Hazel Hawkins
MEMORIAL HOSPITAL

REGULAR MEETING OF THE BOARD OF DIRECTORS
SAN BENITO HEALTH CARE DISTRICT
911 SUNSET DRIVE, HOLLISTER, CALIFORNIA
THURSDAY, FEBRUARY 22, 2024 – 5:00 P.M.
SUPPORT SERVICES BUILDING, 2nd-FLOOR, GREAT ROOM
IN PERSON AND BY VIDEO CONFERENCE
https://zoom.us/j/99806542016?pwd=b2tZNnVrQzNyWFZKNGFtMFVxaXpqdz09
Meeting ID: 998 0654 2016 - Passcode 437257

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.

AGENDA

		Presented By:
1.	**Call to Order / Roll Call**	(Hernandez)
2.	**Board Announcements**	(Hernandez)
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.	(Hernandez)
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.	(Hernandez)

A. Consider and Approve Minutes of the Special Meeting of the Board of Directors – January 8, 2024

B. Consider and Approve Minutes of the Regular Meeting of the Board of Directors – January 25, 2024

C. Consider and Approve Minutes of the Special Meeting of the Board of Directors – February 12, 2024

D. Consider and Approve Policies:

Administrative
- Employment Categories
- Competency Determination and Maintenance
- Paid Time Off

Clinical
- Tenecteplase (TNKase) for Thrombolysis Therapy
- Intravenous Therapy Infection Control Guidelines
- Radiology Department Policies

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

- Skilled Nursing Facilities Reports (Mabie Southside/Northside)
- Laboratory and Radiology
- Foundation Report
- Facilities Report

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

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

5. <u>Medical Executive Committee</u> * ** (Dr. Bogey)

A. Consider and Approve Medical Staff Credentials: February 21, 2024

Recommended Action: Approval of Credentials

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

B. Consider and Approve Privileges NEW - Skilled Nursing Facility Medical Director (Medicine)

Recommended Action: Approval of Privileges

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

C. Consider and Approve Privileges Revised: Psychiatric Mental Health/Family Nurse Practitioner

Recommended Action: Approval of Privileges

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

D. Consider and Approve Policy - SNF Medical Director on the Medical Staff

Recommended Action: Approval of Policy

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

6. <u>Receive Informational Reports</u> (Pages 47 – 134)

A. Update – Potential Transaction Partners

Letters of Interest Overview (R. Peil/B. Riley)

- American Advanced Management, Inc. (Pages 47-55)
- Insight (Pages 56-65)
- County of San Benito JPA (Pages 66-129)
- SBHA – Ovation Collaboration (130-134)

Temporary Advisory Committee Update (Hernandez/Pack)

- Public Comment

B. Chief Executive Officer (Pages 135 – 178) (Casillas)

- Public Comment

C. Chief Nursing Officer (Pages 179 – 180) (Posey)

- Public Comment

D. Finance Committee (Pages 181 – 195) (Robinson)

1. Finance Committee Meeting Minutes – February 15, 2024

2. Review Financial Updates
   - Financial Statements – January 2024
   - Finance Dashboard – January 2024
   - IRS Employer FICA Liability

▶ Public Comment

7. Action Item:

A. Consider and Recommend Approval of MSR Mechanical LLC Proposal for Boiler Retrofit in the Amount of $128,500 (Pages 196 – 197) (Robinson)

Recommended Action: Approval of Proposal

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

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

9. Closed Session (Hernandez)
(See Attached Closed Session Sheet Information)

10. Reconvene Open Session / Closed Session Report (Hernandez)

11. Adjournment (Hernandez)

The next Regular Meeting of the Board of Directors is scheduled for Thursday, March 28, 2024 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.

