accept employment or engage in a business that involves, even nominally, any activity during hours of employment with the Hospital, the use of any of the Hospital's equipment, supplies or property, or any direct relationship with the Hospital's business or operation.

8. You must guard patient and Hospital information against improper access or use by unauthorized individuals.

9. The Hospital's materials, products, designs, plans, ideas and data are the property of the Hospital and should never be given to an outside firm or individual, except through normal channels with appropriate prior authorization.

10. You must avoid any appearance of impropriety when dealing with clinicians and referral sources.

11. All vendors and contractors who have or desire business relationships with the Hospital must abide by the applicable standards of this policy. Should you gain knowledge of vendors or contractors violating the applicable standards, you must report it to your supervisor or the Chief Compliance Officer.

12. You must not sell any merchandise on Hospital premises and you must not sell any merchandise of a medical nature that is of a type or similar to what is sold or furnished by the Hospital, whether on or off Hospital premises, unless prior approval is obtained from the Chief Compliance Officer.

13. You must not request donations for any purpose from other associates, patients, vendors, contractors or other third parties, unless prior approval is obtained from the Chief Compliance Officer.

14. You must not endorse any product or serviced without prior approval from the Hospital's Chief Compliance Officer.

Disclosure of Potential Conflict Situations

You are required to complete a Conflict of Interest disclosure form at the following intervals:

- upon employment or affiliation with the Hospital;
- annually;
- within 30 days any time your professional or commercial relationships change;
- within 30 days any time your institutional responsibilities change;
- upon request by the Chief Compliance Officer.

You also have a continuous duty to update your Conflict of Interest information after any changes in facts that are required to be reported under this policy.

Hazel Hawkins
MEMORIAL HOSPITAL

San Benito Health Care District
Board of Directors Meeting
October 2023
Chief Nursing Officer Report

- **Emergency Department**:
  - Visits: 2,054
  - Admitted: 98
  - Stroke: 4
  - Left Without being seen: 0.5%

- **Med / Surg**:
  - ADC: 9.56

- **ICU:**
  - ADC: 3

- **OB**
  - Deliveries: 33
  - Outpatients Visits: 79

- **OR**
  - Inpatient: 45
  - Outpatient: 142
  - Total ASC cases: 190
  - GI: 103
  - AM Admit: 2

The following is a list of immediate priorities for the Chief Nursing Officer:

1. Planning and executing a robust compliance program.
2. Evaluating staffing and establishing a position control process.
3. Evaluating nursing processes in the hospital and conducting immediate remediation if necessary.
4. Establishing relationships with staff and leaders.
5. Evaluating nursing processes in the skilled nursing facilities and conducting immediate remediation if necessary.

Hazel Hawkins
MEMORIAL HOSPITAL

To: San Benito Health Care District Board of Directors

From: Amy Breen-Lema, Vice President, Clinic, Ambulatory & Physician Services

Date: October 12, 2023

Re: All Clinics – September 2023

September 2023 Rural Health and Specialty clinics' visit volumes

Total visits in all outpatient clinics = 4,553

Orthopedic Specialty	373
Multi-Specialty	629
Sunset Clinic	674
Surgery & Primary Care Clinic	142
San Juan Bautista	297
1st Street	724
4th Street	1100
Barragan	614

Recently, all five rural health clinics at First Street, Fourth Street, San Juan Bautista, Sunset & the Barragan Health Care & Diabetes Center successfully completed site review surveys and were deemed Department of Health Care Services (DHCS) *Certified Primary Care Sites.*

The DHCS requires all participating providers of Medi-Cal Managed Care Plans to meet the required standards on the Facility Site Review and Medical Record Review Survey. Anthem Blue Cross commended the clinics for successfully completing the survey that identifies the sites, as deemed by the Department of Health Care Services, as certified quality medical sites.

Mishel Thomas, Clinic Operations Manager did an exceptional job of leading the readiness and survey activities for the clinics.

Hazel Hawkins
MEMORIAL HOSPITAL
Mabie Southside/Northside Skilled Nursing Facility
Board Report – October 2023

To: San Benito Health Care District Board of Directors

From: Jacqueline Fernandez, MHA, MSN, RN, Interim Director of Nursing, Skilled Nursing Facility/Senior Director of Acute Care Services

1. Census Statistics: September 2023

Southside	2023	Northside	2023
Total Number of Admissions	14	Total Number of Admissions	8
Number of Transfers from HHH	11	Number of Transfers from HHH	7
Number of Transfers to HHH	9	Number of Transfers to HHH	2
Number of Deaths	0	Number of Deaths	0
Number of Discharges	14	Number of Discharges	5
Total Discharges	14	Total Discharges	5
Total Census Days	**1,410**	**Total Census Days**	**1,401**

Note: Transfers are included in the number of admissions and discharges. Deaths are included in the number of discharges. Total census excludes bed hold days.

2. Total Admissions: September 2023

Southside	From	Payor	Northside	From	Payor
3	HHMH	Medicare	7	HHMH	Medicare
1	Re-Admission HHMH	Medicare	1	San Jose Regional	Medicare
3	HHMH	Medi-Cal			
4	Re-Admissions HHMH	Medi-Cal			
3	Re-Admissions VA P.A.	Medi-Cal			
Total: 14			**Total: 8**		

3. Total Discharges by Payor: September 2023

Southside	2023	Northside	2023

Medicare	4	Medicare	4
Medicare MC	0	Medicare MC	0
Medical	10	Medical	1
Medi-Cal MC	0	Medi-Cal MC	0
Private (self-pay)	0	Private (self-pay)	0
Commercial	0	Commercial	0
Total:	**14**	**Total:**	**5**

4. Total Patient Days by Payor: September 2023

[redacted]	2023	[redacted]	2023
Medicare	109	Medicare	114
Medicare MC	0	Medicare MC	0
Medical	1241	Medical	1,197
Medi-Cal MC	0	Medi-Cal MC	0
Private (self-pay)	60	Private (self-pay)	60
Insurance	0	Commercial	30
Bed Hold / LOA	14	Bed Hold / LOA	0
Total:	**1,424**	**Total:**	**1,401**
Average Daily Census	**47.47**	**Average Daily Census**	**46.70**

Hazel Hawkins
MEMORIAL HOSPITAL

To: San Benito Health Care District Board of Directors
From: Bernadette Enderez, Director of Diagnostic Services
Date: October 2023
Re: Laboratory and Diagnostic Imaging

Updates:

Laboratory

1. Service/Outreach
   - Sunnyslope Lab new business hours: Mon-Friday 07:00am – 3:00 pm (closed for lunch 11:00-12:00)

2. Quality Assurance/Performance Improvement Activities
   - Ongoing Cepheid analyzer validation; estimated GO LIVE date: 12/2023
   - STAGO compact analyzer installed; estimated start of validation 11/2023

3. Laboratory Statistics
   - See attached report

Diagnostic Imaging

1. Service/Outreach
   - Due to staffing shortage, the Diagnostic Center next to Ortho clinic is still closed.
   - Offering discounted cash rate for Screening mammogram as part of the October Breast Cancer Awareness month

2. Quality Assurance/Performance Improvement Activities
   - Ongoing policy and protocol updates
   - Collaborated with Registration Team on improving scheduling workflow

3. Diagnostic Imaging Statistics
   - See attached report

LABORATORY STATISTICS

MAIN LABORATORY													
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
2021	891	739	1020	939	955	1058	1080	1272	1563	1504	1491	1584	14096
2022	2035	1336	1506	1323	1277	1165	1112	1252	1092	1257	1186	1209	15750
2023	1187	1236	1394	1125	1173	1112	1092	1197	1271				10787

HHH EMPLOYEE HEALTH WEEKLY COVID TEST (INCLUDING SNF_NEW SNF LOCATION ONLY)													
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
2021	1888	1566	1443	1110	1031	1122	1045	1656	2143	1695	1842	2458	18999
2022	2987	2136	1915	1767	2219	2546	2244	2355	2066	1046	1144	1596	24021
2023	595	114	609	880	28	15	24	48	23				2336

MC CRAY LAB													
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
2021	1263	1274	1394	1125	1119	1193	1165	1248	1192	1187	1100	1099	14359
2022	1230	1044	1206	1069	1033	1025	1061	1130	866	975	810	752	12201
2023	1038	931	1167	975	1054	930	1009	1039	961				9104

SUNNYSLOPE LAB													
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
2021	699	601	624	590	479	636	553	613	580	574	462	487	6898
2022	536	511	632	521	467	488	495	558	423	402	368	186	5587
2023	511	486	551	418	516	458	427	490	381				4238

SJB AND 4TH STREET													
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
2021					41	64	55	29	45	27	37	55	353
2022	63	54	82	72	63	58	23	61	82	82	63	53	756
2023	74	44	83	67	63	81	77	75	79				643

ER AND ASC													
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
2021	1628	1162	1126	1077	1083	1089	1174	1415	1272	1139	1059	1279	14503
2022	1434	839	1040	993	1328	1335	1111	1198	1231	1237	1614	1604	14964
2023	1268	1298	1453	1448	1482	1234	1256	1156	1362				11957

TOTAL OUTPATIENT													
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
2021	6369	5342	5607	4841	4708	5162	5072	6233	6795	6126	5991	6962	69208
2022	8285	5920	6381	5745	6387	6617	6046	6554	5760	4999	5185	5400	73279
2023	4673	4109	5257	4913	4316	3830	3885	4005	4077				39065

TOTAL INPATIENT (ICU,MEDSURG,OB,SNF)													
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
2021	1116	1053	603	654	705	751	761	803	791	986	874	1301	10398
2022	1311	1102	945	678	963	1258	1321	1421	1145	973	1066	1205	13388
2023	816	603	950	710	591	347	214	353	159				4743

Hazel Hawkins
MEMORIAL HOSPITAL

LABORATORY DEPARTMENT

REQUISITION STATISTICS

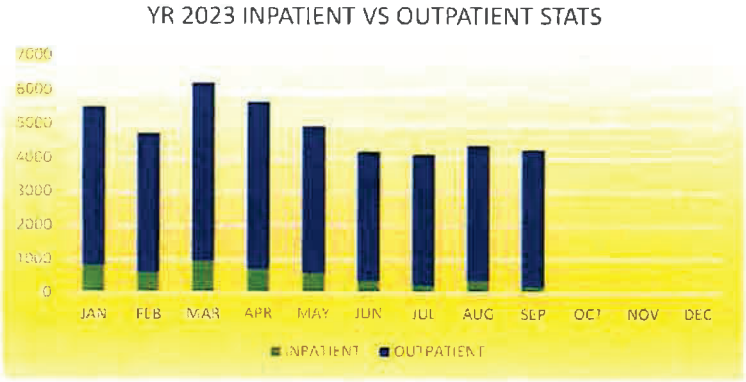
Bernadette Enderez
Director of Laboratory Services

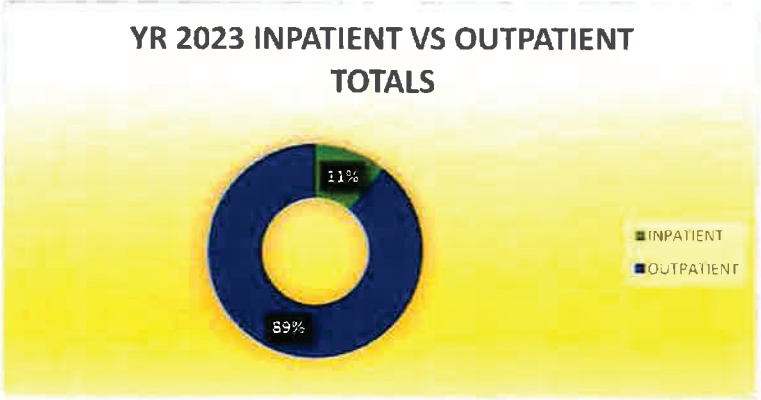
Michael McGinnis, M.D.
Medical Director

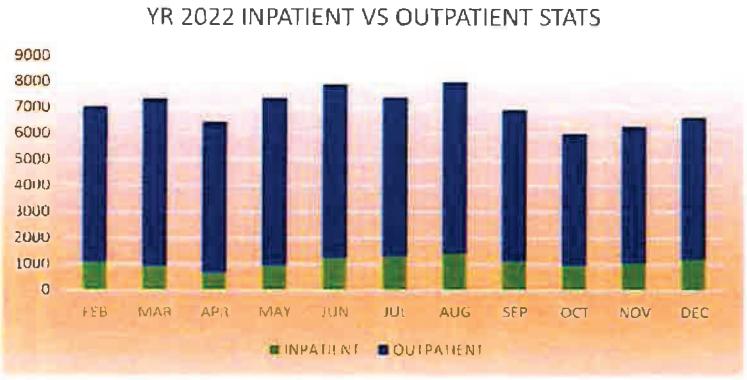
INPATIENT VS OUTPATIENT LABORATORY STATISTICS

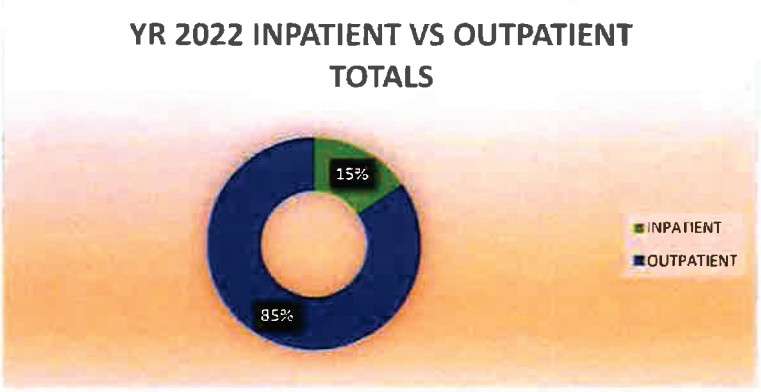
YR 2023														
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL	
INPATIENT	816	603	950	710	591	347	214	353	159				4743	INPATIENT
OUTPATIENT	4673	4109	5257	4913	4316	3830	3885	4005	4077				39065	OUTPATIENT

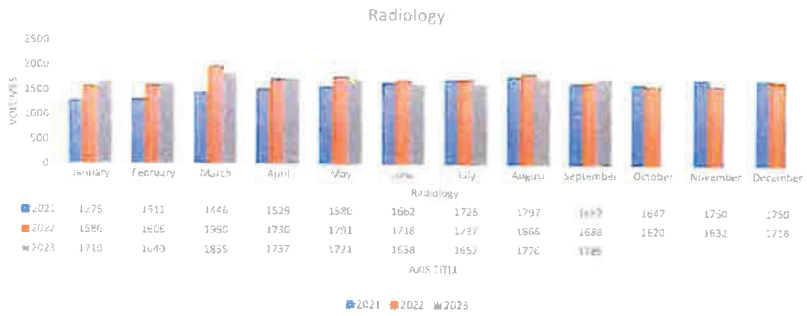
YR 2022														
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL	
INPATIENT	1311	1102	945	678	963	1258	1321	1421	1145	973	1066	1205	13388	INPATIENT
OUTPATIENT	8285	5920	6381	5745	6387	6617	6046	6554	5760	4999	5185	5400	73279	OUTPATIENT

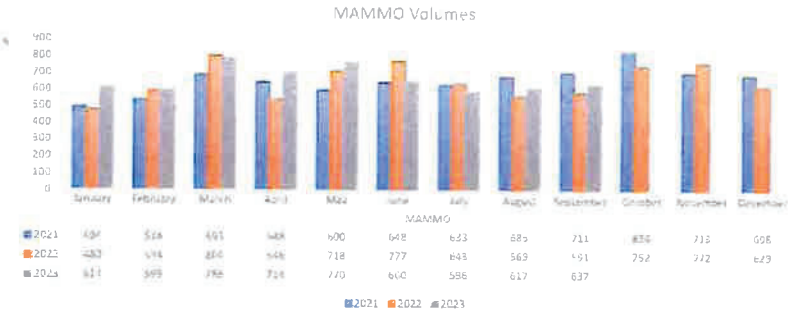


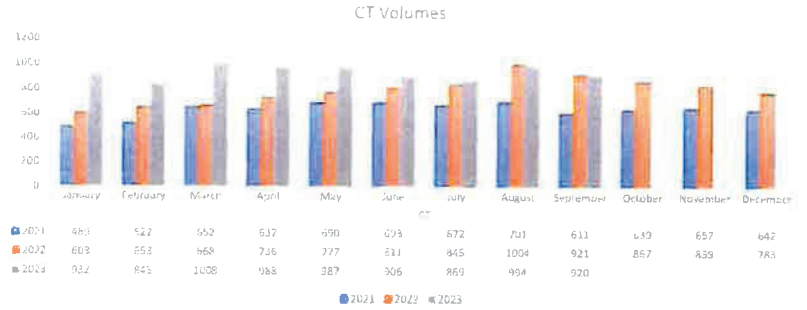


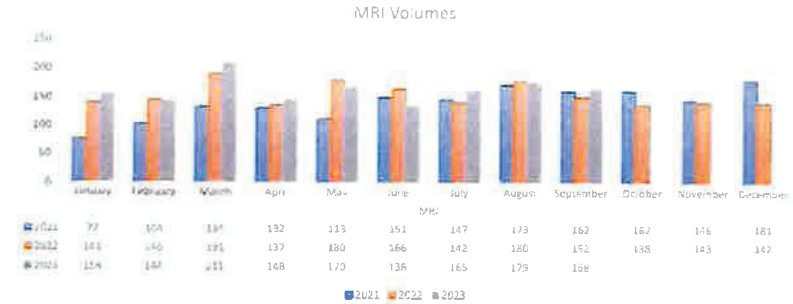


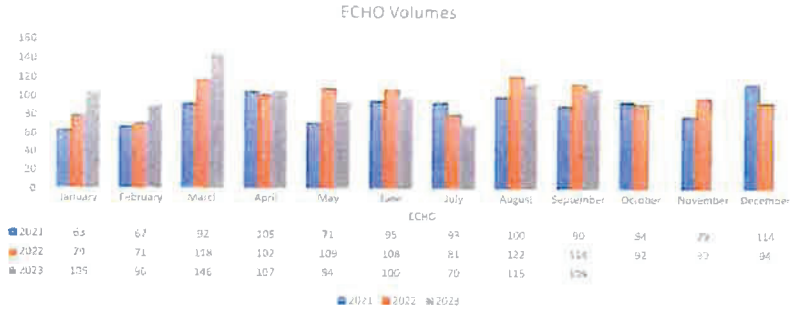


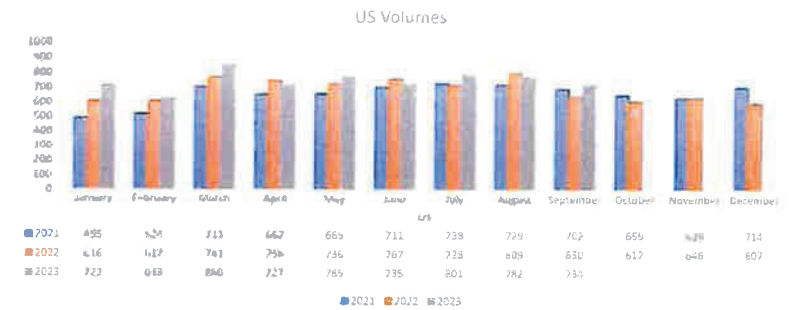

Radiology
VOLUMES
January February March April May June July August September October November December
Radiology
2021 1475 1511 1446 1529 1580 1662 1726 1797 1647 1750 1750
2022 1586 1608 1960 1730 1791 1718 1737 1866 1688 1620 1632 1728
2023 1710 1640 1835 1737 1721 1658 1857 1770
AXIS TITLE
2021 2022 2023


MAMMO Volumes
MAMMO
2021 2022 2023


CT Volumes
2021 2022 2023


MRI Volumes
2021 2022 2023


ECHO Volumes
2021 2022 2023


US Volumes
2021 2022 2023

Hazel Hawkins Hospital
FOUNDATION
Caring for Our Community

TO: San Benito Health Care District Board of Directors
FROM: Liz Sparling, Foundation Director
DATE: October 2023
RE: Foundation Report

The Hazel Hawkins Hospital Foundation Board of Trustees met on October 19 in the Horizon Room.

Financial Report for September

1. Income	$	74,684.84
2. Expenses	$	1,690.67
3. New Donors		4
4. Total Donations		163

Allocations

1. $35,000 from ED Bridge Program Grant – Phase 2 Milestone to HHMH

Directors Report

- The Dinner Dance date for this year's fundraiser is November 4th. The Committee met and selected **Bonnie & Alan Clark** for our Donors of the Year, the **Community Foundation** for the Organization Donor of the Year and **Dr. Barra** as our heart for hazel recipient.
    - We still have tickets available, please contact the Foundation office if you would like to attend. 831.636.2653.
    - Our Online Auction with fantastic auction items will run from October 30 to Nov 5th. Items include courtside Warriors tickets, beach houses, wine tours, delicious dinners, parking at the Hospital and more.
- Our Development Committee continues to reach out to donors in the Community. We have been giving tours of the Hospital and presentations.
- We have Board Members terming out at the end of the year (Seth, Jill and Tisi are terming out and Nan will finish her first term). The Nominating Committee has met and new Board Members will be announced at the November Board Meeting.
- Our Audit has been submitted to our Accountant.
- We were at the San Benito County Fair September 29, 30 & Oct. 1. There was a lot of positive support from visitors to our booth about the Hospital.

MARKETING

- **Social Media Posts**

				REACH	ENGAGEMENTS
INDEPENDENT REVIEW OF HAZEL HAWKINS HOSPIT.. Hazel Hawkins Hospital	Boost post	···	Wed Oct 18, 10:51am	146 Accounts Center accounts r..	38 Post engagements
Our Northside residents also enjoyed their pumpkin .. Hazel Hawkins Hospital	Boost post	···	Tue Oct 17 2:18pm	1K Accounts Center accounts r	406 Post engagements
Many thanks to Kathy Carlson with Spina Farms for t... Hazel Hawkins Hospital	Boost post	···	Tue Oct 17 2:16pm	1.2K Accounts Center accounts r	575 Post engagements
Please consider giving the "Gift of Life" and donating.. Hazel Hawkins Hospital	Boost post	···	Mon Oct 9 9:21am	365 Accounts Center accounts r	13 Post engagements
Enjoying our time meeting our community members .. Hazel Hawkins Hospital	Boost post	···	Fri Sep 29 4:45pm	604 Accounts Center accounts r	195 Post engagements
We just got done decorating our booth for the 2023 .. Hazel Hawkins Hospital	Boost post	···	Tue Sep 26 3:41pm	811 Accounts Center accounts r	210 Post engagements
Thank you to our friends at St. Luke's Episcopal Churc .. Hazel Hawkins Hospital	Boost post	···	Fri Sep 22 2:07pm	778 Accounts Center accounts r	80 Post engagements
This post has no text Hazel Hawkins Hospital	Create ad	···	Mon Sep 18, 1:59pm	212 Accounts Center accounts r	4 Post engagements
October is Breast Cancer Awareness Month HHH is off.. Hazel Hawkins Hospital	Create ad	···	Mon Sep 18 1:58pm	947 Accounts Center accounts r	25 Post engagements

ADVERTISING

- Ads in Free Lance and Mission Village Voice for promotion of low cost mammograms for Breast Cancer Awareness month.

COMMUNITY

- Participated in the San Benito County Fair with our hospital booth promoting hospital services. Booth won a 2nd place ribbon for best use of Fair Theme.

Employee Engagement

Employees:

- Hazel's Headlines
- Food Trucks for Halloween
- Halloween Costume & Pumpkin Carving Contests

Media

Public:

Working with Marcus Young from townKRYER PR agency on proactive PR:

- Answered media requests from BenitoLink & KION
- Press Releases
  - INDEPENDENT REVIEW OF HAZEL HAWKINS HOSPITAL CONCLUDES WITH HIGH MARKS FOR PATIENT OUTCOMES; SENIOR LEADERSHIP

Cost Saving Measures

- Assisting departments with in-house forms creation and printing.

Hazel Hawkins
MEMORIAL HOSPITAL
SKILLED NURSING FACILITIES
HOME HEALTH AGENCY
San Benito Health Care District

INTERDISICPLINARY PRACTICE COMMITTEE
October 18, 2023

CREDENTIALS REPORT

NEW APPOINTMENTS

PRACTITIONER	DEPT/SERVICE	SUPERVISING PHYSICIAN	TERM
Caitlin Shafer, PA	AHP/ Emergency Medicine	Michael Bogey, MD	10/27/23-09/30/25
Emanuel Nistrian, CRNA	AHP/Surgery	N/A	10/27/23-09/30/25
Erin Felkey, CRNA	AHP/Surgery	N/A	10/27/23-09/30/25

REAPPOINTMENTS

PRACTITIONER	DEPT/SERVICE	SUPERVISING PHYSICIAN	TERM

CHANGE IN STATUS

PRACTITIONER	DEPT/SERVICE	SERVICE

RESIGNATIONS/RETIREMENTS

PRACTITIONER	DEPT/SERVICE	CURRENT STATUS	COMMENT
Deborah Hustead, PA-C	AHP/Medicine (Clinic)	AHP	Termination of clinic employment

Rev: 2/16/2022

Hazel Hawkins
MEMORIAL HOSPITAL
SKILLED NURSING FACILITIES
HOME HEALTH AGENCY
San Benito Health Care District

HAZEL HAWKINS MEMORIAL HOSPITAL
APPLICATION FOR CLINICAL PRIVILEGES

OBSTETRICS AND GYNECOLOGY

Name of Applicant:_____

In order to be eligible to request clinical privileges for both initial appointment and reappointment, a practitioner must meet the following minimum threshold criteria:

- Education: M.D. or D.O.
- Formal Training: The applicant must demonstrate successful completion of an ACGME or AOA approved post-graduate residency program in Obstetrics & Gynecology.
- Certification: Board Certification by the American Board of Obstetrics and Gynecology, or active participation in the process leading to certification.
- Successful completion of an ACOG-endorsed course that includes current NICHD nomenclature
- Current NRP certification recommended
- Required Clinical Experience: The applicant for **initial appointment or reappointment** must be able to demonstrate that he/she has satisfactorily performed services as an attending physician in the **past 24 months for at least**:

    1. 50 obstetrical hospital patients for the Obstetric Core, including 5 cesarean sections
    2. 30 gynecologic hospital patients for the Gynecology Core, including 5 major abdominal adnexal or uterine surgeries, laparotomy or laparoscopic

If the applicant meets the above criteria, he/she may request privileges as specified below.

I hereby request privileges as follows:

OB/GYN Core Privileges

Obstetric Core:
Privileges include admission, workup, consultation, diagnosis, and the treatment of female patients of all ages presenting in any condition of pregnancy. These privileges include cesarean sections, vacuum extraction Low/Outlet, forceps extraction Low/Outlet, external cephalic version, OB ultrasound (limited, AFI, fetal position), resuscitation of infant, newborn circumcision, amniocentesis, post-partum bilateral tubal ligation, simple repair of umbilical or incisional hernia at time of another OB/Gyn procedure, repair at delivery of rectovaginal fistula, and all other procedures related to normal and complicated pregnancies. Also included are privileges for ICU management of patients in any phase of pregnancy, including post partum.

____Requested ____Approved

Gynecology Core:
Privileges also include admission, workup, consultation, diagnosis, and preoperative, intraoperative, and postoperative care necessary to correct or treat female patients of all ages presenting with illnesses, injuries, and disorders of the gynecologic system, surgical treatment of urinary stress incontinence, cystoscopy including biopsy, laparoscopy, Laparoscopic-Assisted Vaginal Hysterectomy, endometrial ablation, simple minor surgical procedures and nonsurgical treatment of illness and injuries of the mammary glands and urinary tract. Also included are privileges for ICU management of GYN and post-surgical patients

____Requested ____Approved

Ambulatory Care – Hazel Hawkins Ambulatory Clinics:
Privileges include outpatient management of obstetrical and gynecological patients.

____Requested ____Approved

NOTE: ~~If last 24-months experience does not meet requirements for core privileges listed above and still request privileges, please clarify below.~~

Core privileges do not include any of the following **specific** privileges. For each, the applicant must demonstrate the minimum training and experience as defined below.

OB/GYN Specific Privileges

PROCEDURE	TRAINING	EXPERIENCE INITIAL Approx. Number Performed in Last 24 Months	REQUESTED	APPROVED
Moderate sedation	Passing score on hospital exam			

NOTE: ~~If last 24-months experience does not meet requirements for privileges listed above and still request~~

privileges, please clarify below.

ADDITIONAL AND SPECIFIC PRIVILEGES REQUESTED

PROCEDURE	REQUESTED	APPROVED

I certify that I have had the necessary training and experience to perform the procedures I have requested.

Name of Applicant:_____ Date:_____

Signature of Applicant:_____

APPROVALS:
All privileges delineated have been individually considered and have been recommended based upon the physician's specialty, licensure, specific training, experience, health status, current competence and peer recommendations.

Applicant may perform privileges as indicated.

Exceptions/Limitations: ☐ None ☐ Specify below

_____

_____

_____ _____
Perinatal Chair Date

*Approved **Perinatal Department:***	***3/27/07, rev 03/27/12, rev 5/22/18, rev 02/01/2022, rev 10/11/2023***
*Approved **Medical Executive Committee:***	***4/17/07, rev 04/18/12, rev 6/20/18, rev 02/16/2022***
*Approved **Board of Directors:***	***4/19/07, rev 05/31/12, rev 6/28/18, rev 02/24/2022***

SUBJECT: ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)

POLICY:

The Ongoing Professional Practice Evaluation (OPPE) Policy describes the process by which the San Benito Healthcare District, through the activities of its Medical Staff, evaluates the quality of care provided by practitioners who have been granted clinical privileges by utilizing evidence-based medical practice standards and guidelines. All information related to the OPPE process is considered privileged and confidential in accordance with state and federal laws relating to peer review and other protections.

PURPOSE:

The purpose of the Ongoing Professional Practice Evaluation (OPPE) is to assess and monitor on an ongoing basis the clinical competence and professional behavior of practitioners who have been granted clinical privileges at the San Benito Healthcare District, and to use the outcomes of the assessment to improve the quality of patient care. OPPE information is factored into the decision to maintain, modify or revoke existing clinical privileges. It is also used when appropriate to recommend further evaluation such as a Focused Professional Practice Evaluation (FPPE).

DEFINITIONS:

A. Ongoing Professional Practice Evaluation (OPPE) is data collected for the purpose of assessing a practitioner's clinical competence and professional behavior. Through this process, practitioners received feedback for potential improvement or confirmation of achievement related to the effectiveness of their professional practice in all practitioner competencies.

B. Focused Professional Practice Evaluation (FPPE) is the focused evaluation of practitioner competence in performing a specific privilege or privileges. This process is implemented for all initially requested privileges, and whenever a question arises regarding a practitioner's ability to provide safe, high-quality patient care as identified through OPPE or other processes. See Focused Professional Practice Evaluation policy.

GUIDELINES:

A. All practitioners who have been granted clinical privileges will be reviewed through the OPPE process.

B. The OPPE category elements may include, but are not limited to the following:

- Patient Care: Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life.
- Medical/Clinical Knowledge: Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical, and social sciences and the application of their knowledge to patient care and the education of others.
- Practice-Based Learning and Improvement: Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.
- Interpersonal and Communication Skills: Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams.
- Professionalism: Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession, and society.
- Systems-Based Practice: Practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

C. Each Medical Staff Department or Division will approve the OPPE indicators for its own clinical specialty area. The Medical Executive Committee (MEC) will also approve the OPPE indicators for each clinical specialty area through approval of this policy.

D. An OPPE Report containing the practitioner's performance for the approved indicators for the practitioner's clinical specialty area will be created at a minimum of every 12 months.

E. Each OPPE Report will be reviewed by the practitioner's respective Department Chair. OPPE Reports for the Department Chairs will be reviewed by the Department Vice Chairs. If the Department Chair or the Department Vice Chair is unable to review a particular report, the Chief of Staff or Chief Medical Officer will review the OPPE Report. The person reviewing the OPPE report will be considered the "Report Reviewer".

F. If an OPPE Report contains any of the following triggers, the OPPE Report will be forwarded to the Medical Executive Committee with any comments from the OPPE Report Reviewer for consideration of initiation of a FPPE or other appropriate action for the practitioner:

1. Two (2) or more cases that have been assigned a Case Review Outcome Score of 4 (Inappropriate or Reckless Care) through the Medical Staff Peer Review process relating to the practitioner's performance, OR
2. Three (3) or more events, including validated patient grievances, complaints or behavioral events, relating to the practitioner's performance (excludes elopements and against medical advice (AMA) events), OR
3. Any significant trend as identified by the OPPE Report Reviewer.

G. If an OPPE report is determined to be acceptable by the OPPE Report Reviewer, the OPPE Report will be signed and filed. In addition to the annual OPPE process, OPPE reports will be included at the time of reappointment.

H. Determining if a practitioner is Low/No Volume: A practitioner is considered to be low/no volume is they have the following total patient volumes during their 12 month OPPE cycle:

Staff Status	Patient Volume
Courtesy	Needs at least 1 patient volume
Consultant	Needs at least 1 patient volume
Active	Needs at least 3 patient volumes

~~G.~~

I. Collecting Information on Low/No Volume Practitioners: For a provider who does not meet the volume requirements for the cycle, a peer reference and/or activity will be requested from a facility where the practitioner is more active.

a. The Peer Reference can be from another practitioner who has worked with the provider during the last 12 months and who is within the same scope of practice, or can attest to the provider's clinical abilities with the privileges held.
b. For a request for an inpatient provider from another accredited institution, a list of activity/procedures or complete OPPE cycle will be obtained. The data must be the same date range as the OPPE cycle.
c. For a request for an outpatient provider, a list of activity/procedures within the same type of setting will be obtained. The data must be the same date range as the OPPE cycle.

Should a practitioner fail to provide the activity report or peer reference requested for low/no volume by the date specified in the request, the practitioner will be deemed a voluntary resignation.

J.

Telemedicine OPPE Cycle: The medical staff will provide the distant site with an annual OPPE review of each telemedicine provider that has been credentialed by proxy. At a minimum, this will include volumes for the cycle, information about any adverse outcomes related to telemedicine services provided, and any complaints from patients or staff at the originating site about a telemedicine practitioner.

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K.

Approvals:

Medical Executive Committee:	*08/09/21, 09/21/22*
Board of Directors:	*08/26/21, 09/22/22*

Hazel Hawkins
MEMORIAL HOSPITAL

Interim CEO Report
October 2023

Financial Emergency Update

- Received court-appointed Ombudsman report. Please see attached report
- Met with court-appointed Ombudsman to continue work for future reports for bankruptcy court.
- Hosted second site visit for interested party October 16, 2023.
- Continue to work with pollster to conduct a community poll regarding options for the District moving forward.

CEO Activities

- Hosted a visit with Mr. Miller from Twin Oaks to share ideas on collaboration i.e. Health fairs, guest speakers at events.
- Attended United San Benito kick off.
- Met with San Benito County Health and Human Services staff to discuss masking and to meet the new Health Officer, Dr. Scott.
- Participated in CAH Advocacy Strategic Planning meeting. Discussion included; 340B, Federal initiatives to address Medicare Advantage, and access to capital for facility updates.
- Participated in Hollister High School CTE Advisory Board meeting – Health Science pathway. Will be working with the school on guest speakers, job shadowing, interview sessions, and tours.

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Fax: 415-984-8300

Attorneys for JERRY SEELIG,
as Patient Care Ombudsman

UNITED STATES BANKRUPTCY COURT
NORTHERN DISTRICT OF CALIFORNIA
SAN JOSE DIVISION

In re: SAN BENITO HEALTH CARE DISTRICT DBA HAZEL HAWKINS MEMORIAL HOSPITAL, Debtor.	Chapter 9 Case No. 23-50544 SLJ **PCO'S FIRST INTERIM REPORT**

Jerry Seelig, in his capacity as Patient Care Ombudsman (the "**PCO**")[1] and under 11 U.S.C. section 333(a)(1), files this First Interim Report (the "**Report**"). Pursuant to Bankruptcy Code section 333, the PCO is monitoring the quality of patient care for any significant decline or material compromise. To complete to the best of their ability an in-depth monitoring effort, the PCO has prior to filing this Report visited all the Debtor's facilities and operating units and worked in a cooperative manner with Debtor's managers to obtain needed documents, materials, and financial reports.

These visits, interviews, and the PCO's experience and qualifications have enabled the

[1] *Unless otherwise indicated, use of the term "**PCO**" will collectively refer to Mr. Seelig, his firm* Seelig+Cussigh HCO LLC ("**S+C**"), and the consultants retained by S+C. In conjunction with discharging his duties and preparing this report, the PCO has directed and supervised professionals from S+C. Mr. Seelig and the consultants' resumes are attached hereto as Exhibit A. In summary, Richard Cussigh focused on Medical Records, Health Insurance Portability and Accountability Act ("HIPAA") and subsequent rules-regulations issues, Lisa Grod Ph.D. focused on the skilled nursing facilities ("SNFs"), Jody Knox R.N. focused on all units of the Hospital and Clinics, and Sean Drake focused on supplies, facilities, and patient life and safety regulatory compliance and quality.

PCO to provide the Court with an accurate assessment of patient care at the Debtor's facilities. Should the Court so desire, the PCO will notice and schedule a hearing and be available to answer any questions and report in greater detail.

This Report contains the following categories of information:

I. THE PCO's MONITORING METHODOLOGY and SCOPE

A. Methodology

Following Mr. Seelig's appointment, the PCO implemented a cost-effective plan to visit and monitor the Debtor's patient care and safety at the Debtor's dispersed facilities. The PCO received strong support from the Debtor's management, the corporate senior executives engaged in supporting the facilities, and facility-level administrators and caregivers. Among other things, the PCO:

1. Interviewed the following: (i) the Debtor's CEO, (ii)the CFO, (iii) the Director of Provider Services & Clinic Operations; (iv) the interim corporate Chief Nursing Officer ("**CNO**"); (v) the Clinic Operations Manager; (vi) the Director of Nursing ("**DON**") at each facility; (vii) key corporate managers, including for all facilities; (vii) the system-wide Quality Assurance Director, (v) physicians; (vi) the Quality Assurance-Performance Improvement Director at each facility visited by the PCO; (vii) the Director of Quality Assurance, Risk Management, Accreditation, and Regulatory Compliance; (vii) the key administrator and senior managers at each facility visited; (viii) the comptroller; (ix) the revenue cycle manager who is in billing and collection activities; (x) nurses; (xi) other caregivers; (xii) Department Managers responsible for key care components including but not limited to Infection Control, Medical Records-Health Information Systems, Physical Plant-Facilities, (xii) the Directors of Laboratory, Radiology, Physical Therapy; and (xiii) other knowledgeable parties. Importantly, at each facility the PCO attended clinical care and revenue cycle meetings.

2. Reviewed each facility's internally prepared documentation of patient care and incidents ("incident reports") to identify patients harmed and then research specific patient charts and care components. Concurrent with review of the specific incident reports, the PCO critically examined both the specific-facility and system-wide efforts regarding peer review and performance improvement programs.

3. Reviewed liability-risk, staffing, compliance, and contracting for clinical and nonclinical materials/supplies/temporary staffing documents at the facility and corporate level.

4. Conducted a comprehensive examination of reported state and federal quality measures, including each facility's Joint Commission Surveys[2] and any federal or state agency Statements of Deficiencies and Plans of Corrections for the past two-years.[3]

5. Took extensive notes documenting interviews and in-depth review of relevant documents, prepared, and analyzed facility-specific reports, and distilled all that into the PCO's reports to the Court.

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[2] All hospitals, nursing homes, and certain other health care providers that receive funds from Centers for Medicare and Medicaid Services ("**CMS**") are surveyed and the deficiencies and then the corrections are reported using Form 2567; definitions are found at: www.altsa.dshs.wa.gov/professional/nh/documents/Definitions.pdf In all states the JOINT COMMISSION, the State and the CMS share all survey and accrediting information. The JOINT COMMISSION conducts "surprise survey visits" no less than every three years to investigate all aspects of patient care and safety. At the conclusion of the survey, the JOINT COMMISSION provides the Hospital with a detailed report on deficiencies and demand for correction for each deficiency found. In all federal and state surveys, deficiencies are illustrated on a two-column form (CMS FORM 2567) with deficiencies cited on the left column and the right-hand column left blank for the respondent to provide within ten working days a plan of correction for each deficiency. All submitted forms "Post submission and acceptance of plans of corrections, both the JOINT COMMISSION survey documents and Statements of Deficiency and Plans of Correction" are public and will be provided to the Court if requested.

[3] On-Site Survey Process: a Joint Commission Fact Sheet" at https://www.jointcommission.org/assets/1/18/Onsite_Survey_Process_8_13_18.pdf The JOINT COMMISSION ACCREDITATION CATEGORIES relevant to the Debtors is; "**Accredited** is awarded to a health care organization that is in compliance with all standards at the time of the on-site survey or has successfully addressed requirements for improvement in an Evidence of Standards Compliance within 60 days following the posting of the Accreditation Summary Findings Report and does not meet any other rules for other accreditation decisions.

6. Most recently, the PCO gained access to reports and memorandum prepared by the corporate quality assurance, compliance, and other senior facilities' directors. The PCO has been able to initially assess and report on these reports, materials, and data. The PCO will continue off and on site to review and analyze this and other requested reports/materials/data over the coming weeks. Please refer to Section IV for further discussion of this topic; this activity is also cited as "a PCO next step" in this Report's conclusion.

II. EXECUTIVE SUMMARY

The Executive Summary Section offers the Court in summary form a review of each of the Debtor's operating units, which are: the Hospital; the Rural and Specialty Clinics; and the Skilled Nursing Facilities. In concluding this section, the PCO employed the standards set by 11 USC section 333 to:

- Determine the security and availability of medical records and supporting materials, ***which in summary the PCO assessed as being maintained as required by their respective policies and available for patients' continuity of care.***
- Determine whether there has been a post-petition decline in or material compromise to care, ***which in summary the PCO has assessed that there was no post-petition decline or compromise to care.***
- Determine the potential compromises to care, ***which in summary the PCO has identified specific instances where there is potential for compromise to care.***

A. The Debtor's Health Care and Long Term Care Facilities

The Debtor provides a wide range of integrated health care, social welfare, and long-term care services across multiple sites on and off the main "Hospital campus." To support the Court's understanding of a complex care provider, we quote with supplemental supporting materials, descriptive information found in the "DECLARATION OF MARY CASILLAS IN SUPPORT OF EMERGENCY FIRST DAY MOTIONS"[4] ("Casillas Declaration").

The Hospital: "The District operates the 25-bed acute care Hospital at the District's main

[4] DECLARATION OF MARY CASILLAS IN SUPPORT OF EMERGENCY FIRST DAY MOTIONS Doc 10, para 28 pp 8-10.

campus, located at 911 Sunset Drive, Hollister, California. The Hospital is licensed for 6 perinatal, 4 intensive care, and 15 general acute care beds. The emergency department includes 3 large trauma bays, 16 private rooms, and helipad access. The Hospital is currently designated as a "Critical Access Hospital" ("CAH")[5] by the Centers for Medicare and Medicaid Services ("CMS")[6]. Limited to 25-beds and mandated to provide certain key health and social welfare services, "The CAH designation is designed to **reduce the financial vulnerability** of rural hospitals and **improve access to healthcare** by keeping essential services in rural communities." Notably, the average Emergency Room census of 65-80 patients is well above the average for hospitals serving a similar size Primary Service Area. The PCO believes this is indication of both the community's need for and a willingness to use local Emergency Services; additionally, a census of the size financially supports other services and serves as a viable and vital referral to the Hospital, Clinics, and SNFs.

The Rural and Specialty Clinics: "The District operates five rural health clinics commonly known as Hazel Hawkins Health Clinic, San Benito Community Health Clinic, Barragan Family Health Care and Diabetes Center, Mabie First Street Healthcare Center, and Mabie San Juan Road Healthcare Center (collectively, the "Rural Health Clinics"). The Rural Health Clinics offer primary and specialty care, diabetes services, and laboratory services. The Rural Health Clinics saw 51,140 patient visits in Fiscal Year 2022[7]. The following quote from the leading Rural Health policy/programming publication accurately describes the Rural Health Clinics' value to its community: "The Rural Health Clinic (RHC) program is intended to increase access to primary care services for patients in rural communities. RHCs can be public, nonprofit, or for-profit healthcare facilities....RHCs are required to provide outpatient primary care services, basic laboratory services, and be able to provide "first response" services to common life-threatening injuries and acute illnesses. The main advantage of RHC status for rural providers is

[5] Rural Health Information Hub: https://www.ruralhealthinfo.org/topics/critical-access-hospitals

[6] Casillas Declaration para 29 pp 8-10.

[7] Casillas Declaration para 31 pp 8-10.

enhanced reimbursement rates for providing Medicare and Medicaid services[8]."

The Skilled Nursing Facilities ("SNF"): "The District operates two skilled nursing facilities, commonly known as Mabie Northside Skilled Nursing Facility ("Northside") and William & Inez Mabie Skilled Nursing Facility ("Southside" and, together with Northside, the "Skilled Nursing Facilities"). Collectively, the Skilled Nursing Facilities are licensed for 119 beds. In Fiscal Year 2022, Northside had an average daily census of 38.36 equaling a total of 14,002 patient days and Southside had an average daily census of 43.95 equaling a total of 16,042 patient days. This represented an annual increase in average daily census in each facility as compared to fiscal year 2021." [9] Maintaining access to quality long term care close to the resident's family and friends is an issue that the PCO has been closely engaged in both as program director, consultant, and policy expert; the following quote from the leading Rural Health policy/programming publication accurately describes the Debtor's SNF's value to its community: "A scarcity of long-term care facilities and healthcare providers in rural communities can cause hardship and difficult choices for individuals and their families. In such cases, people who need long-term care must decide, in consultation with their families and other caregivers, if home care is possible or if relocation to a facility outside of their community is necessary. A move to another community can be stressful, and family members might not be able to visit as often as they would like. Communities also experience economic loss and diminished social connections when people leave."[10]

B. The PCO Assessment

1. Health Insurance Portability and Accountability Act ("HIPAA") Compliance:

The patient's medical record is a means of communication between providers as to health status, preventive health services, treatment, planning, and delivery of care and are an indicator of the ongoing quality of care. Patient medical records were sampled to test for the existence and

[8] Rural Health Information Hub: https://www.ruralhealthinfo.org/topics/rural-health-clinics.
[9] Casillas Declaration para 30 pp 8-10.
[10] Rural Health Information Hub: https://www.ruralhealthinfo.org/topics/long-term-care.

timeliness of required medical records, forms, and statements. The purpose of this review was to determine whether patient record documentation was being maintained at the time of our review to support quality and continuity of care. These tests included a review of the Debtors' internal medical record policies, and those internal requirements were used to structure elements included in our test samples.

Medical records were selected from all three of the Debtor facilities to include the hospital, clinics, and nursing homes. A contemporaneous review was conducted to test the current maintenance of the medical record requirements at each of these operations. The hospital's Meditech system was tested for patients admitted between September 7th and September 11th, 2023, and all tested reports were filed and timely. Resident medical records kept in the nursing home PointClickCare, and all resident records requirements selected were found in the system and timely. Finally, clinic records were tested in their eClinicalWorks system for patients scheduled the morning of September 18, 2024, the date of the test. All progress notes were found for patients scheduled for that morning. The Debtor's use of electronic health information systems is being used effectively and it appears that they have good compliance of their medical record maintenance obligations. Patient medical records from all facilities and units visited by the PCO were sampled to test for the existence and timeliness of required medical records, forms, and statements.

These tests, further chart review, and observation by the PCO indicated ***that the Hospital, SNFs, and Clinics both maintained medical records as required by their respective policies on a timely basis; and that the Debtors are meeting the requirements for providing information/documents needed for patient continuity of care.***

2. Assessment the Key Factors Preventing Compromises to Care

a) The Debtor's Interim CEO and Chief Responsible Officer is ***qualified and an experienced professional*** who has served in that role for approximately six months. She has been actively involved in the hospital in various paid and volunteer roles for many years. The Hospital Board and key community parties in interest requested that she take on

this role due to her extensive knowledge of the hospital and her professional expertise for less than two years prior to the filing of the bankruptcy. Importantly, the Chief Financial Officer, The Director of Provider Services & Clinic Operations, the SNF operations director, Medical Director, Emergency Department ("ED" or "ER") Director and other key leaders have been at the Debtor for no less than 15 years; we believe based on interviews and materials review that the bring to the Debtor both the required knowledge of the Managing Entity and/or their operating unit/department's operations and strong professional credentials. Over the past year, the Debtor expanded its team of needed and in some instance required professionals to provide support to the Hospital, the SNFs, and Clinics in critical roles including Chief Nursing Officer, Director of Quality Assurance, Risk Management, Accreditation, and Regulatory Compliance; Comptroller; Revenue Cycle Director; Infection Control/Disaster Preparedness Director; Director of Facilities; and others professionals whose work has based on our initial review and research supports the Debtor's patient care and safety. ***b) Medicare certification, accreditation by Joint Commission, and other regulatory bodies*** established standards of patient care and safety and conduct frequent on-site surveys[11] [12] Jointly, the Debtor's Hospital and Clinics, and separately its laboratories have in the past twelve months had their in-depth Joint Commission survey ("JOINT COMMISSION Unannounced Full Event Report"). In summary:

- The Debtor's hospital and Clinics have maintained their accreditation with comparatively few deficiencies to correct. The Debtor's Laboratories have maintained their accreditation with comparatively few deficiencies to correct.
- With the full cooperation of the Debtor, the POC to the best of their ability and given the time an available have reviewed and discussed with the Debtor the Medicare certification and any Statements of Deficiency and Plans of Corrections,

[11] Op cite at note 2.
[12] Op cite at note 3.

accreditation by Joint Commission documents, and other regulatory bodies established standards of patient care and safety on-site surveys[13] [14] .

- All Hospitals, SNFs, and Rural Clinics are required to attempt to complete a ***Standardized Patient Satisfaction Survey*** at the time of the patient's discharge.[15] The PCO has initiated the process of reviewing survey results at each of the Debtor's operation units and will report to the Court in their next 60-Day Report.

b) Based on the PCO's interviews and an extensive on-site review, the PCO believes that the Debtor's leadership have acted to maintain required levels of staffing, supplies, drug, and equipment.

3. Summary

The PCO reports, based on monitoring and analysis provided above *and* in the Sections

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[13] All hospitals, nursing homes, and certain other health care providers that receive funds from Centers for Medicare and Medicaid Services ("**CMS**") are surveyed and the deficiencies and then the corrections are reported using Form 2567; definitions are found at: www.altsa.dshs.wa.gov/professional/nh/documents/Definitions.pdf In all states the JOINT COMMISSION, the State and the CMS share all survey and accrediting information. The JOINT COMMISSION conducts "surprise survey visits" no less than every three years to investigate all aspects of patient care and safety. At the conclusion of the survey, the JOINT COMMISSION provides the Hospital with a detailed report on deficiencies and demand for correction for each deficiency found. In all federal and state surveys, deficiencies are illustrated on a two-column form (CMS FORM 2567) with deficiencies cited on the left column and the right-hand column left blank for the respondent to provide within ten working days a plan of correction for each deficiency. All submitted forms "Post submission and acceptance of plans of corrections, both the JOINT COMMISSION survey documents and Statements of Deficiency and Plans of Correction" are public and will be provided to the Court if requested.

[14] On-Site Survey Process: a Joint Commission Fact Sheet" at https://www.jointcommission.org/assets/1/18/Onsite_Survey_Process_8_13_18.pdf The JOINT COMMISSION ACCREDITATION CATEGORIES relevant to the Debtors is; "**Accredited** is awarded to a health care organization that is in compliance with all standards at the time of the on-site survey or has successfully addressed requirements for improvement in an Evidence of Standards Compliance within 60 days following the posting of the Accreditation Summary Findings Report and does not meet any other rules for other accreditation decisions.

[15] The HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey is the first national, standardized, publicly reported survey of patients' perspectives of hospital care. HCAHPS (pronounced "H-caps"), also known as the CAHPS Hospital Survey, is a survey instrument and data collection methodology for measuring patients' perceptions of their hospital experience. AT: https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/hospitalqualityinits/hospitalhcahps.htmle.

below, that:

- ***Medical Record and support materials are being maintained as required by their respective policies and available for patients' continuity of care.***
- ***No decline in care post-petition and no* material compromise to care has occurred.**
- ***The PCO has identified and reviews in the Sections below, specific instances in each operating unit that offer the potential for compromise to care that need remediation.***

III. REVIEW OF THE PCO'S MONITORING BY OPERATING UNIT

A. THE HOSPITAL AND ITS KEY OPERATING UNITS' SYSTEM REVIEW

The Hospital's System Review, which included its key operating units effort, was led by Jody Knox MHA, BS, RN, who is a highly skilled health care administrator who has served as a hospital CEO, senior manager in large health care provider organizations, and who has extensive experience in clinic operations.

Upon appointment, the PCO requested and received key documents from the Hospital's Leadership. After reviewing the documents, the PCO conducted initial zoom interviews with the Hospital's leadership team with the purpose of reviewing key indicators to determine if there is any significant decline in the quality of care. The participants were provided a preliminary agenda from which to prepare and provide initial responses that were reviewed during the meeting.

1. Methodology Employed and Review of the Hospital and its Operating Unit

a) The PCO conducted a campus tour that included all patient care areas as well as many, not all areas needed to support patient care. These appeared to be clean, free from debris, hallways clear, ceiling tiles were clean and fire extinguishers that were randomly checked were tagged appropriately.

b) Prior to being on-site the PCO reviewed several policies: Infection Prevention (2023-2024) and Control and Quality Improvement (2022). These are current; however, the Quality Improvement Plan is dated 4/5/2022 and contained therein is to be updated and approved by the District Board annually. Both Plans appear to address the needed regulatory components. The hospital uses the MIDAS system for reporting of occurrence reports and all staff

have access and are encouraged to input information as appropriate. The PCO will be delving further into this as well as validating the Plan against what is communicated to leadership and the Board at the next on-site visit.

c) The PCO attended the morning safety round where department directors and leadership reported out statistics that included but was not limited to census, admissions, expected surgical cases, expected discharges, unusual occurrences, known hospital acquired occurrences (CAUTI, HAI, CLABSI, etc.). During this time they also speak toward any equipment issues, which is a good practice. This daily meeting is a good communication mechanism.

d) While rounding in the various hospital departments, the PCO randomly reviewed medical and patient care equipment for current biomedical checks and appropriate tags. Those reviewed were found to be compliant.

e) The PCO randomly reviewed patient care supplies and medications for expiration dates and those reviewed were found to be compliant.

f) The PCO made rounds in the following departments:

- OB/Women's Health

  Review of this OB unit and a cursory review of the C-Section room demonstrated an LDRP suite fully operational, including neonatal recitative equipment appropriate for a CAH. There is a pediatric hospitalist available 24/7 and they have appropriate OB call coverage.

- Dietary

  Review of the dietary department demonstrated a clean and orderly department. The PCO interviewed staff regarding patient diet needs and how they managed the differing supplements, types of diets and various diet restrictions – all were answered without hesitation. The lead dietary person was interviewed about the interaction between the department and

the clinical dietician and there appears to be a high level of interaction to meet the needs of the patients.

- Materials Management

  The PCO walked the department and had a lengthy discussion with the leader regarding any difficulty obtaining supplies either during COVID crisis time or under the organization's current financial concern. The leader discussed how they have managed to work their vendors to negotiate payment terms when needed. The leader also discussed how they have used other sourcing methods, other than their GPO, i.e. Amazon, to obtain supplies, when their backs were against the wall. Further review in this department demonstrated a robust *first in - first out* ("FIFO") and rotation method to be sure that stock does not expire and that expired supplies/materials are checked regularly.

- Environmental Services

  The PCO met with the lead of the EVS department who is proud of the team she leads as well as the service her team provides. The lead was able to fully describe the method by which each area the team is responsible for is validated for cleanliness. The EVS department has adopted the EcoLab system for environmental cleaning, using the Fluorescent Marker Assessment Tool, a best practice among health care organizations.

- Medical/Surgical Unit

  The PCO rounded in this area and did a cursory review of the area to see that the organization uses an OmniCell for supply control and distribution

and a Pyxis system for medication control and distribution. The PCO also reviewed one unoccupied patient room.

- Pharmacy/IV Admixture Room

The PCO met with the pharmacist on duty at the time of the visit, who explained this is a contracted service through Cardinal Health. All employees in this department are employed through Cardinal, including the director. It was explained that this is a unit dose department, that the hospital/organization is a 340b[16] program recipient. Medications and supplies are ordered via McKesson via the hospital under the direction of the pharmacy department. Controlled substances are in order; the IV admixture hood meets compliance standards. The pharmacist stated that the hood is rarely used as most items in the pharmacy are in "admixture" containers that are premixed by and then come directly from the supplier.

- Laboratory

An in-depth tour with the lab director occurred. The director stated that they have recently received some new equipment and that they are expecting new equipment. The director was detailed in the accounting of how validations occur prior to putting any new equipment or reagents into use. A random review of biomedical tags found these to be compliant. It was interesting to note that most of the laboratory tests run, are outpatient

[16] ***CMS. Gov Newsroom*** " Section 340B of the Public Health Service Act (340B) allows participating hospitals and other providers to purchase certain covered outpatient drugs or biologicals (hereinafter referred to collectively as "drugs") from manufacturers at discounted prices." at:https://www.cms.gov/newsroom/fact-sheets/hospital-outpatient-prospective-payment-system-remedy-340b-acquired-drug-payment-policy-calendar.

in nature. They are College of Pathologist accredited and have a physician on-site medical director several times a week. Clinician licenses were posted.

- Radiology

The PCO reviewed the radiology department with the director and working manager. Clinician licenses were posted. MRI signage was visible. They have a fully functional PACS[17] system that is accessible in the clinics.

a. The PCO will make rounds to the following departments on the next on-site and will include but not limited to:

- Surgery
- Sterile Processing
- GI and Scope Processing
- Registration
- Case Management

Based on the PCO's interviews before, during, and on their September site visit; pre-visit, on site, and post-visit requests documents/materials, prior and on-going review of documents/materials; the PCO assessment is that ***the Hospital is providing high quality patient care and safety with staff and leadership exhibiting a strong commitment to provide cost efficient and effective care. The PCO, in this Report and in meetings with Hospital Leadership and Managers, identified specific clinical practice and procedures, Data collection and***

[17] Intelerad "In medical terms, PACS stands for Picture Archiving and Communication System. A PACS system is an efficient way to securely transport private patient medical imaging information, in contrast, to manually filing, retrieving, or physically transporting film jackets. With PACS, medical professionals can store and digitally transmit images and clinical reports for immediate use at their discretion- a significant improvement over older film-based systems. In addition, medical documents and images can be housed locally or offsite on secure servers and accessed using PACS software, workstations, or mobile devices." at:https://www.intelerad.com/en/2022/01/24/what-is-pacs/.

sharing, QAPI system issues, as well as other potential for compromise to care that need remediation. We believe that the Debtor will engage in a strong remediation effort, which will be monitored by the PCO and reported to the Court in a timely manner.

B. THE RURAL CLINICS' SYSTEM REVIEW

The Clinics' System Review effort was led by Jody Knox MHA, BS, RN, who is a highly skilled health care administrator who has served as a hospital CEO, senior manager in large health care provider organizations, and who has extensive experience in clinic operations.

Upon appointment, the PCO requested and received key documents from the Clinic Leadership. After reviewing the documents the PCO conducted initial zoom interviews with the clinic leadership team of the Rural Health & Specialty Clinic operations with the purpose of reviewing key indicators to determine if there is any significant decline in the quality of care. The participants were provided a preliminary agenda from which to prepare and provide initial responses that were reviewed during the meeting.

1. Assessment Made from Document Review of the Rural Clinics

a) Prior to the initial zoom meeting, the PCO reviewed the most recent Joint Commission accreditation report (June 2021), the July 2023 Lab Joint Commission accreditation report, and the July 2023 Radiology MQSA inspection, however neither the Quality Assurance Performance Improvement nor the Infection Prevention plan were available prior to the interview. At the initial and subsequent meetings on and off premises, attendees were very pleasant, cooperative, and engaged. Key tasks completed were, but not limited to:

b) Along with the reviewing that responses provided by the interviewees to the questions and delving further into those, the PCO asked about staffing, education of staff, patient care, other directors making rounds i.e., ICP, EOC, Pharmacy.

c) The PCO inquired as to how language barriers are addressed.

d) Remote Chart review occurred during the interview, specifically looking at immunization, chart documentation, chart completion, interpreter documentation, medication reconciliation and administration.

e) The PCO sought information as to the Debtor's performance during the COVID-19 outbreak. Key issues, such as the screening process, how they transitioned to tele/video visits, and how they remain on telehealth/video visits today were addressed.

f) Based on interviews and on-site independent and in-depth review, the PCO believes that the Debtor's Clinics are not having any issues obtaining supplies or medications. They have a functioning and inspected Vaccine For Children Program ('VFC"), which provides many of the needed vaccines for pediatric patients.

2. Assessment Gained From Rounding at the Clinics:

Based on the PCO's site in-depth review by the PCO with the support of caregivers (rounding")' and our on and off-site review of documents/materials, our assessment of key indicators of patients care and safety is as follows:

a) All the clinics to be in good repair, medications and sharps were locked, and there was no pattern of expired medications found. Sharps containers were at the appropriate level, hazardous waste was contained, and supplies/medications were adequate per site visited.

b) The Clinics have a state funded Vaccines for Children program and they are in compliance and regularly inspected.

c) Interviews with staff were found that they could articulate infection prevention and patient safety practices in compliance with regulatory standards.

d) Discussions with leadership regarding their quality indicators involved how they identified items to monitor. There is a mechanism to report these through the quality improvement committee and it is done once per year.

e) There is a mechanism to review policies on an ongoing basis. For the most part they adhere to the hospital-wide policies with clinic specific additions as needed.

f) The clinics use MIDAS system for reporting of occurrence reports and all staff have access and are encouraged to input information as appropriate.