***** Items to be Distributed Before or at the Board Meeting**

SAN BENITO HEALTH CARE DISTRICT BOARD OF DIRECTORS
FEBRUARY 22, 2024

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)

[X] 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):
San Benito Health Care District dba Hazel Hawkins Memorial Hospital, Case No. 23-50544 (United States Bankruptcy Court for the Northern District of California, San Jose Division)

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):_____

[ ] PUBLIC EMPLOYEE APPOINTMENT
(Government Code §54957)

Title:

[ ] **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.)

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

Agency designated representative:
Employee organization:
Unrepresented employee:

[ ] **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

SPECIAL MEETING OF THE BOARD OF DIRECTORS
SAN BENITO HEALTH CARE DISTRICT
SUPPORT SERVICES BLDG., 2ND-GREAT ROOM

MONDAY, JANUARY 8, 2024
2:00PM
MINUTES
IN PERSON AND BY ZOOM VIDEO CONFERENCE

MINUTES

Directors Present
Jeri Hernandez, Board Member
Josie Sanchez, Board Member
Rick Shelton, Board Member

Absent
Bill Johnson, Board Member
Devon Pack, Board Member

Also Present
Mark Robinson, Chief Financial Officer
Amy Breen-Lema, VP Clinic, Ambulatory, & Phys. Services
Andrea Posey, Interim Chief Nursing Officer
Heidi Quinn, District Legal Counsel
Chela Brewer, Executive Assistant
Suzie Mays, Director, Project Management

1. **Call to Order- Roll Call**

   Directors Hernandez, Shelton and Sanchez were present; attendance was taken by roll call. A quorum was present and the Special Meeting was called to order at 2:00 pm by Director Hernandez.

   Director Johnson was absent; Director Pack was unable to participate from his teleconference location.

2. **Update on Potential Transaction Partners**

   Richard Peil with B. Riley provided update on potential transactions partners.

   - (AAM) American Advance Management previously presented the District with a Letter of Intent (LOI), which included a term sheet that was broad in nature. AAM is in the process of preparing a revised LOI with definitive financial terms on what the transaction will look like.

- County of San Benito Proposal: There has been no significant change other than there is a scheduled meeting with the County next week, Wednesday, January 17th 2024 at Hazel Hawkins Memorial Hospital.
- San Benito Healthcare Alliance. A meeting with San Benito Healthcare Alliance Principals and their Consultants took place on December 19, 2023. Mr. Peil is expecting an update.

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

3. <u>Action Item</u>

A. Consider Temporary Advisory Committee's Recommendation regarding Insight's Letter of Intent for Proposed Business Transaction with the District and Provide Authority to Negotiate.

Director Hernandez reported that nearly a year ago in February 23, 2023 the Board of Directors received a special presentation by its financial advisor Mr. Richard Peil with B. Riley advisory regarding strategic partnership options. The Board discussed in length B. Riley's efforts to solicit interest in the Hospital and provided overview of three potential scenarios that can maximize the value of the District.

At the March 23, 2023, Regular Board Meeting, the Board identified its priorities, which included:

- Long standing history and experience with hospital administration;
- Proven track record of maintaining quality of care;
- Able to litigate risks and liabilities;
- Further develop clinics and expansion of care; and
- Secure financing.

The Board also formed a Temporary Advisory Committee (Ad Hoc Committee or Committee) and appointed Director Hernandez and Director Pack as the Committee Members.

Over the past year, the Ad Hoc Committee has been meeting with the District advisors regarding various affiliations models such as lease, sale and or a more phased approach. The Ad Hoc Committee is focused on an affiliation model that is in the best interest of the District and the community. The Committee has also discussed the various potential partners who have expressed interest in the District facilities, and has been providing regular updates to the Board and to the public.

Director Hernandez is pleased to present a Letter of Intent (LOI) from Insight to the Board for consideration. The Committee is seeking Board authority to execute the LOI and continue negotiations with Insight. Director Hernandez introduced Richard

Peil with B. Riley, Robert Miller, of Hooper, Lundy & Bookman, District consultants, and Insight, who will provide a presentation.