Based on the PCO's interviews before, during, and on their September site visit; pre-visit,

on site, and post-visit requests documents/materials, prior and on-going review of documents/materials; the PCO assessment is that ***the Clinics are providing high quality patient care and safety with staff and leadership exhibiting a strong commitment to provide cost efficient and effective care. The PCO, in this Report and in meetings with the Hospital and the Clinics' Leadership and Managers, identified specific deficiencies that offer a potential for compromise to care that need remediation. We believe that the Debtor will engage in a strong remediation effort, which will be monitored by the PCO and reported to the Court in a timely manner.***

C. THE SKILLED NURSING FACILITIES' SYSTEM REVIEW

The Debtor operates two Skilled Nursing Facilities (SNFs), Mabie Northside Skilled Nursing Facility ("Northside") and William & Inez Mabie Skilled Nursing Facility ("Southside"), which are in separate buildings on the north and south side of the Hospital main campus. Although they have separate state and federal licenses, they are led by the Hospital's key executives and the Hospital revenue cycle department provides key financial, billing and collecting, and other management services. The SNFs employ their own EMR, yet staff can readily access the other operation units EMRs and databases. We in this section and throughout the Report refer to the facilities as the "SNFs."

Upon appointment, the PCO requested and received key documents from the Skilled Nursing Leadership. The SNF assessment effort was led by Lisa Grod Ph.D. a licensed nursing home administrator with extensive experience in skilled nursing operations.

After reviewing the documents the PCO conducted initial zoom interviews with the leadership team of the SNF operations with the purpose of reviewing key indicators to determine if there is any significant decline in the quality of care. The participants were provided a preliminary agenda from which to prepare and provide initial responses that were reviewed during the meeting. For the three days that the PCO spent at the SNF in September, meetings were held with the executive and senior leadership teams daily.

1. On Site Interviews and Expert Observations

a) **Resident Rounds:** In depth interviews with residents "Resident Rounds" were conducted at Mabie Northside Skilled Nursing Facility ("Northside") and William & Inez Mabie Skilled Nursing Facility ("Southside") and followed by Interdisciplinary Team Meetings (IDT) providing daily reports and updates on every resident residing in both SNF's during the onsite visit.

b) **Facility Rounds** were made with The Infection Preventionist that included resident rooms & bathrooms, laundry, dietary during tray pass, reviewed random sanitation of kitchen: calibration of thermometers, temperature logs for refrigerators and freezers, labeling and dating of open food items, and disaster supplies.

c) **The PCO observed as to Resident Care** that The Northside and Southside facilities were free of odors and the residents were observed to be in activities, participating in Rehab, up in their wheelchairs (in and out of rooms), or resting in bed depending on the time of day.

d) The PCO met with the SNF IP (infection Preventionist) and The Debtor's Director for Infection Prevention and Disaster Preparedness. The PCO conducted in depth reviews with those individuals and has recently received a copy of the June 2022 CDPH survey to review.

e) **Meetings** were held with Interim DON, staff, and Registered Dietician. Meetings included discussions of MDS and documentation, Quality Measure Reports, Weight Variance Meetings, Dining Program, Pressure Ulcer Reports, Pharmacy review including Antipsychotics, Antidepressants, and Antianxiety/Hypnotics and Medication Errors, Incident

reports - Falls, grievance and theft and loss, NHPPD[18], QAPI, Care Plans, catheters, and a Prospective Payment System/Payment Driven Payment Model ("PPS/PDPM")[19] billing review.

f) **Billing and Financial Review:** P & Ls were reviewed along with collections. The PCOs attended a billing meeting with the Northside and Southside SNF team consisting of Physical therapy, Assistant Administrator for each building individual, Director of Billing and other billing department members.

g) **Policies on** theft and loss, grievances, sanitation rounds of Kitchen, and incidents were provided to the PCO along with Internet Quality Improvement & Evaluation System ("iQIES") Reports on Quality Measures for the SNF. [20]

h) **Electronic Medical Record:** The Debtor employs several EMR systems within the SNFs' organization. Point Click Care (PCC) is utilized by the SNF's to document Resident care and create reports related to resident care. Incident reports, Care Plans, MDS, medication management, treatment, dietary plans, and monitor quality measures affecting the residents. Midas another EMR is used by staff members to document incidents - currently staff are being provided education on how to enter an incident into the system. One issue remains

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[18] CALIFORNIA DEPARTMENT OF PUBLIC HEALTH; GUIDELINES "NHPPD means the actual nursing hours performed by direct caregivers per patient day. (o) NHPPD Calculation is the calculation of the NHPPD by dividing the actual nursing hours performed by direct caregivers per patient day by the Average Census" at https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-11-19.aspx#:~:text=(n)%20NHPPD%20means%20the%20actual,day%20by%20the%20Average%20Census.

[19] CMS.Gov "The Balanced Budget Act of 1997 mandates the implementation of a per diem prospective payment system (PPS) for skilled nursing facilities (SNFs) covering all costs (routine, ancillary and capital) related to the services furnished to beneficiaries under Part A of the Medicare program. at https://www.cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf#:~:text=The%20Balanced%20Budget%20Act%20of,A%20of%20the%20Medicare%20program.

[20] Beginning in May 2021, State Survey Agencies (SAs) and CMS locations began a phased transition to the Internet Quality Improvement and Evaluation System (iQIES), which is an internet-based system that includes survey and certification functions. iQIES consolidated and replaced functionality from the prior surveying/assessment systems: QIES, CASPER, and ASPEN; at https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-general-information/iqies.

that there is no interoperability between systems and not all of the necessary information is communicated as determined by which system the information is entered into and in what detail. The outpatient Rehab department is on Web PT, an EMR system to capture Therapy minutes.

i) **Rehabilitation: A** meeting with the Rehab Director took place in the Outpatient Clinic to discuss the staffing needs of qualified therapists, the increased cancellation rates of patients post discharge from hospital for therapy, and an improved EMR to capture Inpatient, Outpatient and SNF rehab minutes independently.

j) **Staffing:** As with many health providers nationally and locally, staffing continues to be an issue in the SNF and the **Hazel Hawkins Physical Therapy & Rehabilitation Service** ("OutPatient Rehab") Center. In the SNF, the preference is to provide overtime to working staff and to minimize using registry unless necessary. The OutPatient Rehab Center currently uses traveling ("registry") nurses. At the time of this meeting. The PCO was unable to review the annual staffing audit done by CDPH.

k) **Covid Testing** Procedures for covid testing in the SNF is based on symptoms only at this time and Return to Work policy follows the CDC guidelines as "may return to work after five days and be masked if no symptoms or fevers. The visitor policy is to wear a mask, take temperature and document in the logbook.

l) **QAPI:** The PCO received a document for QAPI in the SNF that addresses the monthly required committee meetings quarterly: QAPI, Infection Control & Antimicrobial Stewardship Program, and the Pharmaceutical Service Committee. Annual meeting to review Patient Care Policy and Pharm Committee. The PCO received a copy of a July QAPI meeting, yet those notes did not meet the standards of reporting whether the action plan was working or needed to be modified to attain QAPI goals.

m) **Infection Prevention and Disaster Preparedness:** The PCO met with MH the Director to discuss the IP program and training of the newly hired IP LVN for the SNF's. The Emergency Disaster Preparedness Program is being updated and is a work in progress. There are 10 generators on the HHMH site. A discussion was held on shelter in place

versus transfer to outlier facilities. Unable to review transfer agreements at this time, however there were transfer agreements for transportation in place.

At the time of this report, the PCO was unable to contact the Medical Director and the Pharmacy Consultant.

2. Summary

Based on the PCO's interviews before, during, and on their September site visit; pre visit on site, and post visit requests documents/materials, prior and on-going review of documents/materials; the PCO assessment is that ***the SNFs are providing high quality resident care and safety with staff and leadership exhibiting a strong commitment to provide cost efficient and effective care. The PCO, in this Report and in meetings with both the Hospital and the SNF Leadership and Managers, identified specific practice and procedures, Data collection and sharing, QAPI system issues, coding and billing process, as well as other potentials for compromise to care that need remediation. We believe that the Debtor will engage in a strong remediation effort, which will be monitored by the PCO and reported to the Court in a timely manner.***

IV. SYSTEMIC POTENTIAL FOR COMPROMISE TO CARE

The PCO concludes a review of those factors that threaten daily patient care and safety by reporting on what the PCO believes based on their monitoring and experience are the systemic challenges the Debtor faces in preventing compromises to care.

A. Financial Factors Shaping the Debtor's Operations

B. Community Involvement and Support

C. Implementing a Viable and Vital Quality Assurance and Performance Improvement Program

D. Interoperability: The Appropriate and Safe Sharing of Patient Information

A. Financial Factors Shaping The Debtor's Operations

The factors that lead to a health care provider bankruptcy are a concern for the PCO if

they impact Debtor's patient care and safety. As to this Debtor, the Declaration of its CEO stated two key factors leading to Debtor's lack of liquidity:

- "The District's limited access to working capital also presents significant challenges when addressing short-term fluctuations in cash flow.[21]
- The District experienced a significant and unanticipated decrease in revenue and a concurrent increase in expenses that rapidly eroded the District's limited working capital."[22]

Both above can negatively impact patient care by affecting the Debtor's ability to obtain supplies and adequate staffing. Accordingly, these factors are a component in the PCO's ongoing monitoring and reporting efforts.

B. Community Involvement and Support

The PCO has managed and monitored hospitals urban and rural and small and large community long term care facilities, which offers the PCO insights into the issues that are addressed in this section. The Interim CEO and her senior leaderships' need to engage in the time consuming and complex effort to maintain financial support from multiple boards and funding authorities. The Debtor's leadership must also, through communication and quality care, satisfy those who use the hospital, the clinics, and the SNF. They must also convince a significant share of the 65,000 residents of the Debtor's primary health care service area to go to the Debtor's Hospital, Clinics and SNF when they or a child need urgent care; when a fall at little league, an accident at work, in the car, at home demands an Emergency room, and so many other immediate or non-urgent health and long term care needs arise.

The PCO is also no stranger to the turmoil, confusion, and at times anger created when a needed health and long-term care provider in and out of bankruptcy dips into a financial crisis. In our prior work, for everyone who criticized our interim management efforts, there were 10-20 more who said to us at the supermarket, high school football game, house of worship, or in a coffee shop, "thank you for the great job you are doing." Unfortunately, today the Debtor's

[21] Casillas Declaration page 5, para 19-20.
[22] Casillas Declaration page 6, para 21-22.

interaction with the community is more difficult because of the power of social media and other tools, which empower a minority to use public meetings and everyday encounters in the community to promote unsupported allegations, make claims that are in ignorance of rules and regulations and offer personal insults; all of which makes more difficult the work of caregivers and leadership.

Based on the PCO's interviews, review of data/documents/material; and analysis of Emergency Room, Hospital, Clinics, the SNFs' and other Debtor services' data *the PCO has determined that the Debtor's* ***staff and leadership are exhibiting a strong commitment to provide cost efficient and effective care and are making a time consuming effort to communicate their care and financial resources to the community.*** The PCO will continue to monitor risk to care created by the great increase we see in time that the Debtor's leadership and even caregivers give to responding to unfounded allegations and anger fueled by social media.

C. Assuring Quality Assurance and Improving Performance

The PCO quotes from The National Institutes of Health ("NIH") to respectfully remind the Court that "the healthcare system is made up of individual players, but its ultimate goals of patient care and safety are accomplished through teamwork. Likewise, when medical errors occur, though they may result from an individual's actions, the appropriate next steps fall on the institution to identify, learn from, and improve on the prevention of such events."[23] Therefore, at each Debtor's facility and system-wide there must be a viable and vital on-going quality assurance and performance improvement programs.

1. Quality Assurance-Performance Improvement ("QAPI") Program

QAPI is a process whereby information is gathered, tracked, analyzed and reported to the governing board and leadership to develop performance improvement projects. Quality Assurance and Performance Improvement is a key tool for each person involved in care, to find, assess, and fix deficiencies in patient care and safety. As part of the PCO's review of the care delivery

[23] Joel McGowan; Amanda Wojahn; Joseph R. Nicolini "Risk Management Event Evaluation and Responsibilities"; HIH: National Library of Medicine; at: https://www.ncbi.nlm.nih.gov/books/NBK559326/#:~:text=Risk%20management%20in%20healthcare%20is,and%20prevent%20risks%20to%20patients

processes, an important component is implementation and operation of all components of the Debtor's QAPI program.[24]

The key components needed to support an effective QAPI program are the following:

- ***Both Federal and State Rule and Regulations demand monthly or quarterly meetings*** be held by nursing, medical staff, QAPI, infection control, facilities (to include disaster preparedness and other emergency situations). The Hospital and Rural Clinics are Joint Commission accredited and the SNFs are state licensed separately and have their own rules and regulations as well as mandates to provide services to and coordinate with the Hospital.
- ***All Facilities and their Directors must maintain and update policies and procedures*** for their departments/services and all must participate with the Debtor's leadership in developing, implementing, training for, and assessing protocols that facilitate their specific contribution to patient care and services. In addition to all the above efforts at compliance with rules and regulations and licensing, all the Debtor's operating units are a Medicare certified facility with accreditations by The Joint Commission, the College of American Pathologists, the California Department of Public Health Licensing and Certification Division, and other department or service-specific accrediting bodies.
- ***The demand for specific senior managers/directors to comply*** with the required rules, regulations, and protocols, and the need to comply with patient care/services reimbursement rules and procedures means that the PCO monitors both the Debtors corporate operations as well as each Hospital. The Debtors' constant compliance efforts within and across the Hospitals offers the PCO a road map of the quality of

[24] "The core functions of an incident reporting system are twofold. One is to use incidents to identify and prioritize which aspects of a healthcare system and its underlying risks need to be examined more closely (citation omitted). The other is to organize broader investigation and improvement activities to understand and address those risks. These active processes of investigation, inquiry and improvement underpin learning." Macrae, C. "The problem with incident reporting," *BMJ Qual Saf*, 25: 74 (2016).

patient care and safety. Thereby through interviews, observation, and review of documentation the PCO accurately assess the quality of patient care and safety and any decline or compromise in that care.

- ***Meeting the demand and requirement for clinical care meetings.*** The PCO's observations of clinical care meetings, "rounding" with caregivers, chart review, and our own professional experiences revealed both the complexity of the Debtors' patient care, and the key role psycho-social and family support services play during care. The Hospital and the SNFs each utilize daily "stand-up" or "flash-meetings" to effectively review specific clinical events, care and safety incidents, case management, and revenue cycle issues. The PCO observed at the Hospital and the SNFs these meetings; the meetings were well-run with all departments participating. Additionally, the meetings allowed the PCO to identify patients or events that merited further attention.

Based on the PCO's interviews and review of documents/materials; the *PCO has determined that there are deficiencies in the aforementioned program, which are for the most part systemic and dating to prior to the Bankruptcy, **yet currently limit the effectiveness of the Debtor's QAPI program***. **A most recent meeting between the Debtor's leadership and the PCO responded to the PCO's questions and documented for the PCO the steps the Debtor is taking to improve the Debtor's QAPI program.**

2. Incident Reporting

As stated above, be it a hospital, clinic, or SNF, quality patient care is achieved through documenting every care component. Maintaining, and improving patient care and safety demands that the provider and their organization closely examine ***"adverse events'*** (e.g., a medical error, patient injury, or equipment failure) that harms or has the potential to harm a patient, caregiver, or visitor. The collecting and documenting of these adverse events data is ***"Incident Reporting or Occurrence."*** "Done well, it (*the incident report*) both identifies safety hazards and guides. Incident reports help staff identify and change the individual or system-level factors contributing

to medical errors."[25]

All three of the Debtor's care units use a computer system (MIDAS) to input information into the system to document all facets of the incident. The facility or care unit's EMR is then employed for analysis and corrective action.

Based on the PCO's interviews and review of documents/materials; the *PCO has determined that there are deficiencies in Incident Reporting, which are for the most part systemic and dating to prior to the Bankruptcy, **yet currently limit the effectiveness of the Debtor's Incident Reporting and therein the QAPI program***. **A most recent meeting between the Debtor's leadership and the PCO responded to the PCO's questions and documented for the PCO the steps the Debtor is taking to improve the Debtor's Incident Reporting and the QAPI program.**

3. Risk Management

The NIH defines risk management in healthcare as "a complex set of clinical and administrative systems, processes, procedures, and reporting structures designed to detect, monitor, assess, mitigate, and prevent risks to patients."[26] As a key component of QAPI, at most health care providers including the Debtor, Risk Management is headed by the QAPI Director. The Risk Management Department:

- **CERTIFIES PATIENT SAFETY ORGANIZATIONS ("PSOS"), WHICH ARE MANDATED PROVIDER ORGANIZATIONS THAT COLLECT AND ANALYZE DATA AS PART OF THE QAPI EFFORT.**
- **COLLECTS AND DISSEMINATES INFORMATION RELATED TO PATIENT SAFETY, WHILE MAINTAINING A PATIENT SAFETY DATABASE.**
- **WORK TO EDUCATE AND INVOLVE HEALTH CARE PROVIDERS, PATIENTS, AND OTHER INTERESTED PARTIES ON THE PROVIDERS' PATIENT SAFETY EFFORTS.**

The Risk Management department increases patient safety by encouraging confidential

[25] "Why is incident reporting important for healthcare organizations?" **THE Patient Safety Company-Topics**; at https://www.patientsafety.com/en/blog/why-incident-reporting.

[26] Joel McGowan; Amanda Wojahn; Joseph R. Nicolini "Risk Management Event Evaluation and Responsibilities"; HIH: National Library of Medicine; at: **https://www.ncbi.nlm.nih.gov/books/NBK559326/#:~:text=Risk%20management%20in%20healthcare%20is,and%20prevent%20risks%20to%20patients.**

and voluntary reporting of adverse events, which can lead to the prevention and recurrence of medical errors.[27]

Based on the PCO's interviews and review of documents/materials; *the PCO has determined that there are deficiencies in the Risk Management Department, which are for the most part systemic and dating to prior to the Bankruptcy,* ***yet currently limit the effectiveness of the Debtor's Risk Management Department and therein the QAPI program.*** **A most recent meeting between the Debtor's leadership and the PCO responded to the PCO's questions and documented for the PCO the steps the Debtor is taking to improve the Debtor's Risk Management Department and the QAPI program.**

4. Compliance-Ethics Program[28]

As mandated by the 2010 Affordable Care Act ("ACA") as a recipient of Medicare, Medicaid, and Children's Health Insurance Program ("CHIP") funds, the Debtor's Hospital, Clinics, and SNF must establish a compliance-ethics program. Although we refer in this Report as to this key mandated program as "Compliance," most providers now refer to this as the "Compliance-Ethics program or department. Best practices has the Compliance-Ethics department and its director separate from the QAPI program. Most importantly, the Compliance program interacts with and supports the Debtor quality assurance, training, and performance improvement effort. In summary, a Compliance-Ethics program:

- Establishes policies, procedures, and controls for all your providers and support staff.
- Exercises effective compliance and ethics oversight at both the highest levels (compliance and ethics officer, CEO, CFO and Board)
- Trains and continuously communicates in an effective manner with all employees, board members and vendors on compliance and ethics rules, regulations, and standards.

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[27] Paine LA, Baker DR, Rosenstein B, Pronovost PJ. The Johns Hopkins Hospital: identifying and addressing risks and safety issues. Jt Comm J Qual Saf. 2004 Oct;30(10):543-50. [PubMed] ; at: https://www.ncbi.nlm.nih.gov/books/NBK559326/#

[28] "Why Compliance and Ethics Programs in Healthcare Are Mandatory for Quality Care" *The Compliance & Ethics Blog* at https://www.complianceandethics.org/compliance-ethics-programs-healthcare-mandatory-quality-care/#:~:text=What%20is%20key%20is%20that,is%20driven%20by%20the%20government.

- Transparent, viable and vital monitoring and enforcement of all components of the compliance and ethics program
- Respond appropriately to detected offenses and develop corrective action to prevent future offenses.

Based on the PCO's interviews and review of documents/materials; **the *PCO has determined that there are deficiencies in the Debtor's Compliance Ethics Department, which are for the most part systemic and dating to prior to the Bankruptcy, yet currently limit the effectiveness of the Debtor's Compliance Ethics Department and therein the QAPI program*. A most recent meeting between the Debtor's leadership and the PCO responded to the PCO's questions and documented for the PCO the steps the Debtor is taking to improve the Debtor's Compliance Ethics Department and the QAPI program.**

D. <u>Interoperability: The Appropriate and Safe Sharing of Patient Information</u>

The Debtor must share, as do all complex health and long-term care providers, patient information in a safe and accessible form. **HealthIT.gov**, which is the official website for the federal Office of the National Coordinator for Health Information Technology ("ONC") states that as a complex health system, the Debtor "requires diverse electronic health record (EHR) products. One size does not fit all. To realize their full potential, EHR products must be able to share information seamlessly."[29] "Interoperability" is the term used for linking systems within each of the Debtor's facilities, between the Debtor's facilities, and between the Debtor and other care and financial parties.[30]

At the Debtor, interoperability is demanded of their Electronic Medical Record Systems as well as, special applications and reporting systems. In summary, the Hospital employs the "**Meditech**" EMR; the Clinics employ the "**EClinicalWorks**" EMR; and the SNFs employ

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[29] HealthIT.gov – FAQ's at: https://www.healthit.gov/faq/what-ehr-interoperability-and-why-it-important

[30] The PCO highly recommends "Interoperability Challenges Have Real-World Effects on Patients", which is posted on the secure exchange of health information accreditation and training organization DIRECT TRUST's *Blog* at: https://directtrust.org/blog/interoperability-challenges-have-real-world-effects-on-patients/%E2%80%8BDirectTrust

the"**PointClickCare**" EMR. All three must be interoperable with the other EMRs, as well as with the **Midas Incident Reporting** program, the **Lightworks** toolset for Training, **PIXYS** system for pharmacy, **Web Pt** for the outpatient Rehab Center, and multiple other laboratory, radiology, and data integration systems.

Establishing, maintaining, and monitoring the Debtor's EMRs and supporting applications is supported by national standards that defines how:

- Each EMR and applications interact with users,
- Systems including emailing and messaging communicate with each other,
- Information is processed and managed at the Debtor and in required exchanges with outside vendors, providers, payers, and governmental-regulatory agencies,
- The Debtor's various systems integrate with consumers. [31]

The PCO has assessed and will continue to assess and report on the Debtor's interoperability issues.

V. THE PCO'S NEXT STEPS

The PCO has identified the need to continue to monitor quality of patient care and any impact on care. In compliance with his obligations under Bankruptcy Code section 333, the PCO and his team will continue their interviews with management, caregivers, and patients and will ***continue the monitoring function by focusing on the following areas*:**

1. The security and availability to authorized persons of patient medical records and information. Continued sampling of medical records to determine if the charts all required documents and consent forms. Medical Records and Information Interoperability.

2. QAPI, Incident Reporting, Risk, and Compliance Departments and monitor the Debtor's effort to remediate any deficiencies in those programs.

3. SNF patient falls, use of restraints, timely response to patient demands, care delivery processes and outcomes, and other critical data points.

[31] Op cite at 28 page 33

4. Discharge planning and the incidence of readmissions at the Hospital and SNFs.

5. At all facilities and units, the key indicators of Patient Life and Safety Measures, including but not limited to infection rates and infection control, Life Safety and Facilities management efforts, availability of drugs and supplies, and other demanded interviews and document/materials review.

6. Continued review of clinical care and supplies/warranties contracts.

7. Specific practice areas and procedures identified above that pose a potential risk to patient care and safety.

The PCO will report to the Court and parties in interest anything else as warranted.

Dated: October 11, 2023

By:

JERRY SEELIG
In his capacity as the Patient Care Ombudsman

EXHIBIT A:
QUALIFICATIONS OF THE PCO AND HIS CONSULTANTS

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Jerry Seelig

Jerry Seelig is Founder and CEO of **Seelig+Cussigh HCO LLC (S+C)**, which provides a wide range of management, evaluation, and monitoring services to health care providers and governmental agencies. Jerry Seelig has been appointed as **Patient Care Ombudsman** in 26 cases and as **Consumer Privacy Ombudsman** in six health care cases. Most recently, Seelig was appointed PCO for **the SAN BENITO HEALTH CARE DISTRICT DBA HAZEL HAWKINS MEMORIAL HOSPITAL**, Chapter 9 case in Hollister, CA. Hazel Hawkins is a Critical Access Hospital with a full range of acute and ambulatory services including Labor and Delivery-Women's Health program, six primary care and two specialty care services, hospital-owned skilled nursing facilities, an Emergency Room with 80 visits a day, laboratory services, radiology, and other most need patient care and welfare services. Other notable cases include serving as PCO in the **LifeCare Health Partners**, an operator of 17 long-term acute care hospitals based in Plano, Texas **[Hospital Acquisitions LLC] and in the Plaza Healthcare Center LLC**, commonly referred to as *Country Villa* is a licensed operator of 19 skilled nursing facilities (including three facilities that provide sub-acute services) is primarily located in the greater Los Angeles metropolitan area. In the **Arizona District**, Jerry was appointed as PCO for the **Douglas Hospital** case and then as PCO in both the **FLORENCE HOSPITAL AT ANTHEM, LLC, *and* Gilbert Hospital, LLC** cases [including being *reappointed post confirmation as PCO* and then employed as Special Patient Care and Safety Consultant for the Jeremiah Foster, as State Court In four health care bankruptcy cases the Firm and Jerry have completed the tasks demanded under 11 U.S.C. § 351 and have to date been responsible for the cataloging, distribution and when appropriate the destruction of over 200,000 patients' medical records. S+C has been appointed on multiple occasions by the Federal and State Courts to implement cost effective and timely programs to manage medical records programs for providers who have either ceased operations or are transitioning to new ownership.

Carbon Health, a leading innovator in primary and urgent care with over 120 clinics nationwide employed Jerry *to design a contract/provider agreement with leading public Medicaid Managed care plans.* Working with key leadership, Jerry is using his experience and insight to implement an effort that will add risk bearing contracting to Carbon's innovative programs, while expanding its efforts into safety net health and social welfare care. Jerry serves as consultant to **the CEO of LA Care** (the Largest Medicaid Managed Care Plan in the U.S.) and is a member of the **Safety Net Coalition**, which a collaborative effort initiated by California Managed Plans, trade associations, hospitals, medical group, and other parties in interest to raise **MediCa**l rates.

Jerry Seelig works closely with the **California Long Term Care Ombudsman, the LA County Long Term Care Ombudsman** and local **Ombudsman Programs** pro bono support on specific statewide and local issues, as well as support/intervention in troubled provider situations.

On February 4, 2020, the Firm with Jerry as lead partner, was appointed by the California Department of Public Health as Temporary Managers for two skilled nursing facilities in Pasadena, CA. This case was the first effort by the State to use "State Health Facilities Citation Penalties" Funds to take over needed facilities to both ensure quality resident care. [For more information: https://calmatters.org/health/coronavirus/2020/07/coronavirus-california-nursing-homes-pasadena/]

S+C was employed as a monitor by the LA City District Attorney's Office to provide oversight and quality improvement to a skilled nursing facility. With this and other cases, Jerry is engaged in an effort to coordinate funding and programming to improve the quality of hospitals, clinics, skilled care and assisted living providers while concurrently expanding the shelter and health care resources for the mentally ill and homeless.

Jerry has served in a variety of interim management-fiduciary roles both in and out of the Bankruptcy Court including Chapter 11 Trustee, Receiver, Chief Responsible Officer and California Health Care Temporary Manager. Jerry served as "Responsible Officer" [CEO-Administrator] for Primecare **Nevada Inc. Dba Nye Regional Medical Center**, which is the only hospital in the 150-mile primary service area and a sole trauma care response unit located halfway between Las Vegas and Reno, Nevada. At Nye, Jerry immediately built a sustainable medical campus that provided highest quality health care services to Tonopah, Round Mountain, and all the small towns and mining communities in Nye and Esmeralda Counties.

Jerry is a member of the **Central District of California Bankruptcy Court Mediator Panel** and has appeared on multiple state and local bar association panels and continuing education programs. Jerry has been interviewed on *NPR*, in the *Wall Street Journal, Skilled Nursing News, LTC Heroes Podcast*, and has published "op eds" in leading newspapers and has been interviewed in a wide range of local newspapers and industry publications.

In June 2020 Jerry initiated the health care email Newsletter ***"Revitalize"***. [issues can be found at https://thepcos.com/home/news/] Jerry's recent Publications include "Nursing homes still deserve better, a year into the pandemic", Opinion, Feb 22, 2021, ***Philadelphia Inquirer***; "Painful Impact of COVID-19 on the Troubled Skilled-Nursing Industry, XXXIX **ABI Journal** 9, 28, 64-65, September 2020;" "Operating Nursing Homes: Is the Worst Behind Us?", XLI ***ABI Journal*** 4, 22-23, 39, April 2022; and The Skilled Nursing Facility Crisis and the Temporary Manager Solution: A Case Study, Dec 30, 2020, ***CALIFORNIA BANKRUPTCY JOURNAL*** Vol. 35 Cal Bankr. J. No. 3 (2020).

Jerry previously worked with Rick Cussigh at **Transolutions** where he defined and built a strategic alliance with a large publicly traded healthcare information systems vendor to work with hospitals and doctors' clinics to design and implement new medical records systems. He negotiated and completed a marketing and technology alliance with the leading hospital software company, **Cerner Corporation** (NASDAQ:CERN). Jerry also worked with Cussigh to manage and complete a management buyout financed by five sub debt funds.

Jerry received a Bachelor of Urban Planning Degree from **University of Illinois, Urbana** in 1971, a Master's degree with studies in Education, Economics and Social Policy from **Harvard University** in 1972 and Doctoral Studies in Social Work and Public Policy at the **University of Chicago** from 1977-80.

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Rick Cussigh

Rick Cussigh has been employed as consultant in the ten cases where Seelig served as PCO or Consumer Privacy Ombudsman (CPO) and was appointed jointly as CPO in one Case. Cussigh has worked with all levels of management and staff at hospitals and numerous doctors' clinics nationwide and has relevant experience in the management of medical records, Federal and State privacy regulations, and patient care monitoring systems. Rick served as lead professional in both the Horisons Clinics and Justice cases, reviewing and then cataloging in each case over 1,500 boxes of medical records, which documented each provider's treatment of over-50,000 patients.

Based on his extensive experience as an executive and entrepreneur, Rick is often called on to consult on cost accounting, operations management, and strategic planning issues. Rick was the co-author of " Vital Considerations in the Ombudsman Debate", XXVII *ABI Journal* 8, 32-33, 66 October 2008.

Rick founded and led **Transolutions Inc.**, Lake Bluff, IL one of America's largest and most innovative medical transcription companies. Within the Company, at the client hospitals, and working with the largest hospital software company, he was intimately involved in all aspects of analyzing, building and using management tools to record, evaluate and simplify health care delivery. **Transolutions** has provided transcription services to over 70 hospitals and has a US-based workforce in 45 states, which includes over 300 medical transcriptionists, clinicians, and technical staff. In January 2011, Rick successfully exited his investment in Transolutions, Inc. when Accentus, a portfolio company of High Road Capital Partners acquired it.

Prior to that, Rick was Vice President, Chief Financial Officer, **DonTech**, Chicago, IL a $550 million partnership between **Dunn and Bradstreet** (now **RH Donnelly**) and **Ameritech** (now **AT&T**), serving Ameritech Yellow Page Customers in Illinois and Northwest Indiana) where *he* led finance, administrative and information technology organizations. At DonTech, he negotiated million dollar plus contracts while meeting the

owners' demands for performance and financial results.

Rick received a Bachelor of Science, Business Administration in 1979 from **Wayne State University**, Detroit, MI, a Master of Science in Taxation in 1988 **Walsh College**, Troy, MI, and a *State of Michigan: CPA Certificate in 1982.*

Dr. Lisa Grod

Lisa Grod is owner of **LWG & Associates,** specializing in geriatric care management, senior advocacy, and health care and compliance consulting focusing on systems analysis and implementation, health-care audits, compliance, regulatory reimbursement practices, and operational oversight. DR. Grod's consulting services focus on geriatric care management transitions and caregiver oversight, assistance with filing for Medi-Cal (Medicaid), Veterans A & A, and long-term care claims.

As a gerontologist, Grod identifies the psychosocial needs of her clients, including assessment for cognitive levels of impairment and other dementias and provides strategies and tools for families and caregivers. Grod has achieved positive state surveys as a licensed nursing home administrator and residential-care-facilities-for-elderly administrator.

Dr. Grod brings more than 25 years of experience in acute care, academia, and long-term care, providing expertise in organizational leadership and team building, education and training programs, contract negotiation, risk management, mock surveys and disaster preparedness, compliance, and CHOW processes.

Sean Drake

Sean Drake has been employed as consultant to the Chapter 11 Trustee in the Genus case, was a key on-premise member of the team at **Nye Regional Medical Center** and **Vanessa Ly (Today Pharmacy)** cases, as well as the employed consultant to the PCO or consultant to the Chapter 7-11 Trustees in the **Justice, Plaza, Centro, Primecare, Ly, Gilbert** and **Florence Hospital** cases and in the **Lakeview Terrace Case**. Sean has proven expertise as to the complex and interoperable systems used by a wide range of health care operations to provide patient care services, monitor care, and get paid for services provided. Sean is an expert on health care facility design and operations including having a strong knowledge of the cost effectiveness and efficiency of key equipment, devices, and leasehold improvements. Prior to joining S+C Sean managed at Renaissance Surgical Arts in Newport Harbor, CA all of the Environment of Care issues in eight Operating Room startup surgery center in coordination with clinical staff,

reporting to the Medical Board and CEO. Additional responsibilities included Safety Officer, IT support, Facilities Manager, Orderly and OR assistant.

Renaissance filed for bankruptcy and Sean served as special consultant to Patient Care Ombudsman in his efforts to properly distribute or dispose of patient confidential records and supporting field agent to the Chapter 7 Trustee's efforts to dispose of all assets of the estate. Sean worked for the owner of the building housing Renaissance to establish Pacific Coast Surgery Center, including managing all of the legal aspects pertaining to opening a new outpatient surgery center including submission of applications for facility and physician accreditation along with equipment purchases and facility management reporting directly to CEO. For General Electric and Decision Data Computer Corporation as well as with small consulting firms, Sean provided onsite support to businesses and government agencies including the Veteran Administration's Hospitals, Kaiser Permanente, U.S. Bureau of Prisons, U.S. Department of Agriculture and U.S. Weather Bureau, Blue Cross, Chevron, Pacific Bell, U.S. Nuclear Regulatory Commission, U.S. Army, and G.E. Nuclear.

JODY M. KNOX, MHA, BS, RN

PROFESSIONAL EXPERIENCE SUMMARY

Adventist Health Hospital Portland, Oregon
February 2020 – April 2023

Vice President, Physician Services Executive

Responsible for the day-to-day operations of a large multi-specialty medical group (130 providers) and clinics located in the greater Portland area. Including strategy, financial performance, growth initiatives, patient safety and experience, and associate engagement. Group is comprised of 30 clinics located in the greater Portland area with a total operating budget exceeding $300M.

Heritage Provider Network
Regal Medical Group/Lakeside Community Healthcare
March 2014 – January 2020

Senior Vice President, Medical Group Operations

Kindred Healthcare
Kindred Hospital Rancho
Rancho Cucamonga, California
June 2011 – March 2014

Chief Executive Officer

Responsible for the leadership and performance of Kindred Hospital Rancho, a 55-bed acute care hospital with a 2013 EBITDA of greater than $13M.

Los Angeles County Department of Health Services, Hospital Division
RANCHO LOS AMIGOS HOSPITAL
Downey, California Feb 2009 – May 2011

Chief Operating Officer

Responsible for the day-to-day operations of this 395-bed acute care, public hospital. More than 65% of ADC is dedicated to the care of medical/surgical patients at the facility, which encompasses 1.2 million square feet on 53 acres, the remaining 35% is acute rehabilitative care.

REHOBOTH McKINLEY CHRISTIAN HEALTH CARE SERVICES Feb 2007 – Feb 2009
Gallup, New Mexico

Chief Operating Officer

Served as a key resource to the Chief Executive Officer of this 80-bed acute care district hospital. Primary emphasis focused on the day-to-day operations of this integrated delivery organization, which included both the inpatient hospital and the ancillary outpatient and remote departments.

ABRAZO HEALTH CARE 2003 – Sept 2005
Phoenix, Arizona

Regional Director Physician Services

Analysis of resources expended in the delivery of services and identification of opportunities to increase efficiency, effectiveness, and quality. Facilitate activities to expand existing services and develop new program/product lines within a six hospital market. Collaborated with Hospital Executive Teams. Development and maintenance of clinical objectives and standards of practice to effectively provide quality patient care to the community and interaction with facility medical staffs.

EDUCATION

Registered Nurse
Bachelor of Science Health Administration, with Highest Honors, 2004
Master of Science Health Administration, with Honors, 2006

San Benito Health Care District
Finance Committee Minutes
October 19, 2023 - 4:30pm

Present: Jeri Hernandez, Board President
Rick Shelton, Board Treasurer
Mary Casillas, Interim Chief Executive Officer
Mark Robinson, Chief Financial Officer
Amy Breen-Lema, Vice President, Clinic, Ambulatory & Physician Services
Andie Posey, Chief Nursing Officer
Lindsey Parnell, Controller

1. **CALL TO ORDER**
   The meeting of the Finance Committee was called to order at 4:30pm.

2. **APPROVE SEPTEMBER MEETING MINUTES**
   Upon motion by Director Shelton, second by Director Hernandez, the Finance Committee approved the minutes of the September 21, 2023 Finance Committee Meeting, as presented.

3. **REVIEW FINANCIAL UPDATES**
   A. September 2023 Financial Statements
   The Financial Statements for September 2023 were presented for review. For the month ending September 30, 2023, the District's Net Surplus (Loss) is $514,777 compared to a budgeted Surplus (Loss) of ($48,557). The District exceeded its budget for the month by $563,334.

   YTD as of September 30, 2023, the District's Net Surplus (Loss) is $1,149,491 compared to a budgeted Surplus (Loss) of $1,006,310. The District is exceeding its budget YTD by $143,181.

   Acute discharges were 142 for the month, under budget by 56 discharges or 28%. The ADC was 15.00 compared to a budget of 17.44. The ALOS was 3.17. The acute I/P gross revenue was under budget by $2.0 million while O/P services gross revenue was $3.5 million or 15% over budget. ER I/P visits were 98 and ER O/P visits were under budget by just 1 visit or 0%. The Rural Health Clinics treated 3,551 (includes 614 visits at the Diabetes Clinic) while other clinics treated 1,002 outpatients.

   Other Operating revenue exceeded budget by $28,599. Other operating revenue includes a monthly $250,000 accrual for the PY6 QIP.

   Operating Expenses were under budget by $423,384 due mainly to variances in: Employee Benefits being under budget by $193,814 (Sick Leave accounted for $97,000 in savings), Supplies under by $197,986 and Purchased Services under by $109,539.

   Non-operating Revenue was over budget by $61,886 due to donations of $72,526.

   The SNFs ADC was 93.73 for the month. The Net Surplus (Loss) is $162,668 compared to a budget of $211,898. YTD, the Net Surplus (Loss) is $1,075,026, exceeding its budget by $411,736. Effective May 10, 2023, the SNF Medi-Cal rate is $704.86 per day

B. September 2023 Finance Dashboard

The Finance Dashboard and Cash Flow Statement were reviewed by the Committee in detail.

C. Other Financial Updates

Other items noted included:

- A Fair Market Value Appraisal of San Benito Health Care District will be completed by Healthcare Appraisers, Inc.
- An Assessment of San Benito Health Care District was completed by ECG Management Consultants. Administration had the opportunity to review it earlier in the week. It was noted that the report did not include a solvency analysis to support the conclusion that the District did not need to file for Chapter 9.
- The Finance Committee Meeting scheduled for November 13 will be cancelled and incorporated into the Board Meeting scheduled for Thursday, November 16.
- The CHFFA approved the District's Loan under the Distressed Hospital Loan Program and will work directly with legal counsel to revise the loan agreement to include language applicable to the District's Chapter 9 status.

4. **CONSIDER RECOMMENDATION FOR BOARD APPROVAL OF AGREEMENT WITH INTERPOL PRIVATE SECURITY**

   The Vendor Services Agreement with Interpol Private Security has a two-year term, a ten-day termination clause, and budgeted fees $560,000 in year 1. Fees will automatically increase by 3% each year. The Finance Committee recommends this resolution for Board approval.

5. **CONSIDER RECOMMENDATION FOR BOARD APPROVAL OF AGREEMENT WITH IMPERIAL HEALTH PLAN, MEDICARE ADVANTAGE PLAN**

   The Hospital Services Agreement with Imperial Health Plan of California, Inc. has a one-year term, a rolling auto-renewal for 1 year periods, and a 90-day termination clause. Payments for inpatients will be at 115% of DRG and payments for outpatients will be 135% of fee schedule. The Finance Committee recommends this resolution for Board approval.

6. **PUBLIC COMMENT**

   An opportunity was provided for public comment and individuals were given three minutes to address the Board Members and Administration.

7. **ADJOURNMENT**

   There being no further business, the Committee was adjourned at 4:57 pm.

Respectfully submitted,

Lindsey Parnell
Controller

Hazel Hawkins
MEMORIAL HOSPITAL
SKILLED NURSING FACILITIES
HOME HEALTH AGENCY

San Benito Health Care District
A Public Agency
911 Sunset Drive
Hollister, CA 95023-5695
(831) 637-5711

October 19, 2023

CFO Financial Summary for the District Board:

For the month ending September 30, 2023, the District's Net Surplus (Loss) is $514,777 compared to a budgeted Surplus (Loss) of ($48,557). The District exceeded its budget for the month by $563,334.

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Acute discharges were 142 for the month, under budget by 56 discharges or 28%. The ADC was 15.00 compared to a budget of 17.44. The ALOS was 3.17. The acute I/P gross revenue was under budget by **$2.0 million** while O/P services gross revenue was **$3.5 million** or 15% over budget. ER I/P visits were 98 and ER O/P visits were under budget by just 1 visit or 0%. The RHCs & Specialty Clinics treated 3,551 (includes 614 visits at the Diabetes Clinic) and 1,002 visits respectively.

Other Operating revenue exceeded budget by **$28,599.** Other operating revenue includes a monthly $250,000 accrual for the PY6 QIP.

Operating Expenses were under budget by **$423,384** due mainly to variances in: Employee Benefits being under budget by $193,814 (Sick Leave accounted for $97,000 in savings), Supplies under by $197,986 and Purchased Services under by $109,539.

Non-operating Revenue was over budget by **$61,886** due to donations of $72,526.

The SNFs ADC was **93.73** for the month. The Net Surplus (Loss) is **$162,668** compared to a budget of $211,898. YTD, the Net Surplus (Loss) is $1,075,026, exceeding its budget by $411,736. Effective May 10, 2023, the SNF Medi-Cal rate is **$704.86** per day.

HAZEL HAWKINS MEMORIAL HOSPITAL - COMBINED
HOLLISTER, CA 95023
FOR PERIOD 09/30/23

	CURRENT MONTH					YEAR-TO-DATE				
	ACTUAL 09/30/23	BUDGET 09/30/23	POS/NEG VARIANCE	PERCENT VARIANCE	PRIOR YR 09/30/22	ACTUAL 09/30/23	BUDGET 09/30/23	POS/NEG VARIANCE	PERCENT VARIANCE	PRIOR YR 09/30/22
GROSS PATIENT REVENUE:										
ACUTE ROUTINE REVENUE	2,412,521	4,612,453	(1,199,932)	(26)	4,060,175	8,834,932	14,132,252	(5,297,320)	(38)	12,656,096
SNF ROUTINE REVENUE	2,115,500	2,025,000	90,500	5	1,999,000	6,746,578	6,220,000	526,578	9	6,059,500
ANCILLARY INPATIENT REVENUE	4,204,005	5,135,822	(931,817)	(18)	5,268,887	11,880,522	16,246,588	(4,366,065)	(30)	16,130,121
HOSPITALIST\PEDS I\P REVENUE	139,309	164,578	(24,776)	(15)	166,253	412,654	565,339	(152,685)	(27)	574,862
TOTAL GROSS INPATIENT REVENUE	8,850,328	11,937,853	(3,087,525)	(26)	11,384,295	27,874,686	37,164,179	(9,289,493)	(25)	35,420,579
ANCILLARY OUTPATIENT REVENUE	26,519,508	24,031,576	2,487,932	10	22,431,452	79,981,138	74,417,052	5,564,086	8	67,050,267
HOSPITALIST\PEDS O\P REVENUE	50,629	59,424	(8,795)	(15)	59,535	156,948	282,227	(125,279)	(44)	191,882
TOTAL GROSS OUTPATIENT REVENUE	26,570,137	24,091,100	2,479,037	10	22,491,029	80,138,086	74,699,279	5,438,807	7	67,241,248
TOTAL GROSS PATIENT REVENUE	36,462,465	36,049,053	1,412,412	4	33,875,324	107,512,772	111,754,458	(4,241,686)	(4)	102,673,707
DEDUCTIONS FROM REVENUE:										
MEDICARE CONTRACTUAL ALLOWANCES	9,831,584	10,085,597	(554,013)	(6)	9,170,686	28,210,292	32,174,862	(3,964,570)	(12)	29,297,518
MEDICAL CONTRACTUAL ALLOWANCES	10,854,106	9,465,715	1,388,391	14	8,555,486	31,664,297	30,410,788	1,253,509	4	25,689,852
BAD DEBT EXPENSE	543,514	393,214	150,300	38	344,814	1,919,672	1,255,526	664,146	53	894,690
CHARITY CARE	99,316	36,697	62,619	171	23,934	169,949	117,358	52,591	45	105,530
OTHER CONTRACTUALS AND ADJUSTMENTS	4,252,423	8,953,930	339,493	9	1,846,800	12,823,654	12,675,683	147,971	1	10,981,335
HOSPITALIST\PEDS CONTRACTUAL ALLOW	21,867	12,165	9,722	80	3,803	17,030	38,891	(21,862)	(56)	59,647
TOTAL DEDUCTIONS FROM REVENUE	25,342,830	23,967,318	1,375,512	6	21,955,023	76,804,874	76,673,108	(1,868,234)	(2)	67,027,951
NET PATIENT REVENUE	11,119,635	11,081,735	37,900	0	11,920,301	30,707,898	35,081,350	(2,373,452)	(7)	35,645,756
OTHER OPERATING REVENUE	611,098	582,499	28,599	5	703,338	1,787,048	1,747,497	39,551	2	2,656,556
NET OPERATING REVENUE	11,730,732	11,664,234	66,498	1	12,623,599	34,494,946	36,828,847	(2,333,901)	(6)	38,302,312
OPERATING EXPENSES:										
SALARIES & WAGES	4,652,324	4,607,251	45,072	1	4,671,174	13,946,503	14,089,218	(142,715)	(1)	14,790,583
REGISTRY	283,889	200,000	83,889	42	596,591	756,683	600,000	156,683	26	1,787,301
EMPLOYEE BENEFITS	2,207,364	2,412,262	(204,898)	(8)	2,476,037	6,148,244	7,449,049	(1,300,806)	(18)	7,871,891
PROFESSIONAL FEES	1,610,950	1,602,560	8,390	1	1,635,745	4,714,073	4,907,482	(193,380)	(4)	6,555,534
SUPPLIES	1,031,859	1,226,272	(194,393)	(16)	1,224,773	2,916,252	3,683,758	(767,506)	(21)	3,745,258
PURCHASED SERVICES	931,582	1,058,396	(126,814)	(12)	1,256,676	3,189,493	3,245,749	(56,256)	(2)	3,756,483
RENTAL	124,077	130,294	(6,217)	(5)	139,545	367,267	393,405	(26,138)	(7)	467,611
DEPRECIATION & AMORT	327,556	320,773	6,783	2	320,932	979,373	952,327	27,046	3	955,249
INTEREST	36,016	25,417	10,599	42	4,460	87,686	76,281	11,405	15	17,116
OTHER	365,085	423,085	(58,000)	(14)	520,997	1,260,295	1,295,891	(35,596)	(3)	2,412,448
TOTAL EXPENSES	11,570,901	12,006,310	(435,949)	(4)	12,826,930	34,395,869	36,703,160	(2,307,291)	(7)	39,359,519
NET OPERATING INCOME (LOSS)	159,830	(342,076)	501,448	(147)	(203,332)	99,078	125,687	(26,610)	(21)	(1,056,807)

HAZEL HAWKINS MEMORIAL HOSPITAL - CONSOLIDATED
HOLLISTER, CA 95023
FOR PERIOD 09/30/23

	CURRENT MONTH					YEAR-TO-DATE				
	ACTUAL 09/30/23	BUDGET 09/30/23	POS/NEG VARIANCE	PERCENT VARIANCE	PRIOR YR 09/30/22	ACTUAL 09/30/23	BUDGET 09/30/23	POS/NEG VARIANCE	PERCENT VARIANCE	PRIOR YR 09/30/22
NON-OPERATING REVENUE\EXPENSE:										
DONATIONS	72,526	5,000	67,526	1,351	9,765	73,659	15,000	58,659	391	139,108
PROPERTY TAX REVENUE	205,711	205,711	0	0	195,915	617,133	617,133	0	0	587,745
GO BOND PROP TAXES	170,388	170,388	0	0	164,964	511,163	511,164	(1)	0	494,893
GO BOND INT REVENUE\EXPENSE	(68,721)	(68,721)	0	0	(72,048)	(206,163)	(206,163)	0	0	(216,143)
OTHER NON-OPER REVENUE	14,866	13,843	1,023	7	10,255	58,376	41,529	16,847	41	38,620
OTHER NON-OPER EXPENSE	(32,880)	(32,700)	(180)	1	(37,664)	(98,322)	(98,100)	(222)	0	(114,148)
INVESTMENT INCOME	(6,483)	0	(6,483)		0	(5,432)	0	(5,432)		246
COLLABORATION CONTRIBUTIONS	0	0	0	0	0	0	0	0	0	0
TOTAL NON-OPERATING REVENUE/(EXPENSE)	355,407	293,521	61,886	21	271,188	950,414	880,563	69,851	8	930,321
NET SURPLUS (LOSS)	514,777	(48,557)	563,334	(1,160)	68,157	1,149,491	1,006,310	143,181	14	(126,486)
EBIDA	$ 773,547	$ 203,249	$ 570,298	280.59%	$ 333,435	$ 1,922,186	$ 1,761,736	$ 160,450	9.10%	$ 664,157
EBIDA MARGIN	6.59%	1.74%	4.85%	278.42%	2.64%	5.57%	4.78%	0.79%	16.48%	1.73%
OPERATING MARGIN	1.36%	(2.53)%	4.29%	(146.32)%	(1.61)%	0.58%	0.34%	0.24%	69.03%	(2.76)%
NET SURPLUS (LOSS) MARGIN	4.39%	(0.42)%	4.80%	(1,154.09)%	0.54%	3.33%	2.73%	0.60%	21.95%	(0.33)%

HAZEL HAWKINS MEMORIAL HOSPITAL - ACUTE FACILITY
HOLLISTER, CA 95023
FOR PERIOD 09/30/23

	CURRENT MONTH					YEAR-TO-DATE				
	ACTUAL 09/30/23	BUDGET 09/30/23	POS/NEG VARIANCE	PERCENT VARIANCE	PRIOR YR 09/30/22	ACTUAL 09/30/23	BUDGET 09/30/23	POS/NEG VARIANCE	PERCENT VARIANCE	PRIOR YR 09/30/22
GROSS PATIENT REVENUE:										
ROUTINE REVENUE	3,412,521	4,812,453	(1,399,932)	(29)	4,060,175	8,834,932	14,132,252	(5,297,321)	(38)	12,656,096
ANCILLARY INPATIENT REVENUE	3,989,464	4,773,514	(784,050)	(16)	4,708,363	10,373,453	15,123,005	(4,749,552)	(31)	14,869,978
HOSPITALIST I/P REVENUE	159,902	184,678	(24,776)	(13)	166,153	412,654	565,339	(153,685)	(27)	574,842
TOTAL GROSS INPATIENT REVENUE	7,561,887	9,770,645	(2,008,758)	(21)	8,934,691	19,621,038	29,821,596	(10,200,558)	(34)	28,100,816
ANCILLARY OUTPATIENT REVENUE	26,819,508	23,031,676	3,787,832	16	22,431,490	75,981,138	74,417,052	1,564,086	2	67,061,267
HOSPITALIST O\P REVENUE	50,629	59,424	(8,795)	(15)	59,529	156,948	182,227	(25,279)	(14)	191,882
TOTAL GROSS OUTPATIENT REVENUE	26,870,137	23,091,100	3,779,037	16	22,491,019	80,138,086	74,599,279	5,538,807	7	67,253,149
TOTAL GROSS ACUTE PATIENT REVENUE	34,432,024	32,861,745	1,770,279	5	31,425,710	99,759,124	104,420,875	(4,661,751)	(5)	95,353,965
DEDUCTIONS FROM REVENUE ACUTE:										
MEDICARE CONTRACTUAL ALLOWANCES	9,356,831	9,814,649	(457,818)	(5)	8,928,785	27,401,463	31,333,954	(3,932,491)	(13)	28,926,362
MEDI-CAL CONTRACTUAL ALLOWANCES	10,612,231	9,380,899	1,231,332	13	8,397,490	31,038,908	30,089,356	949,552	3	25,221,530
BAD DEBT EXPENSE	527,795	383,214	144,581	38	376,954	1,859,870	1,225,526	634,344	52	887,769
CHARITY CARE	99,316	36,697	62,619	171	23,934	169,949	117,358	52,591	45	105,530
OTHER CONTRACTUALS AND ADJUSTMENTS	4,270,279	3,889,130	381,149	10	3,505,225	12,745,128	12,476,962	268,166	2	10,771,264
HOSPITALIST\BEDS CONTRACTUAL ALLOW	11,887	12,165	9,722	80	1,803	17,000	38,892	(21,892)	(56)	89,647
TOTAL ACUTE DEDUCTIONS FROM REVENUE	24,888,338	23,526,754	1,371,584	6	21,444,181	73,232,518	75,282,048	(2,049,531)	(3)	65,562,502
NET ACUTE PATIENT REVENUE	9,243,686	9,144,591	98,695	1	9,981,529	26,526,607	29,138,827	(2,612,220)	(9)	29,791,463
OTHER OPERATING REVENUE	612,098	582,499	29,599	5	703,198	1,787,048	1,747,497	39,551	2	2,656,956
NET ACUTE OPERATING REVENUE	9,854,784	9,727,490	127,294	1	10,684,537	28,313,655	30,886,324	(2,572,669)	(8)	32,448,419
OPERATING EXPENSES:										
SALARIES & WAGES	3,717,844	3,695,948	21,896	1	3,756,786	11,060,197	11,298,341	(238,145)	(2)	11,980,092
REGISTRY	356,629	167,000	89,629	54	562,309	648,939	501,000	147,939	30	1,678,139
EMPLOYEE BENEFITS	1,705,793	1,899,607	(193,814)	(10)	1,953,921	4,770,350	5,875,357	(1,105,007)	(19)	6,211,585
PROFESSIONAL FEES	1,608,740	1,600,224	8,516	1	1,813,535	4,707,443	4,900,442	(193,000)	(4)	4,549,754
SUPPLIES	939,982	1,137,366	(197,384)	(17)	1,125,278	2,632,235	3,416,736	(784,501)	(23)	3,441,953
PURCHASED SERVICES	844,863	954,402	(109,539)	(12)	1,140,618	2,922,666	2,926,629	(3,963)	0	3,428,824
RENTAL	133,065	129,269	(6,204)	(5)	138,526	364,252	390,292	(26,041)	(7)	468,577
DEPRECIATION & AMORT	288,164	281,320	6,844	2	280,278	861,196	840,960	20,236	2	836,259
INTEREST	36,616	25,617	11,199	44	7,460	87,666	76,251	11,415	15	77,326
OTHER	312,829	366,744	(53,915)	(15)	466,489	1,055,130	1,123,152	(68,022)	(6)	1,205,725
TOTAL EXPENSES	9,834,523	10,257,897	(423,364)	(4)	11,042,103	29,110,292	31,353,160	(2,242,868)	(7)	35,811,063
NET OPERATING INCOME (LOSS)	20,271	(530,407)	550,678	(104)	(357,566)	(796,637)	(466,836)	(329,801)	71	(1,362,644)

HAZEL HAWKINS MEMORIAL HOSPITAL - ACUTE FACILITY
HOLLISTER, CA 95023
FOR PERIOD 09/30/23

	CURRENT MONTH					YEAR-TO-DATE				
	ACTUAL 09/30/23	BUDGET 09/30/23	POS/NEG VARIANCE	PERCENT VARIANCE	PRIOR YR 09/30/22	ACTUAL 09/30/23	BUDGET 09/30/23	POS/NEG VARIANCE	PERCENT VARIANCE	PRIOR YR 09/30/22
NON-OPERATING REVENUE\EXPENSE:										
DONATIONS	72,526	5,000	67,526	1,351	9,765	73,659	15,000	58,659	391	139,108
PROPERTY TAX REVENUE	174,854	174,854	0	0	166,528	524,562	524,562	0	0	499,584
GO BOND PROP TAXES	170,388	170,388	0	0	164,964	511,163	511,164	(1)	0	494,893
GO BOND INT REVENUE\EXPENSE	(68,721)	(68,721)	0	0	(72,048)	(206,163)	(206,163)	0	0	(216,143)
OTHER NON-OPER REVENUE	14,866	13,843	1,023	7	10,255	58,376	41,529	16,847	41	38,620
OTHER NON-OPER EXPENSE	(25,592)	(25,412)	(180)	1	(29,321)	(76,459)	(76,236)	(223)	0	(89,120)
INVESTMENT INCOME	(6,483)	0	(6,483)		0	(5,432)	0	(5,432)		246
COLLABORATION CONTRIBUTIONS	0	0	0	0	0	0	0	0	0	0
TOTAL NON-OPERATING REVENUE/(EXPENSE)	331,838	269,952	61,886	23	250,144	879,706	809,856	69,850	9	867,188
NET SURPLUS (LOSS)	352,109	(260,455)	612,564	(235)	(107,023)	83,068	343,020	(259,952)	(76)	(495,457)

HAZEL HAWKINS SKILLED NURSING FACILITIES
HOLLISTER, CA
FOR PERIOD 09/30/23

	CURRENT MONTH					YEAR-TO-DATE				
	ACTUAL 09/30/23	BUDGET 09/30/23	POS/NEG VARIANCE	PERCENT VARIANCE	PRIOR YR 09/30/22	ACTUAL 09/30/23	BUDGET 09/30/23	POS/NEG VARIANCE	PERCENT VARIANCE	PRIOR YR 09/30/22
GROSS SNF PATIENT REVENUE:										
ROUTINE SNF REVENUE	2,115,900	2,025,000	90,900	5	1,989,000	6,746,576	6,210,000	536,576	9	6,059,500
ANCILLARY SNF REVENUE	214,541	362,308	(147,767)	(41)	460,504	1,007,070	1,123,583	(116,513)	(10)	1,260,242
TOTAL GROSS SNF PATIENT REVENUE	2,330,441	2,387,308	(56,867)	(2)	2,449,504	7,753,646	7,333,583	420,065	6	7,319,742
DEDUCTIONS FROM REVENUE SNF:										
MEDICARE CONTRACTUAL ALLOWANCES	174,754	270,948	(96,194)	(36)	341,302	808,829	840,908	(32,079)	(4)	781,156
MEDI-CAL CONTRACTUAL ALLOWANCES	241,875	104,816	137,059	131	157,995	675,368	371,412	303,956	95	467,902
BAD DEBT EXPENSE	15,720	10,000	5,720	57	(30,640)	59,802	30,000	29,802	99	6,320
CHARITY CARE	0	0	0	0	0	0	0	0	0	0
OTHER CONTRACTUALS AND ADJUSTMENTS	22,145	64,800	(42,656)	(66)	41,585	78,336	198,720	(120,384)	(61)	210,071
TOTAL SNF DEDUCTIONS FROM REVENUE	454,493	450,564	3,929	1	510,842	1,572,356	1,391,060	181,296	13	1,465,449
NET SNF PATIENT REVENUE	1,875,948	1,936,744	(60,796)	(3)	1,938,662	6,181,292	5,942,523	238,769	4	5,854,292
OTHER OPERATING REVENUE	0	0	0	0	0	0	0	0	0	0
NET SNF OPERATING REVENUE	1,875,948	1,936,744	(60,796)	(3)	1,938,662	6,181,292	5,942,523	238,769	4	5,854,253
OPERATING EXPENSES:										
SALARIES & WAGES	934,480	911,305	23,175	3	914,386	2,886,307	2,790,877	95,430	3	2,810,491
REGISTRY	27,260	33,000	(5,740)	(17)	34,283	57,744	59,000	(1,256)	(2)	109,263
EMPLOYEE BENEFITS	501,591	512,655	(11,064)	(2)	522,116	1,377,893	1,572,892	(194,999)	(12)	1,660,305
PROFESSIONAL FEES	2,210	2,336	(126)	(5)	2,220	6,630	7,010	(380)	(5)	7,140
SUPPLIES	91,919	88,306	3,613	4	99,495	284,017	267,022	16,995	6	303,305
PURCHASED SERVICES	86,719	103,994	(17,275)	(17)	116,256	258,024	318,920	(60,897)	(19)	329,609
RENTAL	1,012	1,025	(13)	(1)	1,018	3,035	3,133	(98)	(3)	3,035
DEPRECIATION	39,392	39,453	(61)	0	40,256	118,177	118,367	(190)	0	119,987
INTEREST	0	0	0	0	0	0	0	0	0	0
OTHER	52,266	56,341	(4,075)	(7)	56,508	145,166	172,739	(27,573)	(16)	205,423
TOTAL EXPENSES	1,736,849	1,748,415	(11,566)	(1)	1,784,527	5,176,973	5,349,940	(172,967)	(3)	5,548,456
NET OPERATING INCOME (LOSS)	139,099	188,329	(49,230)	(26)	154,135	1,004,319	592,583	411,736	70	305,837
NON-OPERATING REVENUE\EXPENSE:										
DONATIONS	0	0	0	0	0	0	0	0	0	0
PROPERTY TAX REVENUE	30,857	30,857	0	0	29,389	92,571	92,571	0	0	98,161
OTHER NON-OPER EXPENSE	(7,288)	(7,288)	0	0	(3,345)	(21,863)	(21,864)	1	0	(25,028)
TOTAL NON OPERATING REVENUE/(EXPENSE)	23,569	23,569	0	0	[illegible]	70,708	70,707	1	0	73,133
NET SURPLUS (LOSS)	162,668	211,898	(49,230)	(23)	[illegible]	1,075,026	663,290	411,736	62	368,970