Richard Peil discussed the general terms of the LOI; which calls for the acquisition of all the Hospital's assets, including real estate, buildings and equipment. The estimated purchase agreement is between $59,000,000 and $65,000,000, subject to evaluation and appraisal.

Robert Miller also provided summary of LOI. and answered questions from the Board.

Insight's Atif Bawaha, Chief Strategy Officer, Baseer Tajuddin, General Counsel and Dayne Walling, Director of Public Policy & Government were in attendance. Insight commended the current Hospital leadership, provided an overview of its background, discussed its similarities to the District Hospital, and stated a commitment to invest in the community. A few highlights are set forth below:

Insight has campuses in Michigan, Illinois, and Iowa. There are similarities between Insight and Hazel Hawkins Memorial Hospital. In 2008, Insight acquired Headquarters in the inner city in Michigan. Insight started as a small office with one physician. Now it's a multi-disciplinary Heath Center, offering Neuro Surgery, Pain Management, Orthopedic, Therapy and more services.

- In 2021, Insight acquired the oldest Hospital in Chicago formally owned by Trinity Health, a safety net hospital serving about fifty percent Medicaid patients. They filed for Bankruptcy in the middle of Covid. They had losses at about 8 million per month. Insight acquired the hospital and have been able to successfully turn the hospital around with various service lines.
- Recently, Insight acquired a hospital in Iowa facing financial distress. Insight is in the early stages of stabilizing the hospital.
- Insight Commends Hazel's Leadership Team for stabilizing the hospital,
- Insight wants HHMH to continue to be a Community Hospital, and has the goal to invest in a community
- Insight plans to offer high end services such as Neurology, Surgery and more. In addition, it plans to upgrade the Emergency Department and work toward building physician network and keep service in-house

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

MOTION: By Director Hernandez to approve execution of the Letter of Intent with Insight, and Authorize District Staff to Negotiate with Insight;
Second by Director Shelton.

Moved/Seconded/and Unanimously Carried: Ayes: Directors Hernandez, Sanchez, and Shelton. Approved 3-0 by roll call, with Directors Pack and Johnson absent.

4. Public Comment

An opportunity was provided for public comment and no public comment was received.

5. Closed Session

President Hernandez announced the item to be discussed in Closed Session as listed on the posted Agenda: Conference with Legal Counsel-Existing Litigation, Government Code §54956.9(d)(1) : San Benito Health Care District dba Hazel Hawkins Memorial Hospital, Case No. 23-50544 (United States Bankruptcy Court for the Northern District of California, San Jose Division)

6. Reconvene Open Session/Closed Session Report

The Board of Directors reconvened Open Session at 3:02 p.m. District Counsel Quinn reported that in Closed Session the Board discussed Conference with Legal Counsel-Existing Litigation, Government Code §54956.9(d)(1). Information was provided to the Board, direction was given to Staff, but no reportable action was taken.

7. Adjournment:

There being no further special business or actions, the meeting was adjourned at 3:02 p.m.

The next Regular Meeting of the Board of Directors in scheduled for Thursday, January 25, 2024 at 5:00 p.m.

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REGULAR MEETING OF THE BOARD OF DIRECTORS
SAN BENITO HEALTH CARE DISTRICT
SUPPORT SERVICES BUILDING, 2ND-FLOOR, GREAT ROOM
IN PERSON AND BY VIDEO CONFERENCE

THURSDAY, JANUARY 25, 2024
5:00 P.M.
MINUTES

HAZEL HAWKINS MEMORIAL HOSPITAL

Directors Present
Jeri Hernandez, Board Member
Devon Pack, Board Member
Josie Sanchez, Board Member
Rick Shelton, Board Member

Absent:
Bill Johnson, Board Member

Also Present
Mary Casillas, Interim Chief Executive Officer
Mark Robinson, Chief Financial Officer
Andie Posey, Interim Chief Nursing Officer
Amy Breen-Lema, VP, Clinic Ambulatory & Physician Services
Michael Bogey, MD, Chief of Staff
Heidi A. Quinn, District Legal Counsel
Suzie Mays, Director of Project Management

1. **Call to Order**

   Attendance was taken by roll call; Directors Hernandez, Pack, Sanchez, and Shelton were present. Director Johnson was absent. A quorum was present and Director Hernandez called the meeting to order at 5:00 p.m.