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HAZEL HAWKINS MEMORIAL HOSPITAL
HOLLISTER, CA
For the month ended 09/30/23

	CURR MONTH 09/30/23	PRIOR MONTH 08/31/23	POS/NEG VARIANCE	PERCENTAGE VARIANCE	PRIOR YR 09/30/23
CURRENT ASSETS					
CASH & CASH EQUIVALENT	12,644,124	14,225,430	(1,581,306)	(11)	13,649,396
PATIENT ACCOUNTS RECEIVABLE	59,732,608	56,838,808	2,893,800	5	51,674,982
BAD DEBT ALLOWANCE	(6,390,402)	(6,143,484)	(246,918)	4	(5,927,791)
CONTRACTUAL RESERVES	(36,217,252)	(33,762,665)	(2,474,587)	7	(30,266,699)
OTHER RECEIVABLES	7,249,461	6,797,449	452,012	7	6,095,092
INVENTORIES	4,047,238	4,054,906	(7,668)	0	4,057,813
PREPAID EXPENSES	2,755,364	2,654,291	111,072	4	2,042,543
DUE TO\FROM THIRD PARTIES	2,037,861	2,037,861	0	0	2,784,747
TOTAL CURRENT ASSETS	45,849,003	46,702,597	(853,594)	(2)	44,810,082
ASSETS WHOSE USE IS LIMITED					
BOARD DESIGNATED FUNDS	5,822,024	5,434,735	387,289	7	4,906,264
TOTAL LIMITED USE ASSETS	5,822,024	5,434,735	387,289	7	4,906,264
PROPERTY, PLANT, AND EQUIPMENT					
LAND & LAND IMPROVEMENTS	3,370,474	3,370,474	0	0	3,370,474
BLDGS & BLDG IMPROVEMENTS	100,098,374	100,098,374	0	0	100,098,374
EQUIPMENT	43,715,153	43,684,281	30,873	0	43,302,208
CONSTRUCTION IN PROGRESS	905,142	905,142	0	0	880,124
CAPITALIZED INTEREST	0	8,869	(8,869)	(100)	0
GROSS PROPERTY,PLANT, AND EQUIPMENT	148,089,144	148,067,140	22,004	0	147,651,180
ACCUMULATED DEPRECIATION	(91,385,628)	(91,043,489)	(342,139)	0	(90,362,507)
NET PROPERTY, PLANT, AND EQUIPMENT	56,703,515	57,023,651	(320,135)	(1)	57,288,673
OTHER ASSETS					
UNAMORTIZED LOAN COSTS	452,796	458,857	(6,071)	(1)	470,999
PENSION DEFERRED OUTFLOWS NET	3,797,627	3,797,627	0	0	3,797,637
TOTAL OTHER ASSETS	4,250,423	4,256,494	(6,071)	0	4,268,636
TOTAL UNRESTRICTED ASSETS	112,624,965	113,417,476	(792,512)	(1)	111,273,655
RESTRICTED ASSETS	53,099	125,571	(72,473)	(58)	125,193
TOTAL ASSETS	112,678,064	113,543,048	(864,984)	(1)	111,398,848

HAZEL HAWKINS MEMORIAL HOSPITAL
HOLLISTER, CA
For the month ended 09/30/23

	CURR MONTH 09/30/23	PRIOR MONTH 08/31/23	POS/NEG VARIANCE	PERCENTAGE VARIANCE	PRIOR YR 06/30/23
CURRENT LIABILITIES					
ACCOUNTS PAYABLE	5,634,182	5,532,148	(102,034)	2	4,938,613
ACCRUED PAYROLL	2,684,122	4,388,955	1,704,834	(39)	3,145,253
ACCRUED PAYROLL TAXES	2,009,490	1,410,826	(598,664)	42	1,345,303
ACCRUED BENEFITS	5,789,705	5,560,719	(228,986)	4	6,051,228
ACCRUED PENSION (CURRENT)	4,963,931	4,961,787	(2,144)	0	5,061,807
OTHER ACCRUED EXPENSES	103,245	95,781	(7,463)	8	84,460
PATIENT REFUNDS PAYABLE	1,136	1,136	0	0	961
DUE TO\FROM THIRD PARTIES	3,612,135	4,225,310	613,175	(15)	4,400,056
OTHER CURRENT LIABILITIES	4,236,791	4,130,176	(106,617)	3	1,493,074
TOTAL CURRENT LIABILITIES	29,034,738	30,306,839	1,272,101	(4)	28,720,755
LONG-TERM DEBT					
LEASES PAYABLE	6,515,697	6,522,365	6,668	0	6,542,101
BONDS PAYABLE	34,698,801	34,727,321	28,520	0	34,784,361
TOTAL LONG TERM DEBT	41,214,499	41,249,686	35,188	0	41,326,662
OTHER LONG-TERM LIABILITIES					
DEFERRED REVENUE	0	0	0	0	0
LONG-TERM PENSION LIABILITY	14,706,676	14,706,676	0	0	14,706,676
TOTAL OTHER LONG-TERM LIABILITIES	14,706,676	14,706,676	0	0	14,706,676
TOTAL LIABILITIES	84,955,912	86,263,201	1,307,289	(2)	84,754,093
NET ASSETS:					
UNRESTRICTED FUND BALANCE	26,479,561	26,479,561	0	0	26,479,561
RESTRICTED FUND BALANCE	93,099	165,571	72,473	(44)	165,193
NET REVENUE/(EXPENSES)	1,149,491	634,714	(514,777)	81	0
TOTAL NET ASSETS	27,722,151	27,279,847	(442,304)	2	26,644,755
TOTAL LIABILITIES AND NET ASSETS	112,678,064	113,543,048	864,984	(1)	111,398,848

Hazel Hawkins
MEMORIAL HOSPITAL

San Benito Health Care District
Hazel Hawkins Memorial Hospital
SEPTEMBER 2023

Description	Target	MTD Actual	YTD Actual	YTD Target
Average Daily Census - Acute	17.44	15.00	12.98	18.54
Average Daily Census - SNF	90.01	93.73	94.84	90.00
Acute Length of Stay	2.64	3.17	2.96	2.65
ER Visits:				
Inpatient	160	98	298	464
Outpatient	1,957	1,956	5,824	5,778
Total	2,117	2,054	6,122	6,242
Days in Accounts Receivable	45.0	51.3	51.3	45.0
Productive Full-Time Equivalents	500.90	480.01	471.89	500.90
Net Patient Revenue	11,081,735	10,119,635	32,707,898	35,081,350
Payment-to-Charge Ratio	31.6%	30.5%	30.4%	31.4%
Medicare Traditional Payor Mix	30.00%	26.21%	26.69%	30.30%
Commercial Payor Mix	21.68%	23.10%	23.23%	21.67%
Bad Debt % of Gross Revenue	1.12%	1.58%	1.80%	1.12%
EBIDA	203,249	274,547	1,922,186	1,761,736
EBIDA %	1.74%	6.59%	5.57%	4.78%
Operating Margin	-2.93%	1.36%	0.58%	0.34%
Salaries, Wages, Registry & Benefits %:				
by Net Operating Revenue	61.89%	60.90%	60.42%	60.11%
by Total Operating Expense	60.13%	61.74%	60.77%	60.32%
Bond Covenants:				
Debt Service Ratio	1.25	3.95	3.95	1.25
Current Ratio	1.50	1.58	1.58	1.50
Days Cash on hand	30.00	84.81	84.81	30.00

Met or Exceeded Target
Within 10% of Target
Not Within 10%

Statement of Cash Flows
Hazel Hawkins Memorial Hospital
Hollister, CA
Three months ending September 30, 2023

	CASH FLOW		COMMENTS
	Current Month 9/30/2023	Current Year-To-Date 9/30/2023	
CASH FLOWS FROM OPERATING ACTIVITIES:			
Net Income (Loss)	$514,777	$1,149,491	
Adjustments to Reconcile Net Income to Net Cash Provided by Operating Activities:			
Depreciation	342,139	1,023,125	
(Increase)/Decrease in Net Patient Accounts Receivable	(172,297)	(924,463)	
(Increase)/Decrease in Other Receivables	(452,012)	(1,154,370)	
(Increase)/Decrease in Inventories	7,668	10,575	
(Increase)/Decrease in Pre-Paid Expenses	(111,072)	(722,822)	
(Increase)/Decrease in Due From Third Parties	0	746,886	
Increase/(Decrease) in Accounts Payable	102,035	695,572	
Increase/(Decrease) in Notes and Loans Payable	0	0	
Increase/(Decrease) in Accrued Payroll and Benefits	(875,039)	(356,347)	
Increase/(Decrease) in Accrued Expenses	7,463	18,784	
Increase/(Decrease) in Patient Refunds Payable	0	174	
Increase/(Decrease) in Third Party Advances/Liabilities	(613,175)	(787,921)	
Increase/(Decrease) in Other Current Liabilities	106,617	743,720	Semi-Annual Interest - 2021 Insured Revenue Bonds
Net Cash Provided by Operating Activities:	**(1,657,573)**	**(707,087)**	
CASH FLOWS FROM INVESTING ACTIVITIES:			
Purchase of Property, Plant and Equipment	(22,504)	(437,965)	
(Increase)/Decrease in Limited Use Cash and Investments	0	0	
(Increase)/Decrease in Other Limited Use Assets	(387,289)	(915,760)	Bond Principal & Int Payment - 2014 & 2021 Bonds
(Increase)/Decrease in Other Assets	6,071	18,213	Amortization
Net Cash Used by Investing Activities	**(403,222)**	**(1,335,512)**	
CASH FLOWS FROM FINANCING ACTIVITIES:			
Increase/(Decrease) in Bond/Mortgage Debt	(6,668)	(26,604)	Refinancing of 2013 Bonds with 2021 Bonds
Increase/(Decrease) in Capital Lease Debt	(28,520)	(85,560)	
Increase/(Decrease) in Other Long Term Liabilities	0	0	
Net Cash Used for Financing Activities	**(35,188)**	**(112,164)**	
(INCREASE)/DECREASE IN RESTRICTED ASSETS	**0**	**0**	
Net Increase/(Decrease) in Cash	**(1,581,306)**	**(1,005,272)**	
Cash, Beginning of Period	14,225,430	13,649,396	
Cash, End of Period	**$12,644,124**	**$12,644,124**	$0
Cost per day to run the District	$383,202		
Operational Days Cash on Hand	34.81		

Hazel Hawkins Memorial Hospital
Bad Debt Expense
For the Year Ending June 30, 2024

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
Budgeted Gross Revenue	38,236,593	38,468,812	35,049,053	34,999,737	35,870,267	36,385,781	34,851,365	32,060,010	36,752,432	35,946,200	39,112,090	38,876,681	436,609,021
Budgeted Bad Debt Expense	429,889	432,423	393,214	391,626	402,993	407,930	389,870	358,975	412,378	403,932	440,170	438,441	4,901,841
BD Exp as a percent of Gross Revenue	1.12%	1.12%	1.12%	1.12%	1.12%	1.12%	1.12%	1.12%	1.12%	1.12%	1.13%	1.13%	1.12%
Actual Gross Revenue	34,381,757	36,309,479	36,251,934	-	-	-	-	-	-	-	-	-	106,943,170
Actual Bad Debt Expense	712,509	663,649	543,514	-	-	-	-	-	-	-	-	-	1,919,672
BD Exp as a percent of Gross Revenue	2.07%	1.83%	1.50%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	1.80%
Budgeted YTD BD Exp	1,255,526	1.12%											
Actual YTD BD Exp	1,919,672	1.80%											
Amount under (over) budget	(664,146)	-0.67%											
Prior Year percent of Gross Revenue	1.15%												
Percent of Decrease (Inc) from Prior Year	56.1%												

YTD Charity Exp Budget	117,358
YTD Charity Exp Actual	169,949
Amt under (over) budget	(52,591)
Charity Exp % of Gross Rev	0.16%

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CALIFORNIA HEALTH FACILITIES FINANCING AUTHORITY

901 P Street, Suite 313
Sacramento, CA 95814
p (916) 653-2799
f (916) 654-5362
chffa@treasurer.ca.gov
www.treasurer.ca.gov/chffa

October 6, 2023

Mark Robinson
Chief Financial Officer
San Benito Health Care District dba Hazel Hawkins Memorial Hospital
911 Sunset Drive
Hollister, CA 95023

RE: Distressed Hospital Loan Program

Dear Mark Robinson,

Congratulations! The California Department of Health Care Access and Information notified the California Health Facilities Financing Authority (CHFFA) that San Benito Health Care District dba Hazel Hawkins Memorial Hospital's application is approved for an interest-free cashflow loan from the Distressed Hospital Loan Program (DHLP) to prevent closure of the hospital. Below are some of the terms of the DHLP loan:

Borrower: San Benito Health Care District dba Hazel Hawkins Memorial Hospital
Loan Amount: $10,000,000
Loan Term: 72 months (with 18-month initial deferment period)
Interest Rate: 0% fixed
Monthly Debt Service Amount: $185,185.19

The funding of the DHLP loan is contingent upon (i) Bankruptcy Court Approval, (ii) the full execution of the Loan and Security Agreement and the Promissory Note, including all exhibits, such as the Medi-Cal Intercept Form, a notarized EFT Cancellation Form, and the Loan Funds Disbursement Request, in each case in substantially the form delivered to you concurrently with the delivery of this letter, and (iii) there are sufficient funds in the Distressed Hospital Loan Program Fund.

We are looking forward to working with you during the DHLP loan closing process. If you have any questions, please contact your Loan Officer, Erica Rodriguez, by email at erodriguez@treasurer.ca.gov or by telephone at (916) 653-3841. Your Loan Officer will contact you to begin the loan closing process.

Sincerely,

DocuSigned by:
Carolyn Aboubechara
E8H6B334FCD4A

Carolyn Aboubechara
Executive Director

SAN BENITO HEALTH CARE DISTRICT
VENDOR SERVICES AGREEMENT

This VENDOR SERVICES AGREEMENT ("Agreement") is made and effective, by and between the San Benito Health Care District, a local health care district organized and operated pursuant to Division 23 of the California Health and Safety Code ("District"), and Interpol Private Security ("VENDOR").

District wishes to retain the services of an experienced and qualified VENDOR to provide security services ("Services"). VENDOR represents and warrants it is qualified to perform those Services. In consideration of the mutual covenants and conditions set forth herein, the parties agree as follows:

1. TERM

Unless terminated in accordance with Section 8 below, the Agreement will continue in full force and effect for two (2) years from the Effective Date through the report, as detailed in the Scope of Services attached hereto as Exhibit A.

2. SCOPE OF SERVICES

VENDOR will provide the Scope of Services listed in Exhibit A. VENDOR warrants that all services set forth in the Scope of Services will be performed in a competent, professional and satisfactory manner.

3. PERFORMANCE

a. VENDOR shall at all times faithfully, competently and to the best of its ability, experience, and talent perform all tasks described herein. VENDOR shall employ, at a minimum, generally accepted standards and practices utilized by persons engaged in providing similar services as are required of VENDOR hereunder in meeting its obligations under this Agreement.

b. VENDOR shall keep itself informed of State and Federal laws and regulations which in any manner affect those employed by VENDOR or in any way affect the performance of its Services pursuant to this Agreement. VENDOR shall at all times observe and comply with all such laws and regulations. The District, and its officers, employees, and agents shall not be liable at law or in equity occasioned by failure of VENDOR to comply with this Section.

c. VENDOR agrees that in the performance of this Agreement or any sub-agreement hereunder, neither VENDOR nor any person acting on VENDOR's behalf shall refuse to employ or refuse to continue in any employment any person or discriminate on the basis of race, religious creed, color, national origin, ancestry, disability, medical condition, genetic information, marital status, sexual preference, sex, gender identity, gender expression, military or veteran status or age. Harassment in the workplace is not

permitted in any form. VENDOR further agrees to comply with all laws with respect to employment when performing this Agreement.

d. VENDOR shall maintain prior to the beginning of and for the duration of this Agreement insurance coverage as specified in Exhibit C attached to and part of this Agreement.

e. VENDOR declares and warrants that no undue influence or pressure is used against or in concert with any officer, employee or agent of District in connection with the award, terms or implementation of this Agreement, including any method of coercion, confidential financial agreement or financial inducement. No officer, employee, or agent of District will receive compensation, directly or indirectly, from VENDOR, or from any officer, employee or agent of VENDOR, in connection with the award of this Agreement or any work to be conducted as a result of this Agreement. Violation of this Section shall be a material breach of this Agreement entitling District to any and all remedies at law or in equity.

4. DISTRICT MANAGEMENT

The District Interim Chief Executive Officer ("CEO"), or designee, shall represent District in all matters pertaining to the administration of this Agreement, review and approval of all products submitted by VENDOR, but not including the authority to enlarge the Scope of Work or change the compensation due to VENDOR. The District Interim CEO or designee shall be authorized to act on District's behalf and to execute all necessary documents which enlarge the Scope of Work or change VENDOR's compensation, subject to Section 5 hereof.

5. PAYMENT

a. For Services rendered pursuant to this Agreement, VENDOR shall be paid $32.00 per hour for each Security Officer (Refer to Exhibit A for details) in consideration.

b. Invoices shall be payable within thirty (30) days of receipt of VENDOR's invoice.

c. If any sum payable to Interpol under this Agreement is in arrears, VENDOR will charge interest on such overdue sum (from the due date until paid in full) at the rate of 5 percent (5%) plus an administrative fee of $55.

6. INSPECTION

District shall at all times have the right to inspect the work and materials. VENDOR shall furnish all reasonable aid and assistance required by District for the proper examination of the work and all parts thereof. Such inspection shall not relieve VENDOR from any obligation to perform said services strictly in accordance with the specifications or any modifications thereof and in compliance with the law.

7. SUSPENSION OR TERMINATION OF AGREEMENT

The Agreement may be terminated by mutual consent of both parties, or by 10 days' notice by either party. In the event this Agreement is terminated pursuant to this Section, District shall pay to VENDOR the actual value of the Services performed up to the time of termination, provided

that the Services performed are of value to the District. Upon termination of the Agreement pursuant to this Section, VENDOR shall submit an invoice to District pursuant to Section 5.

8. DEFAULT OF VENDOR/FORCE MAJEURE

a. VENDOR's failure to comply with the provisions of this Agreement shall constitute a default. In the event VENDOR is in default for cause under the terms of this Agreement, District shall have no obligation or duty to continue compensating VENDOR for any Services performed after the date of default and can terminate this Agreement immediately by written notice to the VENDOR. If such failure by the VENDOR to make progress in the performance of Services hereunder arises out causes beyond the VENDOR's control, and without fault or negligence of the VENDOR, it shall not be considered a default.

b. If the Interim CEO or designee determines VENDOR is in default in the performance of any of the terms or conditions of this Agreement, they shall cause to be served upon VENDOR a written notice of the default. The VENDOR shall have ten (10) days after service upon it of said notice in which to cure the default by rendering a satisfactory performance. In the event VENDOR fails to cure its default within such period of time or fails to present District with a written plan for the cure of the default, District shall have the right, notwithstanding any other provision of this Agreement, to terminate this Agreement without further notice and without prejudice to any other remedy to which it may be entitled at law, in equity or under this Agreement.

9. OWNERSHIP OF DOCUMENTS

a. VENDOR shall maintain adequate records of Services provided in sufficient detail to permit an evaluation of Services. VENDOR shall provide free access to the representatives of District or its designees at reasonable times to such books and records; shall give District the right to examine and audit said books and records at VENDOR's office; shall permit District to make copies and transcripts there from as necessary; and shall allow inspection of all work, data, documents, proceedings, and activities related to this Agreement. Such records, together with supporting documents, shall be maintained at the District for a minimum period of five (5) years after receipt of final payment.

b. Upon completion of, or in the event of termination or suspension of this Agreement, all original documents, designs, drawings, maps, models, computer files, surveys, notes, and other documents prepared in the course of providing the Services to be performed pursuant to this Agreement shall become the sole property of District and may be used, reused, or otherwise disposed of by District without the permission of VENDOR.

10. RECORD AUDIT

In accordance with Government Code, Section 8546.7, for expenditures of greater than $10,000, records of both District and VENDOR shall be subject to examination and audit by the Auditor General for a period of three (3) years after final payment.

11. INDEMNIFICATION

VENDOR shall indemnify, defend with legal counsel approved by District, and hold harmless District, its officers, employees, agents, and volunteers (collectively, District) from and against all liability, loss, damage, expense, cost (including without limitation reasonable legal counsel fees, expert fees and all other costs and fees of litigation) of every nature arising out of or in connection with VENDOR's negligence, recklessness or willful misconduct in the performance of work hereunder or its failure to comply with any of its obligations contained in this Agreement, except such loss or damage which is caused by the sole or active negligence or willful misconduct of the District. Should conflict of interest principles preclude a single legal counsel from representing both District and VENDOR, or should District otherwise find VENDOR's legal counsel unacceptable, then VENDOR shall reimburse the District its costs of defense, including without limitation reasonable legal counsel fees, expert fees and all other costs and fees of litigation. The VENDOR shall promptly pay any final judgment rendered against the District (and its officers, employees, agents and volunteers) with respect to claims determined by a trier of fact to have been the result of the VENDOR's negligent, reckless or wrongful performance. It is expressly understood and agreed that the foregoing provisions are intended to be as broad and inclusive as is permitted by the law of the State of California and will survive termination of this Agreement.

VENDOR obligations under this section apply regardless of whether such claim, charge, damage, demand, action, proceeding, loss, stop notice, cost, expense, judgment, civil fine or penalty, or liability was caused in part or contributed to by District. However, without affecting the rights of District under any provision of this agreement, VENDOR shall not be required to indemnify and hold harmless District for liability attributable to the active negligence of District, provided such active negligence is determined by agreement between the parties or by the findings of a court of competent jurisdiction. In instances where District is shown to have been actively negligent and where District's active negligence accounts for only a percentage of the liability involved, the obligation of VENDOR will be for that entire portion or percentage of liability not attributable to the active negligence of District.

No District officer, employee or agent shall be personally liable to VENDOR, in the event of any default or breach by District or for any amount that may become due to VENDOR.

12. INSURANCE

Without limiting VENDOR's indemnification of District, and prior to commencement of work, VENDOR shall obtain, provide, and maintain at its own expense during the term of this Agreement, policies of insurance of the type and amounts described in Exhibit B and in a form that is satisfactory to District.

13. INDEPENDENT CONTRACTOR

a. VENDOR is and shall at all times remain as to District a wholly independent contractor. The personnel performing the services under this Agreement on behalf of VENDOR shall at all times be under VENDOR's exclusive direction and control. Neither District nor any of its officers, employees, or agents shall have control over the conduct of VENDOR or any of VENDOR's officers, employees, or agents, except as set forth in this Agreement.

VENDOR shall not at any time or in any manner represent that it or any of its officers, employees, or agents are in any manner officers, employees, or agents of the District. VENDOR shall not incur or have the power to incur any debt, obligation, or liability whatever against District, or bind District in any manner.

b. No employee benefits shall be available to VENDOR in connection with the performance of this Agreement. Except for the fees paid to VENDOR as provided in the Agreement, District shall not pay salaries, wages, or other compensation to VENDOR for performing services hereunder for District. District shall not be liable for compensation or indemnification to VENDOR for injury or sickness arising out of performing services hereunder.

c. Any and all employees or sub-contractors of VENDOR under this Agreement, while engaged in the performance of any work or services required by VENDOR under this Agreement, shall be considered employees or sub-contractors of VENDOR only and not of District. Any and all claims that may arise under the Workers' Compensation Act on behalf of said employees or sub-contractors, while so engaged and all claims made by a third party as a consequence of any negligent act or omission on the part of the VENDOR's employees or sub-contractors, while so engaged in any of the work or services provided for or rendered herein shall not be District's obligation.

14. NO BENEFIT TO ARISE TO DISTRICT OFFICERS AND EMPLOYEES

No District officer, employee of District, or their designees or agents, and no public officer who exercises authority over or responsibilities with respect to the Services provided under the Agreement during their tenure or for one year thereafter, shall have any interest, direct or indirect, in any agreement or sub-agreement, or the proceeds thereof, for work to be performed in connection with the Services performed under this Agreement.

15. CONFLICT OF INTEREST

VENDOR shall at all times avoid conflicts of interest, or the appearance of conflicts of interest, in the performance of this Agreement, and shall comply with the District's conflict of interest code.

If District determines VENDOR comes within the definition of Contractor under the Political Reform Act (Government Code §87100 et seq.), VENDOR shall complete and file and shall require any other person performing Services under this Agreement to complete and file a "Statement of Economic Interest" with District disclosing VENDOR's and/or such other person's financial interests.

16. NO WAIVER OF BREACH/TIME

The waiver by District of any breach of any term or promise contained in this Agreement shall not be deemed to be a waiver of such term or provision or any subsequent breach of the same or any other term or promise contained in this Agreement. Time is of the essence in carrying out the duties hereunder.

17. CONFIDENTIAL INFORMATION/RELEASE OF INFORMATION

a. All information gained by VENDOR in performance of this Agreement shall be considered confidential and shall not be released by VENDOR without District's prior written authorization. VENDOR, its officers, employees, agents, or sub-contractors, shall not without written authorization from the Interim CEO or unless requested by District Counsel, voluntarily provide declarations, letters of support, testimony at depositions, response to interrogatories, or other information concerning the work performed under this Agreement or relating to any project or property located within the District. Response to a subpoena or court order shall not be considered "voluntary" provided VENDOR gives District notice of such court order or subpoena.

b. VENDOR shall promptly notify District should VENDOR, its officers, employees, agents, or sub-contractors be served with any summons, complaint, subpoena, notice of deposition, request for documents, interrogatories, request for admissions, or other discovery request, court order, or subpoena from any person or party regarding this Agreement and the Services performed thereunder or with respect to any project or property located within the District. District retains the right, but has no obligation, to represent VENDOR and/or be present at any deposition, hearing, or similar proceeding. VENDOR agrees to cooperate fully with District and to provide the opportunity to review any response to discovery requests provided by VENDOR. However, District's right to review any such response does not imply or mean the right by District to control, direct, or rewrite said response.

c. As set forth in Exhibit A, VENDOR agrees to comply with the applicable provisions of the Health Insurance Portability and Accountability Act of 1996, as codified at 42 US.C. 1320 d through d-K ("HIPAA"), and the requirements of any regulations promulgated there under including federal privacy regulations as contained in 45 CFR Part 164 (the "Federal Privacy Regulations") and the federal security standards as contained in 45 CFR part 142 (the "Federal Security Regulations"). Both parties agree not to use or further disclose any protected health information, as defined in 45 CFR 164-504, or individually identifiable health information, as defined in 42 U.S.C. 1320d (collectively "Protected Health Information"), concerning a patient other than as permitted by this Agreement and the requirements of HIPAA including the Federal Privacy Regulations and Federal Security Regulations. Both parties will implement appropriate safeguards to prevent the use or disclosure or a patient's Protected Health Information other than as provided by this Agreement.

18. NOTICES

Any notices which either party may desire to give to the other party under this Agreement must be in writing and may be given either by (i) personal service, (ii) delivery by a reputable document delivery service, such as but not limited to, Federal Express, which provides a receipt showing date and time of delivery, or (iii) mailing in the United States Mail, certified mail, postage prepaid, return receipt requested, addressed to the address of the party as set forth below or at any other address as that party may later designate by notice:

TO DISTRICT: Mary Casillas, Interim CEO
San Benito Health Care District
911 Sunset Drive
Hollister, CA 95023

TO VENDOR: Everett L. Fitzgerald
Interpol Private Security
1745 San Felipe Rd.
Hollister, CA 95023

Notice is effective on the date of personal service, or 5 days following deposit in a United States mailbox, or date of postmark. The parties may agree to notice by email.

19. THIRD PARTY BENEFICIARIES

Nothing contained in this Agreement shall be construed to create, and the parties do not intend to create, any rights in third parties.

20. ASSIGNMENT

VENDOR shall not assign the performance of this Agreement, nor any part thereof, nor any monies due hereunder, without prior written consent of District. Subject to the foregoing, all terms of the Agreement will be binding upon, enforceable by and inure to the benefit of the parties and their successors and assigns.

21. GOVERNING LAW

District and VENDOR understand and agree that the laws of the State of California shall govern the rights, obligations, duties, and liabilities of the parties to this Agreement and also govern the interpretation of this Agreement. Any litigation concerning this Agreement shall take place in San Benito County, or the federal district court with jurisdiction over the District. VENDOR agrees not to commence or prosecute any dispute arising out of or in connection with this Agreement other than in the aforementioned courts and irrevocably consents to the exclusive personal jurisdiction and venue of the aforementioned courts.

22. DISPUTE RESOLUTION; ATTORNEY'S FEES

VENDOR shall continue to perform under this Agreement during any dispute. VENDOR and District hereby agree to make good faith efforts to resolve disputes as quickly as possible. If the dispute is not resolved by meeting and conferring, the matter shall be submitted for formal mediation to a mediator selected mutually by the parties. The expenses of such mediation shall be shared equally between the parties. In the event any dispute arising from or related to this Agreement results in litigation or arbitration, the prevailing party shall be entitled to recover all reasonable costs incurred, including court costs, attorney fees, expenses for expert witnesses (whether or not called to testify), expenses for accountants or appraisers (whether or not called to

testify), and other related expenses. Recovery of these expenses shall be as additional costs awarded to the prevailing party, and shall not require initiation of a separate legal proceeding.

23. AUTHORITY TO EXECUTE THIS AGREEMENT

The person or persons executing this Agreement on behalf of VENDOR warrants and represents that they have the authority to execute this Agreement on behalf of the VENDOR and the authority to bind VENDOR to the performance of its obligations hereunder.

24. ENTIRE AGREEMENT

This Agreement contains the entire understanding between the parties relating to their obligations described in this Agreement. All prior or contemporaneous agreements, understandings, representations, and statements, oral or written, are merged into this Agreement and shall be of no further force or effect. Each party is entering into this Agreement based solely upon the representations set forth herein and upon each party's own independent investigation of any and all facts such party deems material.

25. AMENDMENT

a. Any modification or amendment to this Agreement must be in writing.

b. Neither District nor VENDOR shall be deemed to have waived any obligation of the other, or to have agreed to any modification to this Agreement unless it is in writing, and signed by the party giving the waiver.

26. INTERPRETATION OF CONFLICTING PROVISIONS

In the event of any conflict or inconsistency between the provisions of this Agreement and the Provisions of any exhibit or other attachment to this Agreement, the provisions of this Agreement shall prevail and control.

27. SEVERABILITY

If any term of this Agreement is held invalid by a court of competent jurisdiction or arbitrator the remainder of this Agreement shall remain in effect.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed the day and year first above written.

SAN BENITO HEALTH CARE DISTRICT

Date: By:
Mary Casillas, Interim CEO

INTERPOL PRIVATE SECURITY

Date: 2/25/17

By: _____
Everett L. Fitzgerald

Attachments: Exhibit A Scope of Services
Exhibit B Fees
Exhibit C Insurance Requirements

EXHIBIT A
SCOPE OF WORK/SERVICES

HIPAA COMPLIANCE STATEMENT

This Security Agreement ("Agreement") is entered into by and between Interpol, and the Client, collectively referred to as the "Parties."