2. **Board Announcements**

   Director Pack noted he will be attending a course on Thursdays from 6:30 – 8:30 pm.

   Director Hernandez noted if there are any technical difficulties with Zoom for tonight's meeting, the Zoom meeting will end.

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 Regular Meeting of the Board of Directors – December 21, 2023

   B. Consider and Approve Minutes of the Special Meeting of the Board of Directors – January 8, 2024

C. Consider and Approve Critical Value/Test Reporting and "Read Back" Policy

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

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

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

District Counsel Quinn recommended deferring agenda item 4.B. - Consideration and Approval of the Minutes of the Special Meeting of the Board of Directors of January 8, 2024 for further review. Staff will bring back.

MOTION: By Director Shelton to approve Consent Agenda – General Business, Items A, C, and D, as presented; Second by Director Pack.

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

As Dr. Bogey was not present, President Hernandez recommended moving to the Informational Reports.

5. **Receive Informational Reports**

A. ~~Presentation of Fair Market Valuation~~ - This item was omitted from the amended agenda.

B. Temporary Advisory Committee Update

Director Hernandez reported:

- Directors Hernandez and Pack attended several meetings with San Benito County.
- Directors Hernandez and Pack will conduct site visits to Insight facilities in Michigan and Chicago to look at processes and operations, meet with employees and community members.
- The Committee continues to perform due diligence for all submitted LOIs.

Director Pack reported:

- Due diligence is being performed with regard to Insight. Input is welcome from community leaders and representatives in Illinois and Michigan who have experience with Insight operations.

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

Dr. Bogey arrived, and the Board returned to Agenda Item 5.

6. **Report from the Medical Executive Committee Meeting on January 17, 2024 and Recommendations for Board Approval of the following:**

A. Medical Staff Credentials Reports

Dr. Bogey, Chief of Staff, provided a review of the Credentials Report dated January 17, 2024, which was included in the packet.

Item: Proposed Approval of the Medical Executive Committee Credentials Report for three (3) New Appointments, two (2) Reappointments, and four (4) Resignations/Retirements.

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

MOTION: By Director Hernandez to approve the Credentials Reports as presented; Second by Director Sanchez. .

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

B. Consider and Approve Family Medicine Privilege Revisions

Item: Proposed Approval of the Revised Application for Clinical Privileges for Family Medicine

An opportunity was provided for public comment and no public comment was received.

MOTION: By Director Hernandez to approve the Family Medicine Privileges Revisions as presented; Second by Director Shelton.

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

C. Consider and Approve Certified Registered Nurse Anesthetist Privilege Revisions:

Item: Proposed Approval of the Revised Clinical Privileges Delineation Form for Certified Registered Nurse Anesthetist Privileges

An opportunity was provided for public comment and no public comment was received.

MOTION: By Director Hernandez to approve the Revised Certified Registered Nurse Anesthetist Privileges as presented; Second by Director Pack. .

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

7. **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. Highlights include:

- Meetings have been held with the Temporary Advisory Committee to continue due diligence of all interested parties.
- Met with the Ombudsman to provide an update and schedule a site visit for February. The next Ombudsman report should be coming out in approximately a week. The Ombudsman's duty is to ensure patients are provided quality care during the bankruptcy process.
- Met with representatives of San Benito County (SBC), as well as ECG Consultants and several Board of Supervisor Members, to discuss the next phase of their proposal. The District provided a large amount of HCAI data to SBC, as requested, as part of the due diligence process and will continue to provide information as requested. The District has requested SBC provide a business plan and another meeting will be scheduled in February to discuss next steps.
- The District awaits the judge's ruling pertaining to the bankruptcy, which is anticipated to occur sometime in February.
- Two employee forums were held on January 9 to provide updates to the staff on the status of the District.
- California Hospital Association has requested Ms. Casillas to sit on a panel at the Rural Health Care Symposium in March to provide an overview regarding the status of Hazel Hawkins and steps that have been taken to keep the hospital open.
- The corrected HR Dashboard turnover rate was included in the packet.