WHEREAS, the Company is providing security services to the Client, and as part of these services, may have access to protected health information (PHI) as defined by the Health Insurance Portability and Accountability Act (HIPAA).

WHEREAS, the Parties recognize the importance of safeguarding PHI and complying with all applicable HIPAA regulations.

Now, Therefore, the Parties hereby agree as follows:

CONFIDENTIALITY: The Company acknowledges that it may come into contact with PHI while performing its security services. The Company shall maintain the confidentiality and security of all PHI in accordance with HIPAA regulations. This includes implementing appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of PHI.

TRANINING: The Company shall ensure that its employees and agents who may have access to PHI receive appropriate training in HIPAA compliance. Training shall include understanding the privacy and security rules and the obligations of this Agreement.

USE AND DISCLOSURE: The Company shall only use and disclose PHI as necessary to perform the security services described in this Agreement or as required by law. Unauthorized use or disclosure of PHI is prohibited.

REPORTING: The Company shall promptly report any breach of PHI to the Client as required by HIPAA regulations.

INDEMNIFICATION: The Company shall indemnify and hold the Client harmless from any HIPAA violations resulting from the Company's actions or omissions.

TERM AND TERMINATION: This HIPAA Compliance Statement shall remain in effect for the duration of the Agreement and for as long as the Company retains any PHI. Either Party may terminate this Agreement with written notice if the other Party breaches its HIPAA compliance obligations.

GOVERNING LAW: This HIPAA Compliance Statement shall be governed by and construed in accordance with the laws of California.

Hours of Coverage & Description:

Interpol Private Security's personnel will make visible foot patrols throughout their posts in undetermined patterns. It is required for personnel to interact with patients/employees in a helpful and informative manner. The personal safety of staff, patients, visitors, and contractors are Interpol's #1 priority. Interpol personnel will assist with the protection of property and other assets against fraud, theft, and damage.

Based on current egress/ingress and vulnerable entry points of Hazel Hawkins Memorial Hospital, Interpol recommends a minimum of two Security officers onsite 24-hours a day 7 days per week. The Security officers will patrol the facility/properties every 30 to 60 minutes to assure all exterior doors and windows remain secure. The Security officers will respond to emergency situations and assist at the direction of the client. Security will also provide a visual deterrent to all individuals looking to vandalize/damage the property.

EXHIBIT B
FEES

Holiday Coverage:
Christmas Day, Thanksgiving Day, New Year's Day, Martin Luther King Day, President's Day, Easter, Memorial Day, Labor Day, Veterans Day, and 4th of July. Please note the days listed above will be billed at Holiday rate.

Regular billing rates shall be used for all regularly scheduled work for the hours specified for the first 8 hours per security personnel. Over Time rates shall be used for all hours over 8 to 12 hours per day per security personnel. All hours in excess of 12 hours per day per security personnel shall be paid at double the regular billing rates. **(OT rates are subject to Client requesting hours outside of normal operational hours)**

Annual Increases: Billing rates shall automatically increase by three percent (3%) per year on each anniversary of this Agreement.

Expenses: Client agrees to reimburse IPS for the reasonable costs associated with providing services under the Agreement signed when such costs are incurred at Client's request. Client may request receipts. Such costs shall be included in the regular invoices.

SPECIAL RATES FOR ADDITIONAL SERVICES

1. Requests for extra service with short lead time will be billed at the overtime rate as follows: (a) Requests received between 8 a.m., Monday through 6 p.m., Friday, in a non-holiday week, will be billed at the overtime rate for the first 48 hours of service, if less than 48 hours' notice is received; (b) Requests received between 6 p.m., Friday through 8 a.m., Monday, or 6 p.m. on the evening of a holiday through 8 a.m. on the morning following the holiday, will be billed at the overtime rate for the first 72 hours of service, if less than 72 hours' notice is received.

2. A labor strike or other emergency situation that creates a working environment for security personnel that is more hazardous than the normal condition under this agreement signed will be caused to negotiate in good faith a temporary billing rate for modified services.

3. On or before the expiration date of one (1) year from the initial date of service under an agreement signed, the parties hereto agree to reopen negotiations in good faith for the purpose of considering revised billing rates. However, service rates and quantity of service may be amended at any time upon the mutual agreement in writing by authorized agents of IPS and the Client without otherwise affecting any understandings contained in this Agreement.

Should there be a change in state or federal minimum wage rate, workers' compensation rate, liability insurance rate, city, state or federal tax contribution by employers, or other imposed

costs that are beyond the control of IPS and that have an adverse effect on the operating costs of IPS, Client agrees to negotiate in good faith revised billing rates that will reimburse IPS for its added costs.

Hazel Hawkins Memorial Hospital Estimated Bill Rate				
Security Hours	**Client Bill Rate**	**Hours Per Week**	**Invoice total per Week**	**Invoice total per Year**
(2) Officers Day Shift	$32.00	112	$3,584	$186,368
(2) Officers Swing Shift	$32.00	112	$3,584	$186,368
(2) Officers Grave Shift	$32.00	112	$3,584	$186,368
		336	$10,752	$559,104

EXHIBIT C
INSURANCE SPECIFICATIONS

General Liability Insurance. VENDOR shall maintain commercial general liability insurance with coverage at least as broad as Insurance Services Office form CG 00 01, in an amount not less than $1,000,000 per occurrence, $2,000,000 general aggregate, for bodily injury, personal injury, and property damage. The policy must include contractual liability that has not been amended. Any endorsement restricting standard ISO "insured contract" language will not be accepted.

Umbrella Or Excess Liability Insurance. [Optional depending on limits required] VENDOR shall obtain and maintain an umbrella or excess liability insurance policy with limits that will provide bodily injury, personal injury and property damage liability coverage at least as broad as the primary coverages set forth above, including commercial general liability, automobile liability, and employer's liability. Such policy or policies shall include the following terms and conditions:
A drop down feature requiring the policy to respond if any primary insurance that would otherwise have applied proves to be uncollectible in whole or in part for any reason;
Pay on behalf of wording as opposed to reimbursement:
Concurrency of effective dates with primary policies;
Policies shall "follow form" to the underlying primary policies; and
Insureds under primary policies shall also be insureds under the umbrella or excess policies.

Workers' Compensation Insurance. VENDOR shall maintain Workers' Compensation Insurance (Statutory Limits) and Employer's Liability Insurance (with limits of at least $1,000,000). VENDOR shall submit to District, along with the certificate of insurance, a Waiver of Subrogation endorsement in favor of District, its officers, agents, employees and volunteers.
Vendor Services Agreement 07.19.2022

OTHER PROVISIONS OR REQUIREMENTS

Proof of Insurance. VENDOR shall provide certificates of insurance to District as evidence of the insurance coverage required herein, along with a waiver of subrogation endorsement for workers' compensation. Insurance certificates and endorsements must be approved by District's Risk Manager prior to commencement of performance. Current certification of insurance shall be kept on file with District at all times during the term of this contract. District reserves the right to require complete, certified copies of all required insurance policies, at any time.

Duration of Coverage. VENDOR shall procure and maintain for the duration of the contract insurance against claims for injuries to persons or damages to property, which may arise from or in connection with the performance of the Work hereunder by VENDOR, his agents, representatives, employees or subconsultants.

Primary/Noncontributing. Coverage provided by VENDOR shall be primary and any insurance or self-insurance procured or maintained by District shall not be required to contribute with it. The limits of insurance required herein may be satisfied by a combination of primary and

umbrella or excess insurance. Any umbrella or excess insurance shall contain or be endorsed to contain a provision that such coverage shall also apply on a primary and non-contributory basis for the benefit of District before the District's own insurance or self-insurance shall be called upon to protect it as a named insured.

District's Rights of Enforcement. In the event any policy of insurance required under this Agreement does not comply with these specifications or is canceled and not replaced, District has the right but not the duty to obtain the insurance it deems necessary and any premium paid by District will be promptly reimbursed by VENDOR or District will withhold amounts sufficient to pay premium from VENDOR payments. In the alternative, District may cancel this Agreement.

Acceptable Insurers. All insurance policies shall be issued by an insurance company currently authorized by the Insurance Commissioner to transact business of insurance or is on the List of Approved Surplus Line Insurers in the State of California, with an assigned policyholders' Rating of A- (or higher) and Financial Size Category Class VII (or larger) in accordance with the latest edition of Best's Key Rating Guide, unless otherwise approved by the District's Risk Manager.

Waiver of Subrogation. All insurance coverage maintained or procured pursuant to this Agreement shall be endorsed to waive subrogation against District, its elected or appointed officers, agents, employees and volunteers or shall specifically allow VENDOR or others providing insurance evidence in compliance with these specifications to waive their right of recovery prior to a loss. VENDOR hereby waives its own right of recovery against District, and shall require similar written express waivers and insurance clauses from each of its subconsultants.

Enforcement of Contract Provisions (Non Estoppel). VENDOR acknowledges and agrees that any actual or alleged failure on the part of the District to inform VENDOR of non-compliance with any requirement imposes no additional obligations on the District nor does it waive any rights hereunder.

Requirements Not Limiting. Requirements of specific coverage features or limits contained in this Section are not intended as a limitation on coverage, limits or other requirements, or a waiver of any coverage normally provided by any insurance. Specific reference to a given coverage feature is for purposes of clarification only as it pertains to a given issue and is not intended by any party or insured to be all inclusive, or to the exclusion of other coverage, or a waiver of any type. If the VENDOR maintains higher limits than the minimums shown above, the District requires and shall be entitled to coverage for the higher limits maintained by the VENDOR. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to the District.

Notice of cancellation. VENDOR agrees to oblige its insurance agent or broker and insurers to provide to District with a thirty (30) day notice of cancellation (except for nonpayment for which a ten (10) day notice is required) or nonrenewal of coverage for each required coverage.

Additional insured status. General liability policies shall provide or be endorsed to provide that District and its officers, employees, and agents shall be additional insureds under such policies. This provision shall also apply to any excess/umbrella liability policies.

Prohibition of undisclosed coverage limitations. None of the coverages required herein will be in compliance with these requirements if they include any limiting endorsement of any kind that has not been first submitted to District and approved of in writing.

Separation of insureds. A severability of interests provision must apply for all additional insureds ensuring that VENDOR's insurance shall apply separately to each insured against whom claim is made or suit is brought, except with respect to the insurer's limits of liability. The policy(ies) shall not contain any cross-liability exclusions.

Pass-Through Clause. VENDOR agrees to ensure that its sub-consultants, sub-contractors, and any other party involved with the project who is brought onto or involved in the project by VENDOR, provide the same minimum insurance coverage and endorsements required of VENDOR. VENDOR agrees to monitor and review all such coverage and assumes all responsibility for ensuring that such coverage is provided in conformity with the requirements of this section. VENDOR agrees that upon request, all Agreements with consultants, subcontractors, and others engaged in the project will be submitted to District for review.

District's Right to Revise Specifications. The District reserves the right at any time during the term of the contract to change the amounts and types of insurance required by giving the VENDOR ninety (90) days advance written notice of such change. If such change results in substantial additional cost to the VENDOR, the District and VENDOR may renegotiate VENDOR's compensation.

Self-Insured Retentions. Any self-insured retentions must be declared to and approved by District. District reserves the right to require that self-insured retentions be eliminated, lowered, or replaced by a deductible. Self-insurance will not be considered to comply with these specifications unless approved by District.

Timely Notice of Claims. VENDOR shall give District prompt and timely notice of claims made or suits instituted that arise out of or result from VENDOR's performance under this Agreement, and that involve or may involve coverage under any of the required liability policies.

Additional Insurance. VENDOR shall also procure and maintain, at its own cost and expense, any additional kinds of insurance, which in its own judgment may be necessary for its proper protection and prosecution of the Work.

IMPERIAL
HEALTH PLAN
OF CALIFORNIA

HOSPITAL SERVICES AGREEMENT

Between

IMPERIAL HEALTH PLAN OF CALIFORNIA, INC.

And

Hazel Hawkins Memorial Hospital/San Benito Healthcare District

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HOSPITAL SERVICES AGREEMENT

Between

IMPERIAL HEALTH PLAN OF CALIFORNIA, INC.

And

This Agreement is made effective as of the **1st day of November 2023** (the "Effective Date"), by and between the IMPERIAL HEALTH PLAN OF CALIFORNIA, INC., (the PLAN) and affiliates (collectively herein referred to as the "Plan"), and **Hazel Hawkins Memorial Hospital/San Benito Healthcare District TIN: 94-6034863** licensed as a hospital by the State of California pursuant to the California Health and Safety Code.

IN WITNESS WHEREOF, the subsequent agreement between PLAN and HOSPITAL is entered into by and between the undersigned parties.

HOSPITAL:	**PLAN:**
	IMPERIAL HEALTH PLAN OF CALIFORNIA (the "Plan")
Hazel Hawkins Memorial Hospital/San Benito Healthcare District	
Hospital Provider Name Above	
Executed by:	Executed by:
_____	_____
Signature	Signature
	Paveljit S. Bindra, MD, MBA, MSc, FACC
_____	
Printed Name	Chief Executive Officer
_____	
Title	
_____	_____
Date	Date
Address for Notices:	Address for Notices: 1100 E. Green St.,

Pasadena, CA 91106
Attn: CEO

IMPERIAL HEALTH PLAN OF CALIFORNIA, INC. AGREEMENT

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IMPERIAL HEALTH PLAN OF CALIFORNIA, INC. AGREEMENT

RECITALS

A. WHEREAS, the PLAN is licensed by the Department of Managed Health Care as a Knox-Keene licensed (restricted) health care Service Plan pursuant to Health and Safety Codes Section 1340 et seq Welfare & Institutions Code §14087.54.

B. WHEREAS, HOSPITAL, is licensed in accordance with the requirements of the California Health Facilities Licensure Act (Health and Safety Code, Sections 1250 et seq.) and the regulations promulgated pursuant thereto, is currently certified under Title XVIII of the Federal Social Security Act, complies with the Joint Commission Accreditation (JCA) standards, and has on its medical staff physicians who have contracted with PLAN to provide physician services to Medicare members enrolled in the Plan under a Plan-to-Plan Agreement.

C. WHEREAS, the PLAN desires to arrange for hospital and other services for its Medicare Members, and HOSPITAL desires to provide Hospital and other services for such Medicare Members.

NOW THEREFORE, in consideration of the foregoing recitals and the mutual promises and covenants herein, receipt and sufficiency of which are hereby acknowledged, the parties agree and covenant as follows:

SECTION 1.
DEFINITIONS

As used in this Agreement, the following terms will have the meaning set forth herein below, except where, from the context, it is clear that another meaning is intended. Many words and terms are capitalized throughout this Agreement to indicate that they are defined as set forth in this Section.

1.1 Administrative Day. Any day in an acute care facility for which inpatient care is not required regardless of patient disposition on discharge, for whose care has been approved by the PLAN as such.

1.2 Agreement. This agreement and all of the Exhibits attached hereto and incorporated herein by reference.

1.3 Attending Physician. (a) any physician who is acting in the provision of Emergency Services to meet the medical needs of the Member or (b) any physician who is, through referral from the Member's Primary Care Physician, actively engaged in the treatment or evaluation of a Member's condition.

1.4 Authorization Request Form (ARF). The form approved by PLAN for the provision of specified Covered Services set forth in the Provider Manual.

1.5 Capitation Payment. The prepaid monthly amount that PLAN pays to Primary Care Physician (PCP) as compensation for those Covered Medical Services which are set forth in Attachment C, attached to and incorporated within the Provider Agreement with PLAN.

1.6 Case Managed Members. Members who have been assigned or who chose a Primary Care Physician for their medical care.

1.7 Case Management. The responsibility for primary and preventive care, and for the referral, consultation, ordering of therapy, admission to hospitals, provision of Medicare covered health education and preventive services, follow-up care, coordinated hospital discharge planning that includes necessary post-discharge care, and maintenance of a medical record with documentation of referred and follow-up services.

1.8 Complex Case. Members requiring comprehensive care management and coordination of services. Such Members may be identified through pre-certification requests by utilization management and inpatient concurrent review, those with complex psychosocial care needs, and those with high acute impact scores or high forecasted costs. Criteria include: complex health conditions, barriers, and/or risks needing ongoing intervention. Frequently managed conditions, diseases or high-risk groups include, but are not limited to: Alzheimer, diabetes, stage renal disease, cancer or other chronic illnesses that result in high utilization or under-utilization of health care resources, congenital anomalies, multiple chronic illnesses, serious trauma, spinal injuries, and transplants.

1.9 Contract Year. The 12-month period following the effective date of this Agreement between HOSPITAL and PLAN and each subsequent 12-month period following the anniversary of the agreement. If the date of commencement of operations is later than the effective date, the PLAN operational date will apply.

1.10 Covered Medical Services. Those Covered Services that are set forth in the Provider Handbook some of which are to be provided to, or arranged for, Members by HOSPITAL, within the scope of its licensure, pursuant to this Agreement and for which HOSPITAL is to be compensated by PLAN in accordance with Attachment B of this Agreement.

1.11 Covered Services. All Medically Necessary services to which Members are entitled from PLAN as set forth in the Provider Handbook, including Primary Care Services, medical, hospital, preventive, ancillary, emergency and health education services. Covered Services includes Covered Medical Services.

1.12 Direct Referral Authorization Form (DRAF). The Plan's form, evidencing referral by PCP or Medical Director, or designee for initial specialist consultation or return follow-up with forty-five (45) days.

1.13 Emergency Medical Condition. A medical condition which is manifested by acute symptoms of sufficient severity, including severe pain, such that a prudent lay-person who possesses an average knowledge of health and medicine could reasonably expect the

absence of immediate medical attention to result in: 1) placing the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

1.14 Emergency Services. Those health services needed to evaluate or stabilize an Emergency Medical Condition.

1.15 Encounter Form. The UB04 or CMS1500 claim form used by HOSPITAL to report to the PLAN provision of Covered Services to Members.

1.16 Enrollment. The process by which an individual is assigned to the PLAN in compliance with the Plan-to-Plan Agreement.

1.17 Excluded Services. Those services for which the Plan is not responsible and for which it does not receive a capitation payment as outlined in Section 4 of this Agreement.

1.18 Fiscal Year. The 12 month period starting January 1.

1.19 Governmental Agencies. Any agency that has legal jurisdiction over the PLAN or Members, such as: the United States Department of Health and Human Services ("DHHS") including its agency for Centers for Medicare and Medicaid Services (CMS) and the California Department of Managed Health Care ("Department").

1.20 Hospital. Any acute general care or psychiatric hospital licensed by DHCS.

1.21 Identification Card. The card that is contains: a) Member name and identification number, b) Member's Primary Care Physician, and c) other identifying data. The card is not proof of Member eligibility with PLAN or proof of Medicare eligibility.

1.22 Limited Service Hospital. Any hospital which is under contract to the Plan, but not as a Primary Hospital.

1.23 Medical Director. The Medical Director of Plan or his/her designee, a physician licensed to practice medicine in the State of California, employed by PLAN to monitor the quality assurance and implement Quality Improvement Program of PLAN. Also called Chief Medical Officer.

1.24 Medically Necessary. Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. These services will be in accordance with professionally recognized standards of medical practice and not primarily for the convenience of the Member or the participating provider.

1.25 Medical Transportation. "Medical transportation services" means the transportation of the sick, injured, invalid, convalescent, infirm or otherwise incapacitated persons by ambulances, specially equipped vans or wheelchair vans licensed, operated, and equipped in accordance with applicable state or local statutes, ordinances or regulations. Medical

transportation services do not include transportation of beneficiaries by passenger car, taxicabs or other forms of public or private conveyances.

1.26 Member. An Eligible Medicare eligible individual Beneficiary who is enrolled in the PLAN under a Plan-to-Plan Agreement.

1.27 Non-Medical Transportation. Transportation services required to access medical appointments and to obtain other Medically Necessary Covered Services by Member who do not have a medical condition necessitating the use of medical transportation.

1.28 Non Physician Medical Practitioner. A physician assistant, nurse practitioner, or certified midwife authorized to provide primary care under physician supervision.

1.29 Observation Day. A period of a minimum of 8 hours in duration during which services furnished by a hospital on the hospital's premises, including use of a bed and at least periodic monitoring by a hospital's nursing staff, which are reasonable and Medically Necessary and appropriate to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Such services are covered only when provided by the order of a physician. In no instance shall PLAN pay for normal postoperative monitoring during a standard recovery period.

1.30 Out-of-Area. The geographic area outside the Plan's Service Area.

1.31 Participating Referral Provider. Any health professional or institution contracted with PLAN that meets the Standards for Participation in the Medicare Program to render medical services to Members.

1.32 Physician. Either an Attending Physician, Primary Care Physician or IPA, who has entered into an Agreement with PLAN and who is licensed to provide medical care by the Medical Board of California and who has contracted with PLAN to provide medical services to Members.

1.33 Physician Patient Load Limitation. The maximum number of Members for whom the Primary Care Physician has contracted to serve, which has been accepted by the PLAN. Such limit may be changed by mutual agreement of the parties.

1.34 Plan-to-Plan Agreement. The Agreement between the Plan and a licensed Medicare Plan to provide Covered Medical Services to individual who have been assigned to the Plan by the Medicare Advantage Plan.

1.35 Primary Care Physician or PCP. A physician duly licensed by the Medical Board of California. The Primary Care Physician is responsible for supervising, coordinating, and providing Primary Care Services to Members; initiating referrals; and for maintaining the continuity of care for the Members who select or are assigned to the Primary Care Physician. Primary care physicians include general and family practitioners, and internists, but may or may not include Obstetrician-Gynecologists depending on their scope of practice.

1.36 Primary Care Services. Those services provided to Members by a Primary Care Physician. These services constitute a basic level of healthcare usually rendered in ambulatory settings and focus on general health needs.

1.37 Primary Hospital. Any hospital located within the Service Area that has entered into an Agreement with the PLAN.

1.38 Provider Manual. The Plan's Manual describing operational policies and procedures relevant to Providers.

1.39 Quality Improvement Program (QIP). Systematic activities to monitor and evaluate the clinical and non-clinical services provided to Members according to the standards set forth in statute, regulations, and the Plan-to-Plan Agreement. The QIP consists of processes, which measure the effectiveness of care, identifies problems, and implements improvement on a continuing basis towards an identified, target outcome measurement.

1.40 Referral Physician. Any qualified physician who is duly licensed in California. A Referral Physician must have an Agreement with PLAN or authorized by a subcontracted Plan provider. Primary Care Physician may refer any Member for consultation or treatment to a Referral Physician.

1.41 Referral Services. Covered services, which are not Primary Care Services, provided by physicians on referral from the Primary Care Physician or provided by the Primary Care Physician as a non- capitated service.

1.42 Service Area. The counties of Alameda, Santa Clara, Fresno, Kern, Los Angeles, Orange, Riverside, San Benito, Merced, Monterey, San Bernardino, San Diego, San Mateo, Kings and San Francisco, Santa Barbara and Ventura counties.

1.43 Treatment Authorization Request or TAR or Prior Authorization. The PLAN's form for the provision of inpatient Non-Emergency Services as set forth in the Provider Manual.

1.44 Urgent Care Services. Medical services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (e.g., sore throat, fever, minor lacerations, and some broken bones).

1.45 Utilization Management Program. The program(s) approved by PLAN, which are designed to review and monitor the utilization of Covered Services. Such program(s) are set forth in the PLAN's Provider Manual.

1.46 Vision Care. Routine basic eye examinations, lenses and frames provided every 24 months.

SECTION 2.
QUALIFICATIONS, OBLIGATIONS AND COVENANTS

2.1 HOSPITAL is responsible for:

2.1.1 Provision of Covered Services. HOSPITAL shall provide to Members those Covered Services that are Medically Necessary which HOSPITAL is licensed to provide and customarily provides to all HOSPITAL patients. Those services which HOSPITAL customarily provides but which are specifically excluded from this Agreement, if any, are described in Section 4. HOSPITAL will perform such hospital services in an economic and efficient manner consistent with professional standards of medical care generally accepted by the medical community. Any Primary Care Physician or Specialist Physician who admits or treats a Member in HOSPITAL must be a member in good standing of HOSPITAL'S organized medical staff with appropriate clinical privileges to admit and treat such Member. HOSPITAL is responsible for coordinating the provision of Covered Services with the Member's assigned Primary Care Physician.

2.1.2 Admission and Transfer of Members. Upon receipt of prior authorization from PLAN or its designee, HOSPITAL shall admit Members in accordance with its admission protocols and community standards. In the event that a Member is transferred to or from HOSPITAL to another hospital that is a Participating Hospital, HOSPITAL will complete all transfer and authorization forms requested by PLAN, and as necessary, to ensure the continuity of care of the Member.

2.1.3 Referral and Authorization. Except for Emergency Services, HOSPITAL will provide Hospital Services to Members only when HOSPITAL has received an appropriate prior written authorization for such services from PLAN or its designee.

2.1.4 Plan Policies and Procedures Compliance. HOSPITAL will comply with the policies and procedures approved by PLAN for the provision of Covered Services under the Medicare Managed Care Program. HOSPITAL agrees to comply with all policies and procedures set forth in the Provider Manual. The Provider Manual is available through the PLAN website at https://www.imperialhealthplan.com/california PLAN may modify the Provider Manual from time to time. PLAN shall notify HOSPITAL at least sixty (60) days prior to any material change in its Provider Manual. HOSPITAL has the right to negotiate and agree to any change. In the event that PLAN and HOSPITAL cannot agree regarding the proposed modification within thirty (30) business days, HOSPITAL has the right to terminate this Agreement prior to implementation of the change. In the event of a conflict between the Agreement and the Provider Manual, the terms of the Agreement shall prevail.

2.1.5 Standards: HOSPITAL shall:

(a) Standards of Care. Provide Covered Services to Members that are Medically Necessary that are the same standards of care, skill, diligence and in the same economic and efficient manner as are generally accepted practices and standards prevailing in the professional community.

(b) Licensure. Maintain in good standing the license and accreditation of its facility or facilities in accordance with Section 1250 et seq. of the Health and Safety Code and the licensing regulations contained in Title 22 and 17 of the California Code of Regulations. HOSPITAL agrees to remain certified under Title XVIII of the Federal Social Security Act, and shall notify PLAN immediately if any action of any kind is initiated against HOSPITAL which could result in (a) the suspension or revocation of its license; or (b) the suspension or loss of accreditation, or (c) the imposition of any sanction against HOSPITAL under the Medicare Program; or (d) the material impairment of its ability to provide hospital services hereunder. HOSPITAL shall provide PLAN with evidence of such licensure and accreditation upon execution of this Agreement.

(c) Officers, Owners, and Stockholders. Be responsible for providing upon execution of this Agreement the information regarding officers, owners and stockholders as set forth in Attachment A, attached to and incorporated herein.

(d) Facilities, Equipment and Personnel. Provide and maintain sufficient facilities, equipment, personnel, and administrative services to perform the duties and responsibilities as set forth in this Agreement.

(e) Hospital Privileges. Use its best efforts in granting HOSPITAL privileges in accordance with its medical staff bylaws for qualified Participating Providers affiliated with PLAN.

(f) Medical Records. Ensure that a medical record will be established and maintained for each Member. Each Member's medical record will be established upon the Member's first visit. The record will contain that information normally included in accordance with generally accepted HOSPITAL practices and standards prevailing in the professional community. HOSPITAL will facilitate the sharing of medical information with other providers subject to all applicable laws and professional standards regarding the confidentiality of medical records. HOSPITAL will make such records available to authorized PLAN personnel and its designees in order for PLAN to conduct its Quality Improvement and Utilization Management Programs.

(g) Cultural and Linguistic Services. HOSPITAL shall provide services to Members in a culturally, ethnically and linguistically appropriate manner. HOSPITAL shall recognize and integrate Members' practices and beliefs about disease causation and prevention into the provision of Covered Services. HOSPITAL shall comply with Plan's language assistance program standards developed under California Health and Safety Code Section 1367.04 and Title 28 CCR Section 1300.67.04 and shall cooperate with Plan by providing any information necessary to assess compliance. HOSPITAL is responsible for providing interpretive services. However, if

HOSPITAL unable to meet a member's interpretive needs, HOSPITAL may utilize the PLAN's telephonic language assistance program, if available.

2.1.6 Participation in Quality Improvement and Utilization Management Programs.

HOSPITAL will cooperate and participate in PLAN'S Quality Improvement and Utilization Management Programs and will comply with the policies and procedures associated with these Programs. This includes participation in facility reviews, chart and access audits and focused reviews. In the event there is a conflict in the PLAN's and HOSPITAL's policies and procedures, the parties shall meet and confer to reach to reach mutual agreement related to this section 2.1.6.

(a) HOSPITAL will participate in the development of corrective action plans for any areas that fall below PLAN standards and ensuring medical records are readily available to the PLAN staff as requested.

(b) HOSPITAL recognizes the possibility that PLAN, through the utilization management and quality improvement process, may be required to take action requiring consultation with its Medical Director or with other physicians prior to authorization of services or supplies or to terminate this Agreement.

(c) In the interest of program integrity or the welfare of Members, PLAN may introduce additional utilization controls as may be necessary.

(d) In the event of such change, a thirty (30) day notice will be given to the HOSPITAL. HOSPITAL will be entitled to appeal such action to the Quality and Utilization Advisory Committee, (QUAC), the Physician Advisory Group and then to the PLAN Board of Commissions.

2.1.7 HOSPITAL will apply standards established by PLAN's Quality Improvement and Utilization Management Programs in determining appropriate referrals, length of stay and discharge planning in a manner to affect the goals set forth in program descriptions and work plans of both programs.

2.1.8 Actions Against HOSPITAL. HOSPITAL will adhere to the requirements as set forth in the PLAN Provider Manual and notify PLAN by certified mail within fifteen (15) days of HOSPITAL's learning of any action taken which results in restrictions on HOSPITAL's provision of services regardless of the duration of the restriction or exclusion from participation in the Medicare Program in accordance with the Standards of Participation.

2.1.9 Data Requirements. HOSPITAL shall:

(a) Financial and Accounting Records. Maintain, in accordance with standard and accepted accounting practices, financial and accounting records relating to services provided or paid for hereunder as will be necessary and

appropriate for the proper administration of this Agreement, the services to be rendered, and payments to be made hereunder or in connection herewith.

(b) Encounter and Claims Data. Provide encounter and claims data for all services for each Member visit and hospitalization. Such data will be provided by HOSPITAL to PLAN in a form acceptable to PLAN at no cost, at least monthly, on a UB-04 Claim Form, other claim forms as may be designated by PLAN or by electronic transfer. All forms (data) submitted should contain the data elements as outlined in the PLAN Provider Manual.

(c) Reports. Submit reports as required by PLAN upon PLAN's reasonable written request.

2.1.10 Promotional Materials. HOSPITAL consents to be identified as a hospital in written materials published by PLAN, including without limitation, the provider directory and marketing materials prepared and distributed by PLAN. HOSPITAL may also post information on HOSPITAL's website and other related marketing materials that it is a contracted provider with the PLAN.

2.1.11 Domestic Partners. Any HOSPITAL licensed in accordance with California Health & Safety Code Section 1250 will ensure that Members are permitted to be visited by the Member's domestic partner, the children of the Member's domestic partner, and the domestic partner of the Member's parent or child.

2.1.12 HOSPITAL is not obligated hereunder to provide Members with inpatient, outpatient or emergency services that are not currently maintained by HOSPITAL due to religious or other reasons as of the effective date of this Agreement.

2.1.13 HOSPITAL will retain the right, within its sole discretion, to alter, enlarge, reconstruct, modify, or shut down all or any part of its facilities, provided however, that written notice of any action described herein, which would materially affect the services available to Members hereunder, will be given to PLAN at least sixty (60) days prior to implementation of such change, and PLAN will have the right to terminate this Agreement upon providing HOSPITAL with thirty (30) days prior written notice in accordance with Section 9 of this Agreement.

2.1.14 Hospital Admission. Hospital agrees to notify PLAN Utilization Management Department within forty-eight (48) hours of all in-patient admissions.

2.1.15 Concurrent Review. HOSPITAL will cooperate with PLAN in conducting concurrent review of in-patient services provided to members. PLAN UM nurses may conduct onsite review in addition to HOSPITAL UM Staff providing periodic updates of member's medical condition to PLAN. HOSPITAL agrees to retrospective review of members medical records when concurrent review was not available. Hospital agrees to use nationally recognized criteria, PLAN UM guidelines developed and approved by the Quality/Utilization Advisory Committee (Q/UAC) and applicable laws and regulations to determine

appropriateness of all admission as well as in the determination of medical necessity for the continuation of all hospital stays.

2.1.16 Discharge Planning. HOSPITAL will continue to be responsible for discharge planning and will make reasonable efforts to cooperate with PLAN discharge planning efforts. HOSPITAL will only discharge a Member when the Member is clinically stable for discharge and HOSPITAL has performed Sufficient Discharge Planning.

2.1.17 Grievances and Appeals. HOSPITAL will cooperate with PLAN in identifying, processing and resolving all Member complaints and grievances in accordance with the Plan grievance policy and procedure set forth in the Provider Manual and Quality Improvement Program.

2.2 PLAN is responsible for:

2.2.1 Administration and Provision of Data. PLAN shall perform all administrative, accounting, enrollment, eligibility verification and other functions necessary or appropriate for the operation, administration and marketing of the PLAN and consistent with the terms of this Agreement. PLAN shall provide HOSPITAL with management information and data reasonably necessary to carry out the terms and conditions of this Agreement and for the operation of the PLAN. PLAN shall promote population health by sharing applicable data with HOSPITAL. Parties shall meet and confer about what data and format will work.

2.2.2 Enrollment and Eligibility Verification. Members shall be enrolled in the Medicare Program in accordance with applicable State and Federal Laws. PLAN shall determine the identity and eligibility of all Members. Upon request by HOSPITAL, either before or after providing Hospital Services to Members, PLAN shall verify that a Member is eligible for benefits under the PLAN in accordance with procedures set forth in the Provider Manual.

2.2.3 Quality Assurance and Utilization Management Programs. PLAN shall establish and maintain a Quality Assurance Program, including a Quality Assurance Committee, for the purpose of evaluating, monitoring and improving the quality of clinical care and services provided to Members by HOSPITAL and other Participating Providers. The Quality Assurance Program shall be established and operated in accordance with applicable State and Federal Laws and the standards of applicable Accreditation Organizations. PLAN shall also establish and maintain a Utilization Management Program to provide for prior authorization for referrals for Covered Services and admissions for HOSPITAL Services, concurrent utilization review for HOSPITAL Services, and retrospective utilization review for Emergency Services and Urgently Needed Services. The Utilization Management Program shall be established and operated in accordance with applicable State and Federal Law and the standards of applicable Accreditation Organizations.

SECTION 3.
SCOPE OF SERVICES

3.1 Access to Covered Service. HOSPITAL will provide available Medically Necessary Covered Services on a readily available and accessible basis 24-hours a day in accordance with PLAN policies and procedures as set forth in the Provider Manual. HOSPITAL agrees to render quality medical services consistent with community standards of care to Medicare Members.

3.2 Confirmation of Eligibility. Prior to rendering services to Members, HOSPITAL will confirm Members' eligibility by a) accessing the PLAN web- based eligibility, b) checking the PLAN automated eligibility telephone service and/or c) contacting PLAN member services department directly. If patient holds himself out to be a Member, HOSPITAL will attempt to verify eligibility by following the above procedures. If HOSPITAL is unable to verify the purported Member's eligibility, HOSPITAL will render any Urgent Care necessary. At the first available opportunity, HOSPITAL will again attempt to verify eligibility. Eligibility may not be retroactively denied once approved.

3.3 Emergency Services. HOSPITAL will provide Emergency Services to Member's in accordance with PLAN policies and procedures, as set forth in the PLAN Provider Manual, and Utilization Management Program.

3.3.1 PLAN will reimburse HOSPITAL for treatment and services rendered by HOSPITAL's Emergency Department hereunder in accordance with Attachment B of this Agreement and in accordance with PLAN Provider Manual policies and procedures.

3.3.2 HOSPITAL will make reasonable efforts to notify the Member's assigned Primary Care Physician immediately upon treatment and PLAN within 24-hours of treatment or next business day in accordance with PLAN Provider Manual, policies and procedures and Utilization Management Program.

3.3.3 HOSPITAL and PLAN understand that authorization is not required prior to rendering Emergency Services.

SECTION 4.
EXCLUSIONS FROM AND LIMITATIONS OF COVERED SERVICES

4.1 Services Not Payable. Members in need of services, that are not Covered Services will not be eligible for reimbursement by the PLAN.

4.2 Services Neither Covered nor Compensated. Subject to those exclusions from Covered Services, HOSPITAL understands that HOSPITAL will not be obligated to provide Members with, and the PLAN will not be obligated to reimburse HOSPITAL for the following Excluded Services:

(a) Dental Services, as defined in Title 22 CCR Section 51307(a). However, medical services necessary to support dental services are Covered Service for Members and are not excepted;

(b) Home and community based services and Department of Developmental Services Administered Medicaid Home and Community Based Services, Multipurpose Senior Services as defined in the California Welfare and Institutions Code Section 9400 et seq., Adult Day Health Care Services as defined in Title 22 CCR Section 54001, Pediatric Day Health Care Services as defined in Title 22 CCR Section 51184(j), alcohol and drug treatment program services (including outpatient heroin detoxification), and Local Education Authority Services as defined in Title 22 CCR Sections 51360 and 51190.

(c) Short-Doyle/Medi-Cal mental health services (inpatient and outpatient), Medi-Cal specialty mental health services and services provided by specialty mental health providers (inpatient and outpatient); provided, however, the following are Covered Services for Members and are not excepted: (i) outpatient mental health services within the Primary Care Physician's scope of practice, (ii) emergency room professional services except services provided by specialty mental health providers, (iii) facility charges for emergency room visits which do not result in a psychiatric admission, (iv) laboratory and radiology services necessary for the diagnosis, monitoring or treatment of a Member's mental health condition, (v) emergency medical transportation for emergency mental health services, (vi) certain prescribed non-emergency medical transportation services to access mental health services, (vii) initial health history and physical assessments required upon admission for psychiatric inpatient hospital stays and consultations related to Medically Necessary Covered Services, and (viii) psychotherapeutic drugs that are covered by the Medicare.

(d) Services rendered in a State or Federal governmental hospital;

(e) Laboratory services provided under the State serum alpha fetoprotein testing program administered by the Genetic Disease Branch of the Department of Health Care Services;

(f) Fabrication of optical lenses;

(g) Targeted Case Management Services as specified in Title 22 CCR Sections 51185 and 51351;

(h) Direct Observed Therapy for tuberculosis;

(i) Personal Care Services defined in Title 22 CCR Sections 51183 and 51350;

(j) Certain Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency (AIDS), and psychotherapeutic drugs

(k) Other Services as may be determined by the PLAN, and as noticed to participating Hospital. In the event of such a change, a thirty (30) day notice will be given to the Hospital.

SECTION 5.
REIMBURSEMENT, ACCOUNTS, REPORTING AND RECOVERIES

5.1 Payment for Authorized Services Only. The PLAN will reimburse HOSPITAL for Medically Necessary Covered Services, after prior-authorization is received from PLAN or its designee (for non-emergent Covered Services), in conformance with the Provider Manual and the schedule in Attachment B of this Agreement.

5.1.1 PLAN and HOSPITAL agree that PLAN is responsible for payment of emergency services, and that, except for emergencies, HOSPITAL shall not be entitled to reimbursement for any Covered Services provided to a Member unless HOSPITAL has obtained the necessary authorization from PLAN in accordance with PLAN's Provider Manual policies and procedures.

5.1.2 The Member's attending physician will determine the need for acute care in accordance with usual standards of medical practice in the community nationally recognized criteria, PLAN Utilization Management (UM) guidelines developed and approved by the Quality Assurance Committee and California Department of Health and Welfare Code of Regulations Title 22.

5.1.3 Member's attending physician will determine the Medically Necessary course of treatment to be provided in the HOSPITAL.

5.1.4 Nothing in this Agreement is intended to create (nor shall it be construed to create) any right by PLAN or by PLAN's Participating Providers (except in their capacity as Members of HOSPITAL's medical staff) to interfere with the method(s) by which HOSPITAL or attending physicians render services hereunder.

5.1.5 All rate changes or adjustments shall be made only if the parties have executed a formal amendment to Agreement to provide for same. Rates may not be adjusted without prior written approval of HOSPITAL.

5.2 Claims Submission. HOSPITAL shall submit a complete UB-04 form or submit complete data through electronic transfer, in accordance with the Provider Manual and Attachment B of this Agreement. Reimbursement will be made within thirty (30) calendar days of receipt of an uncontested claim which is accurate, complete and otherwise in accordance with the PLAN provider manual. PLAN shall request missing information related to an unclean claim within 30 calendar days of receipt of the initial claim. All unclean claims will be paid within 30 calendar days of receipt of the information necessary to

determine PLAN liability. After the requested information is submitted to the PLAN, the PLAN will either approve, deny or modify the amount to be reimbursed based on the information provided. The PLAN's claims adjudication process will not conflict with CMS' claims adjudication process. If the HOSPITAL does not submit the requested information to determine PLAN liability within 180 calendar days from the date of the request, the PLAN will notify the HOSPITAL that the claim remains pending as "unclean." All claims for Covered Services must be submitted to the PLAN within twelve (12) months from the date that service was provided. If for any reason it is determined that PLAN overpaid HOSPITAL, PLAN may deduct monies in the amount equal to the overpayment from any future payments to HOSPITAL using an industry standard process so that HOSPITAL is clearly aware how to interpret the claims activity.

5.2.1 A summary report will accompany each check identifying the Members who received Covered Services from HOSPITAL and the appropriate amount of reimbursement disbursed per Member.

5.2.2 HOSPITAL agrees not to submit separate claims for reimbursement for Medicare Members who receive outpatient and emergency medical services during the same calendar day as in-patient admission of the Medicare Member to the HOSPITAL.

5.3 Entire Payment. HOSPITAL will accept from PLAN compensation as payment in full and discharge of PLAN's financial liability for Covered Services provided to eligible PLAN Members by HOSPITAL, and will be reimbursed as listed hereunder in those amounts set forth and in the manner and at the times as specified in Attachment B of this Agreement and in accordance with PLAN Provider Manual policies and procedures. HOSPITAL will look only to PLAN for such compensation with the exception of copayments, coinsurance and deductibles. PLAN has the sole authority to determine reimbursement policies and methodology of reimbursement under this Agreement.

5.4 Member Hold Harmless. HOSPITAL will not submit claims to or demand or otherwise collect reimbursement from a Member, or from other persons on behalf of the Member, for any service included in the program's Covered Services in addition to a claim submitted to the PLAN for that service. Furthermore, HOSPITAL will hold harmless DHCS, CMS and Members in the event PLAN cannot or will not pay for services provided by HOSPITAL under this Agreement.

5.5 Coordination of Benefits. DHCS and CMC are the payors of last resort recognizing Other Health Coverage as primary carrier. HOSPITAL must bill the primary carrier before billing PLAN for reimbursement of Covered Services and, with the exception of authorized share of cost payments, will at no time seek compensation from Members. The HOSPITAL may look to the Member for non-covered services.

5.5.1 The determination of liability will be in accordance with the usual procedures employed by the appropriate Governmental Agencies and applicable law, the Medicare Provider Manual, and the Provider Manual.

5.5.2 The authority and responsibility for Coordination of Benefits will be carried out in accordance with applicable law.

5.5.3 HOSPITAL will make best efforts to report to PLAN the discovery of third party insurance coverage for a Medicare Member within five (5) business days of discovery.

5.5.4 HOSPITAL will recover directly from Medicare for reimbursement of medical services rendered. Medicare payments will be reported to the PLAN on the UB04 encounter form or electronic transfer tape as indicated in the Provider Manual.

5.5.5 For all enrollees eligible for both Medicare and Medicaid, enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. Downstream Provider may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Providers will: (1) accept the MA plan payment as payment in full, or (2) bill the appropriate State source. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)].

5.6 Third Party Liability Tort. In the event that HOSPITAL provides services to Members for injuries or other conditions resulting from the acts of third parties, the Plan will have the right to recover from any settlement, award or recovery from any responsible third party the value of all Covered Services which have been rendered by HOSPITAL pursuant to the terms of this Agreement.

5.6.1 HOSPITAL will cooperate with the PLAN in their efforts to obtain information and collect sums due as result of third party liability tort, including Workers' Compensation claims for Covered Services.

5.6.2 HOSPITAL will make best efforts to report to PLAN the discovery of third party tort action for a Member within five (5) business days of discovery.

5.7 Subcontracts

5.7.1 All subcontracts between HOSPITAL and HOSPITAL's subcontractors pertaining to the provision of Covered Services under this Agreement ("Subcontractors") will be in writing, and will be entered into in accordance with the requirements of DHCS, CMS and, Health and Safety Code Section 1340 et seq.; Title 28, CCR, Section 1300 et seq.; and any other applicable federal and State laws and regulations.

5.7.2 All such subcontracts and their amendments will become effective only upon written approval by PLAN and will fully disclose the method and amount of compensation or other consideration to be received by the Subcontractor from the HOSPITAL.

HOSPITAL will notify the PLAN when any subcontract is amended or terminates. HOSPITAL will make available to PLAN and Governmental Agencies, upon request, copies of all agreements between HOSPITAL and Subcontract(s) for the purpose of providing Covered Services.

5.7.3 All agreements between HOSPITAL and any Subcontractor will require Subcontractor to comply with the following:

(a) Records and Records Inspection. Make all applicable books and records available at all reasonable times for inspection, examination or copying by the Governmental Agencies; and, retain such books and records for a term of at least ten (10) years from the close of DHCS' fiscal year in which the Subcontract is in effect and submit to HOSPITAL and PLAN all reports required by HOSPITAL, PLAN or DHCS.

(b) Surcharges. Subcontractor will not collect a Surcharge for Covered Services for a Member or other person acting on their behalf. If a Surcharge erroneously occurs, Subcontractor will refund the amount of such Surcharge to the Member within fifteen (15) business days of the occurrence and will notify PLAN of the action taken. Upon notice of any Surcharge, PLAN will take appropriate action consistent with the terms of this Agreement to eliminate such Surcharge, including, without limitation, repaying the Member and deducting the amount of the Surcharge and the expense incurred by PLAN in correcting the payment from the next payment due to HOSPITAL.

(c) Notification. Notify the PLAN in the event the agreement with Subcontract is amended or terminated. Notice will be given in the manner specified in Section 10.4 (Notices) below.

(d) Assignment. Agree that assignment or delegation of the subcontract will be void unless prior written approval is obtained from the PLAN.

(e) Additional Requirements. Be bound by the provisions of Section 9.7 (Survival of Obligations After Termination), and Section 7 (Hospital Indemnification), and any other provisions of this Agreement that state that they apply to subcontractors.

SECTION 6.
RECORDS AND CONFIDENTIALITY

6.1 Maintenance of Records. HOSPITAL shall maintain books, charts, documents, papers, reports, management information systems, procedures and records (including, but not limited to, financial, accounting, and administrative records, patient medical records, encounter data, prescription files, laboratory results, subcontracts and Authorizations) and supporting documentation related to Members and Services provided hereunder to Members both medical and non-medical, to the cost thereof, to the manner and amount of payments,

including payments received from Members or others on their behalf, to the manner in which HOSPITAL administers its daily business, and to the financial condition of HOSPITAL ("Records"). Records include notes, documents, reports and other information related to Provider disputes and determinations. HOSPITAL shall maintain Records in accord with the general standards applicable to that book or record keeping, and shall ensure that an individual is responsible for securing and maintaining such Records. Records shall be legible, current, organized, accurate, comprehensive, and kept in a secure location with detail (i) consistent with appropriate medical and professional practice and prevailing community standards, (ii) which permits effective internal professional review and external medical audit process, and (iii) which facilitates an adequate system for follow- up treatment. The Member's medical record shall reflect (i) whether the Member has executed an advance directive, (ii) the language needs of the Member, and (iii) any request for, offer of and refusal of language interpretation services. The Provider Manual outlines additional Medical Records requirements. HOSPITAL shall be fully bound by the requirements in Title 42 of the Code of Federal Regulations, relating to the maintenance and disclosure of Member Records received or acquired by federally assisted alcohol or drug programs. HOSPITAL shall preserve Records for the longer of (i) ten (10) years after termination of this Agreement, and (ii) the period of time required by state and federal law and Membership Contracts, including the period required by, to the extent applicable, the Knox-Keene Act and Regulations, and by the Medicare Program, unless a longer period is stipulated. If there is any litigation, claim, negotiation, audit, review, examination, evaluation, or other action pending at the end of such period, then HOSPITAL shall retain said Records until such action is completed.

6.2 Access to and Copies of Records. PLAN and its authorized agents shall have access to and may inspect the Records, subject to reasonable request and notification requirements, and subject to any legal requirements regarding confidentiality. HOSPITAL shall transmit Record information by fax when requested. HOSPITAL shall provide copies of Records to PLAN upon request, at no charge for the first copy and at Twenty-five cents ($.25) per page for any additional copies. HOSPITAL shall, subject to any legal requirements regarding confidentiality, provide access to Records and other information as required by Government Officials and accrediting organizations. Medical Records for Members shall be available to providers at Member encounters as set forth in Title 28 CCR Section 1300.67.1 (c). Members shall have access to their Medical Records, and where legally appropriate, may receive copies of, amend, or correct their Medical Records. HOSPITAL shall provide any notice to, or obtain any consent from, Members or, as appropriate, persons authorized to consent on behalf of Members, as may be required by any applicable federal or State laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the California Medical Information Act ("CMIA"), regarding the receipt, use and disclosure of Protected Health Information and Medical Information, as those terms are defined in HIPAA and CMIA respectively.

6.3 Copies of Clinical Information. For all Members receiving covered Services, HOSPITAL will promptly forward copies of initial consultation reports upon completion of consult, and summaries of patient care or patient results upon completion of patient care or discharge, to the Member's Primary Care Physician. HOSPITAL shall provide copies of such clinical information to the Primary Care Physician at no charge.

6.4 Disclosure to Government Officials. HOSPITAL shall comply with all provisions of law regarding access to books, documents and records. Without limiting the foregoing, HOSPITAL shall maintain, provide access to, and provide copies of Records, this Agreement and other information to the Director of the Department, DHCS, External Quality Review Organizations, the Bureau of State Audits, the State Auditor, the Joint Legislative Audit Committee, the California Department of General Services, the California Department of Industrial Relations, certified Health Plan Employer Data Information Set ("HEDIS") auditors from the National Committee on Quality Assurance, the California Cooperative Healthcare Reporting Initiative, the U.S. Department of Justice, the Secretary of the U.S. Department of Health and Human Services, the U.S. Comptroller General, the Centers for Medicare and Medicaid Services, Peer Review Organizations, their designees, representatives, auditors, vendors, consultants and specialists and such other officials entitled by law (collectively, "Government Officials") as may be necessary for compliance by PLAN with the provisions of all state and federal laws and contractual requirements governing PLAN, including, but not limited to, the Act and the regulations promulgated thereunder and the requirements of Medicare program. Such information shall be available for inspection, examination and copying at all reasonable times at HOSPITAL's place of business or at some other mutually agreeable location in California. Copies of such information shall be provided to Government Officials promptly upon request. The disclosure requirement includes, but is not limited to, the provision of information upon request by DHCS, subject to any lawful privileges, relating to threatened or pending litigation by or against DHCS. HOSPITAL shall use all reasonable efforts to immediately notify DHCS of any subpoenas, document production requests, or requests for records received by HOSPITAL related to this Agreement.

6.5 Reporting

6.5.1 HOSPITAL, upon reasonable advance request, shall supply PLAN or PLAN's designated agent with periodic reports and information pertaining to (i) Services provided to Members by HOSPITAL or its subcontracted health care providers, (ii) Provider directory and network information, and (iii) HOSPITAL's financial resources, on such forms and within such times as requested by PLAN, and which will enable PLAN to meet all federal and state legal and contractual reporting requirements. HOSPITAL shall also supply PLAN with other reports as reasonably requested.

6.5.2 HOSPITAL certifies and warrants that all reports, invoices, papers, documents, books of account, instruments, data, information, forms of evidence and other Records submitted to Plan or Government Officials pursuant to this Agreement are current, accurate, timely, true, complete and in full compliance with legal and contractual requirements, and do not contain any material misrepresentations or omissions. HOSPITAL shall immediately notify PLAN if any of HOSPITAL's certifications and warranties cease to be true at any time during the term of this Agreement.

6.6 Confidentiality of Information

6.6.1 Notwithstanding any other provision of this Agreement, names of Members receiving public social services hereunder are confidential and are to be protected from unauthorized disclosure. For the purpose of this Agreement, all information, records, data, and data elements collected and maintained for the operation of the Agreement and pertaining to Members shall be protected by HOSPITAL from unauthorized disclosure. HOSPITAL and its employees, agents, and subcontractors shall protect from unauthorized disclosure names and other identifying information concerning persons either receiving services pursuant to this Agreement or persons whose names or identifying information become available or are disclosed to HOSPITAL, its employees, agents, or subcontractors as a result of services performed under this Agreement, except for statistical information not identifying any such person.

6.6.2 With respect to any identifiable information concerning any Member or person that is obtained by HOSPITAL, HOSPITAL, its employees, agents and subcontractors (i) will not use any such information for any purpose other than carrying out the express terms of HOSPITAL's obligations under this Agreement, (ii) will promptly transmit to PLAN all requests for disclosure of such information except Member requests for Medical Records in accordance with applicable law, and (iii) will not disclose except as specifically permitted by this Agreement, any such information to any party other than PLAN or DHCS, without prior written authorization specifying that the information is releasable under Title 42, and regulations adopted thereunder, and (iv) will, at the expiration or termination of this Agreement, return all such information to PLAN or maintain such information according to written procedures sent to PLAN by DHCS for this purpose. Upon PLAN's request, HOSPITAL shall provide a signed Declaration of Confidentiality in the format set forth in the Provider Manual, prior to the Effective Date.

6.6.3 HOSPITAL shall comply with all federal, state and local laws which provide for the confidentiality of Records and other information. HOSPITAL shall not disclose any confidential Records or other confidential information received from PLAN or Government Officials or prepared in connection with the performance of this Agreement, unless PLAN or Government Officials specifically permits HOSPITAL to disclose such Records or information. HOSPITAL shall promptly transmit to PLAN any and all requests for disclosure of such confidential Records or information. HOSPITAL shall not use any confidential information gained by HOSPITAL in the performance of this Agreement except for the sole purpose of carrying out HOSPITAL's obligations under this Agreement. HOSPITAL shall comply with Title 42 and all other applicable provisions of law which provide for the confidentiality of records and prohibit their being opened for examination for any purpose not directly connected with the administration of public social services. Whether or not covered by such sections, confidential medical or personnel records and the identities of clients and complainants shall not be disclosed unless there is proper consent to such disclosure or a court order requiring disclosure. Confidential information gained by HOSPITAL from access to any such records, and from contact with its clients and complainants, shall be used by HOSPITAL only in connection with its conduct of the program under this Agreement.

6.6.4 HOSPITAL shall protect the security and confidentiality of all eligibility and enrollment data and all other personal information and protected health information about Members in accordance with the Information Practices Act, Civil Code Section 1798 et seq., and all other applicable State and federal laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the regulations promulgated thereunder. All financial, statistical, personal, technical and other data and information relating to the State's operations which are designated confidential by the State and which become available to HOSPITAL shall be protected by HOSPITAL from unauthorized use and disclosure. HOSPITAL shall not use any individual identifiable information or other confidential information for any purpose other than carrying out the provisions of this Agreement. Upon request by PLAN, HOSPITAL shall provide a copy of its policies and procedures for preserving the confidentiality of medical records, as outlined in California Health and Safety Code Section 1364.5. HOSPITAL shall make itself available to DHCS at no cost to DHCS to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against DHCS, its directors, officers or employees based upon claimed violation of HIPAA, the HIPAA regulations or other laws relating to security and privacy, except where HOSPITAL is a named adverse party.

SECTION 7.
INSURANCE AND INDEMNIFICATION

7.1 Hospital Insurance. Throughout the term of this Agreement and any extension thereto, HOSPITAL will maintain appropriate insurance programs or policies as follows:

7.1.1 Each participating HOSPITAL covered by this Agreement will secure and maintain, at its sole expense, liability insurance, or other risk protection programs, in the amounts of at least ONE MILLION DOLLARS ($1,000,000) per person per occurrence and THREE MILLION DOLLARS ($3,000,000) in aggregate, including "tail coverage" in the same amounts whenever claims made malpractice coverage is involved.

7.1.2 Notification of PLAN by HOSPITAL of cancellation or material modification of the insurance coverage or the risk protection program will be made to PLAN at least thirty (30) days prior to any cancellation. Upon PLAN's request, documents evidencing professional liability insurance or other risk protection required under this Subsection will be provided to PLAN upon execution of this Agreement.

7.1.3 General Liability Insurance. In addition to Subsection 6.1.1 above, HOSPITAL will also maintain, at its sole expense, a policy or program of comprehensive liability insurance (or other risk protection) with minimum coverage including and no less than Three Hundred Thousand Dollars ($300,000) per person for HOSPITAL'S property together with a Combined Single Limit Body Injury and Property Damage Insurance of not less than Three Hundred Thousand Dollars ($300,000). Documents evidencing such coverage will be provided to PLAN upon request. The HOSPITAL

will arrange with the insurance carrier to have automatic notification of insurance coverage termination or modification given to PLAN.

7.1.4 Workers' Compensation. HOSPITAL'S employees will be covered by Workers' Compensation Insurance in an amount and form meeting all requirements of applicable provisions of the California Labor Code. Documents evidencing such coverage will be provided to PLAN upon request. The HOSPITAL will arrange with the insurance carrier to have automatic notification of insurance coverage termination or modification given to PLAN.

7.2 Plan Insurance. PLAN, at its sole cost and expense, will procure and maintain a professional liability policy to insure PLAN and its agents and employees, acting within the scope of their duties, in connection with the performance of PLAN's responsibilities under this Agreement.

7.3 Hospital Indemnification. HOSPITAL shall indemnify and hold harmless PLAN its officers, directors, agents, and employees, from and against any and all loss, damage, liability, or expense (including without limitation, reasonable attorney's fees), of any kind arising by reason of the acts or omissions of HOSPITAL and its officers, directors, agents, employees, agents and shareholders acting alone or in collusion with others. HOSPITAL also agrees to hold harmless both the State and Members in the event that PLAN cannot or will not pay for services performed by HOSPITAL pursuant to this Agreement. The terms of this section shall survive the termination of this Agreement.

7.4 PLAN Indemnification: PLAN shall indemnify and hold harmless HOSPITAL its officers, directors, agents, and employees, from and against any and all loss, damage, liability, or expense (including without limitation, reasonable attorney's fees), of any kind arising by reason of the acts or omissions of PLAN and its officers, directors, agents, employees, agents and shareholders acting alone or in collusion with others. The terms of this section shall survive the termination of this Agreement.

SECTION 8.
DISPUTE RESOLUTION

8.1 Dispute Resolution. For disputes unresolved by the PLAN provider appeals process, PLAN and HOSPITAL agree to meet and confer in good faith to resolve any disputes that may arise under or in connection with this Agreement. In all events and subject to the provisions of this Section which follow, HOSPITAL shall be required to comply with the provisions of the Government Claims Act (Government Code Section 900, et. seq.) with respect to any dispute or controversy arising out of or in any way relating to this Agreement or the subject matter of this Agreement (whether sounding in contract or tort, and whether or not involving equitable or extraordinary relief) (a "Dispute").

8.2 Judicial Reference. The parties may mutually agree in writing (but shall not be obligated to agree) that a Dispute shall be heard and decided by a referee appointed pursuant to California Code of Civil Procedure Section 638 (or any successor provision thereto, if applicable), who shall hear and determine any and all of the issues in any such action or proceeding, whether of fact or law, and to report a statement of decision, subject to judicial review and enforcement as provided by California law, and in accordance with Chapter 6 (References and Trials by Referees), of Title 8 of Part 2 of the California Code of Civil Procedure, or any successor chapter. The referee shall be a retired judge of the California superior or appellate courts determined by agreement between the parties, provided that in the absence of such agreement either party may bring a motion pursuant to the said Section 638 for appointment of a referee before the appropriate judge of the Sacramento Superior Court. The parties acknowledge that they forego any right to trial by jury in any judicial reference proceeding. The parties agree that the only proper venue for the submission of claims to judicial reference shall be the courts of general jurisdiction of the State of California located in Los Angeles. The parties reserve the right to contest the referee's decision and to appeal from any award or order of any court. The designated non prevailing party in any Dispute shall be required to fully compensate the referee for his or her services hereunder at the referee's then respective prevailing rates of compensation. For the avoidance of doubt, neither party shall be obligated or required to submit the Dispute to judicial reference, arbitration or any other alternative dispute resolution procedure.

8.3 Limitations. Notwithstanding anything to the contrary contained in this Agreement, any suit, judicial reference or other legal proceeding must be initiated within one (1) year after the date the Dispute arose or such Dispute shall be deemed waived and forever barred; provided that, if a shorter time period is prescribed under the Government Claims Act (Government Code Section 900, et. seq.), then, the shorter time period (if any) prescribed under the Government Claims Act shall apply.

8.4 Venue. Unless otherwise specified in this Section, all actions and proceedings arising in connection with this Agreement shall be tried and litigated exclusively in the state or federal (if permitted by law and a party elects to file an action in federal court) courts located in the County of Sacramento California.

SECTION 9.
TERM AND TERMINATION

9.1 Initial Term and Renewal. This Agreement shall be effective as of the Effective Date and shall remain in effect for a term of one (1) year, and will thereafter renew automatically for one (1) year terms unless terminated sooner as set forth below.

9.2 Termination Without Cause. HOSPITAL or PLAN may terminate this Agreement without cause at any time upon providing the other party with ninety (90) days prior written notice.

9.3 Immediate Termination for Cause by PLAN. The PLAN may terminate this Agreement immediately by written notice to HOSPITAL upon the occurrence of any of the following events:

9.3.1 The suspension or revocation of HOSPITAL'S license; or

9.3.2 HOSPITAL fails to meet PLAN Credentialing Criteria;

9.3.3 The discontinuance by HOSPITAL of the provision of Covered Services as confirmed and agreed by both parties hereto; or

9.3.4 If PLAN determines pursuant to procedures and standards adopted in its Utilization Management Program or Quality Improvement Program that HOSPITAL has provided or arranged for the provision of services to Members which are not medically necessary or provided or failed to provide Covered Services in a manner which violates any provision of this Agreement or the Provider Manual; or

9.3.5 If PLAN determines that the continuation hereto constitute as a threat to the health, safety or welfare of any Member; or

9.3.6 If PLAN determines that HOSPITAL has filed a petition for bankruptcy or reorganization, insolvency, as defined by law, or PLAN determines that HOSPITAL is unable to meet financial obligations as described in this Agreement; or

9.3.7 If HOSPITAL breaches Section 10.10 (Marketing Activity and Patient Solicitation) (such breach of said Section 10.10 shall not be subject to the cure specified in Section 9.4 (Termination for Cause with Cure Period)).

9.4 Immediate Termination for Cause by HOSPITAL. The HOSPITAL may terminate this Agreement immediately by written notice to PLAN upon the occurrence of any of the following events:

9.4.1 revocation of PLAN's license necessary for the performance of this Agreement;

9.4.2 PLAN breaches any material term, covenant, or condition of this Agreement.

9.4.3 PLAN's stop-loss insurance, reinsurance or insolvency insurance is canceled or not renewed.

9.5 Termination for Cause With Cure Period. In the event of a material breach by either party other than those material breaches set forth in Section 9.3 (Immediate Termination for Cause by Plan) above of this Agreement, the non-breaching party may terminate this Agreement upon thirty (30) days written notice to the breaching party setting forth the reasons for such termination; provided, however, that if the breaching party cures such breach within twenty (20) days of receipt of this notice, then this Agreement will not be terminated because of such breach unless the breach is not subject to cure.

9.6 Continuation of Services Following Termination. Should this Agreement be terminated, HOSPITAL will, upon mutual agreement, continue to provide Covered Services to Members who are under the care of HOSPITAL at the time of termination until the services being rendered to the Members by HOSPITAL are completed, unless PLAN has made

appropriate provision for the assumption of such services by another hospital. HOSPITAL will ensure an orderly transition of care for Members, including but not limited to the transfer of Member medical records. Payment by PLAN for the continuation of services by HOSPITAL after the effective date of termination will be subject to the terms and conditions set forth in this Agreement including, without limitation, the compensation provisions herein. The costs to HOSPITAL of photocopying such records will be reimbursed by the PLAN at a cost not to exceed $.25 per page.

9.7 Member Notification Upon Termination. Notwithstanding Section 9.3 (Immediate Termination for Cause by PLAN), upon the receipt of notice of termination by either PLAN or HOSPITAL, and in order to ensure the continuity and appropriateness of medical care to Medicare Members, PLAN at its option, may immediately inform Members of such termination notice.

9.8 Survival of Obligations After Termination. Termination of this Agreement will not affect any right or obligations hereunder which will have been previously accrued, or will thereafter arise with respect to any occurrence prior to termination. Such rights and obligations will continue to be governed by the terms of this Agreement. The following obligations of HOSPITAL will survive the termination of this Agreement regardless of the cause giving rise to termination and will be construed for the benefit of the Member: a) Section 9.5, Continuation of Services Following Termination; b) Section 6, Records And Confidentiality; and, c) Section 7.3, HOSPITAL Indemnification. Such obligations and the provisions of this Section will supersede any oral or written agreement to the contrary now existing or hereafter entered into between HOSPITAL and any Member or any persons acting on their behalf. Any modification, addition, or deletion to the provisions referenced above or to this Section will become effective on a date no earlier than thirty (30) days after the DHCS has received written notice of such proposed changes. HOSPITAL will assist PLAN in the orderly transfer of Members to other Participating Hospitals.

9.9 Access to Medical Records Upon Termination. Upon termination of this Agreement and request by PLAN, HOSPITAL will allow the copying and transfer of medical records of each Member to the HOSPITAL assuming the Member's care at termination. Such copying of records will be at PLAN's expense if termination was not for cause. PLAN will continue to have access to records in accordance with the terms hereof.

9.10 Interruption of Services. Should a substantial part of the services which HOSPITAL has agreed to provide hereunder be interrupted for a period in excess of thirty (30) days, PLAN shall have the right to terminate this Agreement upon providing ten (10) days prior written notice to HOSPITAL.

9.10.1 In the event the operations of HOSPITAL's facilities, or any substantial portion thereof, are interrupted by war, fire, insurrection, riots, the elements, earthquakes, acts of God, or without limiting the foregoing, any other cause beyond the control of HOSPITAL, the HOSPITAL shall be relieved of its obligations with respect to the provisions of this Agreement (or such portions hereof which HOSPITAL is thereby rendered incapable of performing) for the duration of such interruptions.

9.10.2 Nothing contained herein shall be construed to limit or reduce PLAN's obligation to pay HOSPITAL for Covered Services rendered to Members prior to or subsequent to an event described herein.

SECTION 10.
GENERAL PROVISIONS

10.1 Assignment. Neither party may assign its rights, duties or obligations under this Agreement, either in whole or in part, without the prior written consent of the other.

10.2 Amendment. This Agreement may be amended at any time upon written agreement of both parties. This Agreement may only be amended by the PLAN upon thirty (30) days written notice to the HOSPITAL if the amendment is required due to change in regulatory provisions. No obligation under this Agreement or an Attachment hereto may be waived by any party hereto except by an instrument in writing in the form of an Amendment.

10.2.1 If the HOSPITAL does not give written notice of termination within sixty (60) days, as authorized by Section 10.4 (Notices), HOSPITAL agrees that any such amendment by PLAN will be a part of the Agreement.

10.2.2 Unless HOSPITAL notifies PLAN that it does not accept such amendment, the amendment, will become effective sixty (60) days after the date of PLAN's notice of proposed amendment.

10.2.3 Notwithstanding the foregoing, PLAN may amend this Agreement with prior written notice to HOSPITAL in order to maintain compliance with State and Federal Law and the agreement. Such amendment shall be binding upon HOSPITAL and shall not require the consent of HOSPITAL.

10.3 Severability. If any term, provision, covenant, or condition of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions hereof will remain in full force and effect and will in no way be affected, impaired, or invalidated as a result of such decision.

10.4 Notices. All notices required or permitted to be given by this Agreement shall be in writing and may be delivered personally, by certified or registered U.S. Postal Service mail, return receipt requested, postage prepaid, or by U.S. Postal Service Express mail, Federal Express or other overnight courier that guarantees next day delivery, and shall be deemed sufficiently given if served in the manner specified in this Section. Notices shall be delivered or mailed to the parties at the addresses set forth beneath their respective names on the signature page of this Agreement. Each party may change its address by giving notice as provided in this Section. Notices given by certified or registered mail, return receipt requested, shall be deemed given on the date of delivery shown on the receipt card, or if no delivery date is shown, the postmark date. Notices delivered by U.S. Postal Service Express mail, Federal Express or overnight courier that guarantees next day delivery shall be deemed given twenty-four (24) hours after delivery of the notice to the U.S. Postal Service, Federal Express or overnight courier.

10.5 Entire Agreement. This Agreement, together with the Attachments and the PLAN Provider Manual, contains the entire agreement between PLAN and HOSPITAL relating to the rights granted and the obligations assumed by this Agreement. Any prior agreement, promises, negotiations or representations, either oral or written, relating to the subject matter of this Agreement not expressly set forth in this Agreement are of no force or effect.

10.6 Headings. The headings of articles and paragraphs contained in this Agreement are for reference purposes only and will not affect in any way the meaning or interpretation of this Agreement.

10.7 Governing Law. The laws of the State of California, the United States of America, and the contractual obligations of PLAN will govern the validity, construction, interpretation and enforcement of this Agreement. Any provision required to be in this Agreement by law, regulation, or the Plan-to-Plan Agreement will bind PLAN and HOSPITAL whether or not provided in this Agreement.

10.8 Treatment Alternatives. PLAN or HOSPITAL will not interfere with and will allow the physician-patient communication regarding appropriate treatment alternatives nor will a penalty be accessed to the physician for discussing medically necessary or appropriate medical care for the patient.

10.9 Reporting Fraud and Abuse. HOSPITAL is responsible for reporting all cases of suspected fraud and abuse, as defined in 42 CFR, Section 455.2, where there is reason to believe that an incident of fraud and/or abuse has occurred by Members or by PLAN contracted physicians within 10 days to PLAN for investigation.

10.10 Marketing Activity and Patient Solicitation. HOSPITAL will not engage in any activities involving the direct marketing of Members without the prior approval of PLAN and DHCS.

10.11 Direct Solicitation. HOSPITAL will not engage in direct solicitation of Members for enrollment, including but not limited to door-to-door marketing activities, mailers and telephone contacts.

10.12 Nondisclosure and Confidentiality. Both parties shall not disclose the payment provisions of this Agreement except as may be required by law.

10.13 Non-Exclusive Agreement. To the extent compatible with the provision of Covered Services to Members for which HOSPITAL accepts responsibility hereunder, HOSPITAL reserves the right to provide hospital services to persons who are not Members. Nothing contained herein will prevent HOSPITAL from participating in any other prepaid health care program.

10.14 Counterparts. This Agreement may be executed in two (2) or more counterparts, each one of which will be deemed an original, but all of which will constitute one and the same instrument.

10.15 HIPAA. HOSPITAL and PLAN each acknowledge that it is a "Covered Entity" as that term is defined in the Standards for Privacy of Individually Identifiable Health Information adopted by the U.S. Department of Health and Human Services, as modified (the "HIPAA

Privacy Rule"). Each party shall adequately protect the confidentiality of individually identifiable health information and shall comply with the HIPAA Privacy Rule and with all State and Federal Laws governing the confidentiality of Members' individually identifiable health information. If the HOSPITAL identifies any inappropriate uses of or breach of the HIPAA Privacy Rule with respect to PLAN or Members, the HOSPITAL must notify PLAN's Privacy Officer immediately.

SECTION 11.
RELATIONSHIP OF PARTIES

11.1 Overview. None of the provisions of this Agreement are intended, nor will they be construed to create, any relationship between the parties other than that of independent parties contracting with each other solely for the purpose of effectuating the provisions of this Agreement; neither is this Agreement intended, except as may otherwise be specifically set forth herein, to create a relationship of agency, representation, joint venture or employment between the parties. Unless mutually agreed, nothing contained herein will prevent HOSPITAL from independently participating as a provider of services in any other health maintenance organization or system of prepaid health care delivery.

11.2 Oversight Functions. Nothing contained in this Agreement will limit the right of PLAN to perform its oversight and monitoring responsibilities as required by applicable state and federal law, as amended.

11.3 Relationship of HOSPITAL and Contracting Physicians. It is expressly understood and agreed that no Contracting Physician or other physician shall be entitled to admit, or treat, or prescribe for Member in HOSPITAL if physician is not in good standing of HOSPITAL's Medical Staff with appropriate clinical privileges to admit and treat Members in HOSPITAL. Medical Staff membership and clinical privileges may be granted to Contracting Physicians by HOSPITAL's Governing Board, acting in conjunction with its Medical Staff, in accordance with the standards, procedures, and other provisions of HOSPITAL's Medical Staff Bylaws and the Rules and Regulations relating thereto which have been adopted by HOSPITAL's Medical Staff with the approval of said Board.

11.4 HOSPITAL Privileges of PLAN Participating Physicians. Nothing contained in this Agreement shall be construed to grant any greater rights to Participating Physicians with respect to the granting and retention of Medical Staff membership and privileges than are available to any other licensed physician; however, HOSPITAL agrees to consider, conforming to timelines in the applicable policies and procedures, any and all applications for Medical Staff membership or privileges submitted by physicians wishing to become a Participating Physician, but prevented from doing so for lack of privileges at a Primary Hospital. HOSPITAL shall render such decisions within one hundred and eighty (180) days of such application as long as the application is submitted with all requirements. Incomplete applications shall not follow this timeline. If application is denied, HOSPITAL shall submit to applicant, in writing, an explanation of the reasons for such denials.

HOSPITAL and any delegate performing the covenants of the HOSPITAL shall not deny medical staff membership or clinical privileges for reasons other than a physician's individual qualifications as determined by professional and ethical criteria, uniformly applied to all medical staff applicants and Members. Determination of medical staff membership or clinical privileges shall not be made upon the basis of:

11.4.1 The existence of a contract with the HOSPITAL or with others;

11.4.2 Membership in or affiliation with any society, medical group or teaching facility or upon the basis of any criteria lacking professional justification, such as sex, race, creed, disability, or national origin.

HOSPITAL shall henceforth notify PLAN when it revokes or modifies privileges of any physician who is also contracted with the PLAN. Written notification shall be submitted to the PLAN at the time of occurrence.

11.5 HOSPITAL does not waive the provisions of Evidence Code 1157 with regard to Medical Staff records.

SECTION 12.
ADDITIONAL LEGAL REQUIREMENTS

12.1 Compliance With Laws.

12.1.1 HOSPITAL represents, certifies and warrants that it is currently, and for the duration of this Agreement shall remain in compliance with all applicable local, State and federal laws and regulations as they become effective, including, but not limited to, those (i) regarding licensure and certification, (ii) necessary for participation in the Medicare Program, including the antifraud and abuse laws and regulations and the patient self-determination amendments of the Omnibus Budget Reconciliation Act of 1990, (iii) regarding advance directives including, but not limited to, Title 42 CFR Sections 422.128 and 438.6(i) and California Probate Code Sections 4673 to 4678 and Sections 4800 to 4806, and applicable regulations, (iv) regulating the operations and safety of facilities, including but not limited to, Title 22 CCR Section 53230, (v) regarding federal and State Occupational Health and Safety Administration (OSHA) standards, (vi) regarding communicable disease and immunization reporting, (vii) regarding not allowing smoking within any portion of any indoor facility used for the provision of health services for children as specified in the U.S. Pro-Children Act of 1994 (20 United States Code Section 6081 and following), (viii) regarding the provision of information to Members concerning Prostate Specific Antigen testing consistent with the standard set forth in California Business and Professions Code Section 2248, (ix) regarding provisions of the Health Insurance Portability and Accountability Act of 1996 and regulations, and provisions of the California Confidentiality of Medical Information Act, (x) set forth in Public Contract Code Section 6108 relating to the Sweat-free Code of Conduct, and (xi) relating to copyright laws. Payment under this Agreement will not be used

for the acquisition, operation or maintenance of computer software in violation of copyright laws.

12.1.2 As required by Title 31 U.S.C. Section 1352, if payments under this Agreement are $100,000 or more, HOSPITAL certifies to the best of its knowledge and belief that no Federally appropriated funds have been paid or will be paid, by or on behalf of HOSPITAL, to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Agreement, and the extension, continuations, renewal, amendment, or modification of this Agreement. If payments under this Agreement are $100,000 or more, HOSPITAL shall submit to PLAN the "Certification Regarding Lobbying" set forth in the Provider Manual. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Agreement, HOSPITAL shall complete and submit to PLAN standard form LLL, "Disclosure of Lobbying Activities" in accordance with its instructions. HOSPITAL shall file such disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affects the accuracy of the information contained in any disclosure form previously filed by HOSPITAL. HOSPITAL shall require that the language of this certification be included in all subcontracts at all tiers which exceed $100,000 and that all subcontractors shall certify and disclose accordingly. All such disclosure forms of subcontractors shall be forwarded to PLAN.

12.1.3 HOSPITAL shall not employ, maintain a contract with or contract with directly or indirectly, entities or individuals excluded, suspended or terminated from participation in the Medicare Program, for the provision of any Services to Members, including but not limited to, health care services, utilization review, medical social work, or administrative services with respect to Members.

12.1.4 HOSPITAL shall provide, as applicable, the ownership disclosure statement(s), the business transactions disclosure statement(s), the convicted offenses disclosure statement(s), and the exclusion from state or federal health programs disclosure statement(s), prior to the Effective Date, on an annual basis, upon any change in information, and upon request, if required by law or by PLAN's contract with other health plans for the provision of Medicare Services. Legal requirements include, but are not limited to, Title 22 CCR Section 51000.35, 42 USC Sections 1320 a-3 (3) and 1320 a-5 et seq., and 42 CFR Sections 455.104, 455.105 and 455.106. HOSPITAL shall also provide, as applicable, the "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions" and shall comply with its instructions, if required by law. Such Debarment Certification and its instructions are set forth in the Provider Manual.

12.1.5 If HOSPITAL uses economic profiling information related to any of its individual physicians or other health care Practitioners, it shall provide a copy of such information related to an individual Practitioner, upon request, to that Practitioner in accordance with the requirements of Section 1367.02 of the California Health and Safety Code. Additionally, HOSPITAL, upon request, shall make available to PLAN its policies and procedures related to economic profiling used by HOSPITAL. The term "economic profiling" as used in this Section 7.1 (e) shall be defined in the same manner as that term is defined in Section 1367.02 of the Health and Safety Code. The requirement of this Section 7.1 (e) to provide a copy of economic profiling information to an individual Practitioner shall survive termination of this Agreement in accordance with Section 1367.02 of the Health and Safety Code.

12.1.6 HOSPITAL shall immediately notify PLAN of (i) investigations of HOSPITAL in which there are allegations relating to fraud, waste or abuse, and (ii) suspected cases where there is reason to believe that an incident of fraud, waste or abuse has occurred. HOSPITAL shall comply with PLAN's antifraud plan, including it policies and procedures relating to the investigation, detection and prevention of and corrective actions relating to fraud, waste and abuse. HOSPITAL represents, certifies and warrants that it is currently, and for the duration of this Agreement shall remain in compliance with all applicable State and federal laws and regulations designed to prevent or ameliorate fraud, waste and abuse including, but not limited to, applicable provisions of the federal and State civil and criminal law, Program integrity requirements at 42 CFR Section 438.608, the Federal False Claims Act (31 USC Section 3729 et seq.), Employee Education About False Claims Recovery (42 USC Section 1396a(a)(68)), the California State False Claims Act (California Government Code Section 12650 et seq.), and the anti- kickback statute (Section 1128B(b) of the Social Security Act).

12.1.7 If required by Health and Safety Code Section 1375.4, (1) HOSPITAL shall meet the financial requirements that assist PLAN in maintaining the financial viability of arrangements for the provision of Services in a manner that does not adversely affect the integrity of the contract negotiation process, (2) HOSPITAL shall abide by PLAN's process for corrective action plans if there is a deficiency, and (3) PLAN shall disclose information to HOSPITAL that enables HOSPITAL to be informed regarding the financial risk assumed under this Agreement. In cases where the Solvency Regulations apply (28 CCR Sections 1300.75.4 through 1300.75.4.8), PLAN and HOSPITAL shall meet the requirements set forth in such Regulations. Members may request general information from PLAN or HOSPITAL about any bonuses or incentives paid by PLAN, if applicable.

12.1.8 HOSPITAL shall maintain an organizational structure sufficient to conduct the proposed operations and ensure that its financial resources are sufficient for sound business operations. If applicable, HOSPITAL shall submit financial information consistent with the filing requirements of DMHC unless otherwise specified by DHCS. If HOSPITAL is required to file monthly financial statements with DMHC, then HOSPITAL shall simultaneously file monthly financial statements

with DHCS. In addition, HOSPITAL shall file monthly financial statements with DHCS upon request.

12.1.9 If payments under this Agreement are in excess of $100,000, HOSPITAL shall comply with the following provisions unless this Agreement is exempt under 40 CFR Section 15.5. (i) HOSPITAL shall comply with all applicable standards, orders or requirements issued under section 306 of the Clean Air Act (42 USC Section 1857 (h)), section 508 of the Clean Water Act (33 USC Section 1368), Executive Order 11738, and the Environmental Protection Agency regulations (40 CFR Part 15). (ii) HOSPITAL shall comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC Section 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC Section 1251 et seq.), as amended.

12.2 Nondiscrimination.

12.2.1 HOSPITAL shall not discriminate against Members or deny benefits to Members, on the basis of race, color, creed, religion, language, sex, gender, marital status, political affiliation, ancestry, sexual orientation, sexual preference, national origin, health status, age (over 40), physical or mental disability, medical condition (including cancer), pregnancy, childbirth, or related medical conditions, veteran's status, income, source of payment, status as a Member of PLAN, or filing a complaint as a Member of PLAN. Members may exercise their patient rights without adversely affecting how they are treated by HOSPITAL. HOSPITAL shall not condition treatment or otherwise discriminate on the basis of whether a Member has executed an advance directive. HOSPITAL shall fully comply with all federal, state and local laws which prohibit discrimination, including but not limited to, Title VI of the Civil Rights Act of 1964, Title 45 CFR Part 91 the Age Discrimination Act of 1975, Section 504 of the Rehabilitation Act of 1973, 42 U.S.C. Section 2000(d), 45 C.F.R. Part 80 and 84, Title 28 CFR Part 36, Title IX of the Educational Amendments of 1973, California Government Code Section 11135, California Civil Code Section 51 and rules and regulations promulgated thereto, and all other laws regarding privacy and confidentiality. HOSPITAL shall provide reasonable access and accommodation to persons with disabilities to the extent required of a health services provider under the Americans with Disabilities Act and regulations, guidelines issued pursuant to the ADA, any applicable state law.

12.2.2 During the performance of this Agreement, HOSPITAL, its employees and agents, shall not unlawfully discriminate, deny benefits to, harass, or allow harassment against any employee or applicant for employment because of race, religion, color, national origin, ancestry, physical disability including Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), and AIDS-Related Complex (ARC), mental disability, medical condition (including health impairments related to or associated with cancer for which a person

has been rehabilitated or cured), marital status, political affiliation, age (over 40), sex, gender sexual preference, sexual orientation, pregnancy, childbirth, or related medical conditions, or the use of family and medical care leave and pregnancy disability leave pursuant to state and federal law. Hospital, its employees and agents, shall insure that the evaluation and treatment of its employees and applicants for employment are free of such discrimination and harassment. Hospital, its employees and agents, shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 (a-f), and following) and the applicable regulations promulgated there under (California Code of Regulations, Title 2, Section 7285.0 and following). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code Section 12990 (a-f), set forth in Chapter 5 of Division 4 of Title 2 of the California Code of Regulations are incorporated into this Agreement by reference and made a part hereof as if set forth in full. Hospital shall give written notice of its obligations under this clause to labor organizations with which it has a collective bargaining or other agreement.

12.2.3 Federal Equal Opportunity Requirements.

(a) HOSPITAL will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. HOSPITAL will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. HOSPITAL shall post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973 and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC Section 4212). Such notices shall state HOSPITAL's obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

(b) HOSPITAL will, in all solicitations or advancements for employees placed by or on behalf of HOSPITAL, state that all qualified applicants will receive consideration for employment without regard to race, color, religion,

sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

(c) HOSPITAL will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of HOSPITAL's commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

(d) HOSPITAL will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

(e) HOSPITAL will comply with and furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

(f) In the event of HOSPITAL's noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Agreement may be cancelled, terminated, or suspended in whole or in part and the Agreement may be declared ineligible for further federal and state contracts in accordance with procedures authorized in Federal Executive Order No. 11246 as amended and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

(g) HOSPITAL will include the provisions of subparagraphs (c)(1) through (c)(7) in every subcontract unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 USC 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor. HOSPITAL will take such action with respect to any subcontract as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions including sanctions for noncompliance provided, however, that in the event HOSPITAL becomes involved in, or is threatened with litigation by a subcontractor as a result of such direction by DHCS, HOSPITAL may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

ATTACHMENT A
DISCLOSURE FORM

TAX I.D.#

_____ _____
Name of Hospital

The undersigned hereby certifies that the following information regarding the Hospital is true and correct as of the date set forth below:

Form of Hospital (Corporation, Partnership, Sole Proprietorship, Individual, etc.):

_____

If a proprietorship, Co-Owner(s). If a partnership, partners

_____

If a corporation, stockholders owning more than ten percent (10%) of the stock of the Provider

_____

If a corporation, President, Secretary, Treasurer, Directors and Other Officers:

_____

Stockholders owning more than ten percent (10%) of the stock of the Provider:

_____

Major creditors holding more than five (5) percent of Provider debt:

_____

If not already disclosed above, is Hospital, or a co-owner, partner, stockholder, director or officer either directly or indirectly related to or affiliated with Plan? Please explain:

_____
_____
_____
_____
_____

Dated: _____ Signature: _____

Name: _____
(Please type or print)

Title: _____
(Please type or print)

ATTACHMENT B
REIMBURSEMENT

A. In exchange for Covered Services provided by Hospital to Enrollees in accordance with the terms of this Agreement, authorized by Health Plan when applicable, and within the scope of Hospital's licensing and certification, Health Plan shall pay Hospital's clean claims for such services at the following rates:

Services	**Reimbursement**
Inpatient services	115% of Hospital's Medicare Allowable Payment

Medicare Allowable Payment (Inpatient Services) will be updated in accordance with CMS changes within forty-five (45) days of receipt of new effective date.

Subject to the provisions stated herein. Hospital agrees to accept as payment in full from Health Plan for Covered Services rendered to Health Plan's Medicare Advantage Members, 115% of Hospital's Medicare allowable in effect as of the date such services are rendered and in accordance with Medicare Advantage laws, rules and regulations, less any co-payments, coinsurance, deductibles or other cost-share amounts due from such Members.

Included DRG Reimbursement Components: Notwithstanding anything to the contrary in the Agreement, the parties agree that Plan shall reimburse for Medicare inpatient prospective payment system components, in the same manner as original Medicare, including the following:

1. Base Rate MS-DRG (Includes Operating Federal Specific Portion and Capital Federal Specific Portion);

2. Capital IME

3. Disproportionate Share (Operating and Capital)

4. Bad Debt - Payor agrees to reimburse Hospital an amount as determined below for that portion of Hospital's bad debt that results from uncollected Medicare Advantage Member co-payments and deductibles. The amount reimbursed by Payor shall equal Medicare's percentage of Hospital's bad debt attributable to Medicare Advantage Members' copayments and deductibles. Payor shall have the right to audit the amounts claimed by Hospital. Hospital shall provide documentation satisfactory to Payor that Hospital has complied in all respects with all CMS regulations and rules related to Medicare beneficiary collection and bad debt write offs in connection with collection and attempts at collection of copayments and deductibles of Members enrolled in Medicare Advantage product and all other Medicare patients of Hospital. Such documentation shall be provided to Payor no later than two hundred ten (210) days following the close of the fiscal year for which bad debt reimbursement is claimed by Hospital. Failure of Hospital to provide complete documentation within such time period shall result in a fifty per cent (50%) reduction in the reimbursement. Payment of any undisputed amounts will be made by Payor within ninety (90) days following receipt by Payor of Hospital's documentation and invoice for the amount it claims for bad debt reimbursement. Notwithstanding anything to the contrary in the Agreement, the parties agree that Payor shall not reimburse Hospital for bad debt and/or any other term in addition to the base rate and the outlier in the event the CMS changes its reimbursement policies regarding such. In the event of any such

change, Payor's reimbursement will be adjusted to reflect such change without requiring contract amendment.

5. Uncompensated Care

6. Outlier Payments

7. CMS approved New Technology pass through amounts

8. Factor 8 components if approved and paid by CMS

Excluded DRG Reimbursement Components: Notwithstanding anything to the contrary in the Agreement, the parties agree that Plan shall not reimburse Hospital for the following Medicare inpatient prospective payment system components:

1. Operating IME

2. Operating and Capital GME

3. Nursing

Outpatient/Emergency Room services	135% of Medicare APC rates, less applicable copayments, coinsurance and deductibles

APC Payments shall be consistent with CMS guidelines effective on the date of service the Outpatient Services are rendered.

Notwithstanding any other reimbursement or compliance terms specified in this Agreement for all Covered Services rendered to Medicare Advantage Members (including but not limited to Members enrolled in Medicare-Medicaid alignment plans or their equivalent), the final payment amount to Hospital as determined under this Agreement shall not be reduced by value based purchasing, sequestration or any other mandatory savings reductions.

Physician Outpatient Service Reimbursement

1. For Medicare, Primary Care Provider Services are reimbursable at **One Hundred and Thirty Five Percent (135%) of Prevailing CMS Medicare rates**, for authorized services for which claims shall be processed in accordance with CMS Medicare Processing and Payment Guidelines, timely filing and timely payment , under terms mutually acceptable to both Health Plan and Provider, to enable Provider to provide health care services, to health plan members in the Medicare Advantage program; If there is no payment rate in the local and geographically adjusted Medicare Fee-For-Service schedule, as of the date of service, payment shall be reimbursed at **Thirty Percent (30%) of Billed Charges.**
2. For Medicare, Specialty Provider Services are reimbursable *at* **One Hundred and Thirty Five Percent (135%) of Prevailing CMS Medicare rates**, for authorized services for which claims shall be processed in accordance with CMS Medicare Processing and Payment Guidelines, timely filing and timely payment, under terms mutually acceptable to both Health Plan and Provider, to enable Provider to provide health care services, to health plan members in the Medicare Advantage program; If there is no payment rate in the local and geographically adjusted Medicare Fee-For-Service schedule, as of the date of service, payment shall be reimbursed at **Thirty Percent (30%) of Billed Charges.**

ATTACHMENT C
HOSPITAL IDENTIFICATION SHEET

The following must match the W-9 supplied by provider. Please enter "NA" if not applicable or not available.

Hospital Name		Billing Address (Pay to address):

DBA Name - if applicable		
Telephone No.		
Fax No.		Primary Address:
Tax I.D. # (Tin)		
License No.		
DEA No.		
State ID No.		Secondary Address:
Group NPI No.		
Email Address		
		Number (#) of Beds:

Hazel Hawkins Hospital
FOUNDATION
Caring for Our Community

TO: San Benito Health Care District Board of Directors
FROM: Liz Sparling, Foundation Director
DATE: October 2023
RE: Foundation Report

The Hazel Hawkins Hospital Foundation Board of Trustees met on October 19 in the Horizon Room.

Financial Report for September

1. Income	$	74,684.84
2. Expenses	$	1,690.67
3. New Donors		4
4. Total Donations		163

Allocations

1. $35,000 from ED Bridge Program Grant – Phase 2 Milestone to HHMH

Directors Report

- The Dinner Dance date for this year's fundraiser is November 4th. The Committee met and selected **Bonnie & Alan Clark** for our Donors of the Year, the **Community Foundation** for the Organization Donor of the Year and **Dr. Barra** as our heart for hazel recipient.
    - We still have tickets available, please contact the Foundation office if you would like to attend. 831.636.2653.
    - Our Online Auction with fantastic auction items will run from October 30 to Nov 5th. Items include courtside Warriors tickets, beach houses, wine tours, delicious dinners, parking at the Hospital and more.
- Our Development Committee continues to reach out to donors in the Community. We have been giving tours of the Hospital and presentations.
- We have Board Members terming out at the end of the year (Seth, Jill and Tisi are terming out and Nan will finish her first term). The Nominating Committee has met and new Board Members will be announced at the November Board Meeting.
- Our Audit has been submitted to our Accountant.
- We were at the San Benito County Fair September 29, 30 & Oct. 1. There was a lot of positive support from visitors to our booth about the Hospital.