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

B. Chief Nursing Officer

Ms. Posey provided highlights of the Chief Nursing Officer Report, which can be found in the Board packet.

- Dee Cross, RN, MLS, started on December 18 as interim DON of the Skilled Nursing Facilities. She is currently completing assessments and implementing needed changes.
- A hemorrhage cart has been added to the OR for OB patients in recovery.
- A formal patient experience program is being implemented to increase patient experience, which includes nurse leader rounding on each patient daily. This allows any concerns to be addressed in a timely fashion.
- Innova is assisting to implement a clinical documentation integrity project. This will consistent of documentation review for accuracy and completeness to help ensure good patient care and good financial management.

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

C. Financial Report

1. Finance Committee Meeting Minutes – January 18, 2024

2. Review Financial Updates

   - Financial Statements – December 2023
   - Finance Dashboard – December 2023
   - Supplemental Payments

Highlights include:

- Two agencies are involved with the Distressed Hospitals Loan Program (DHLP), including HCAI, which handles loan approvals, and CHFFA, which handles the actual loans. Weekly discussions have been held with the Cal-Mortgage representative since January 2023, who also attends meetings with CHFFA. The District completed the DHLP application in June, sent the application in July, and received the approval letter in October. All are aware of the District's financial status. According to the Cal-Mortgage representative, thirteen of the seventeen hospitals have received funding. Madera Community Hospital and Hazel Hawkins have not yet received funding. Madera filed Chapter 11 and is not a district hospital. Hazel Hawkins filed Chapter 9 and is a district hospital. The loan documents received from CHFFA were written to support a hospital in Chapter 11. For this reason, CHFFA is working to provide revisions for the District to report as needed. The District continues to work with HCAI and CHFFA weekly to complete this process. Once the loan is distributed, it will be set up as a draw as needed versus a direct check.
- The District currently has 51 days cash on hand and $19M, versus one year ago having 12 days cash on hand and $5M. This is in large due to a decrease in expenses. Changes have also been made to billing in the Emergency Department.

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

8. **Action Items**

A. Consider Recommendation for Board Approval of Consolidated CHA/ Hospital Council Dues 2024

Staff reviewed the proposed consolidated California Hospital Association / Hospital Council dues for 2024, which totaled $53,381. The invoice and installment arrangement were included in the packet.

An opportunity was provided for public comment and no public comment was received.

MOTION: By Director Hernandez to approve the Consolidated CHA/Hospital Council Dues for 2024 in the amount of $53,381; Second by Director Shelton. .

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

B. Consider Approval of Professional Services Agreement and a Recruitment Agreement for Joseph Fabry, D.O.

Staff reviewed the Professional Services Agreement and the Physician Recruitment Agreement for Joseph Fabry, D.O. The Professional Services Agreement is for a two year term with an estimated annual compensation of $536,000. The Physician Recruitment Agreement is for $20,000 and is forgivable over two years. Both agreements were included in the packet.

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

MOTION: By Director Hernandez to approve the Professional Services Agreement for Joseph Fabry, D.O. for a two year term and an estimated annual compensation of $536,000, as well as the

Recruitment Agreement for Joseph Fabry, D.O. for $20,000, as presented; Second by Director Shelton.

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

C. Consider Consider Approval of Professional Services Agreement for Stefan Klein, MD.

Staff reviewed the Professional Services Agreement for Stefan Klein, M.D. for a one-year term at a rate of $2,900 per coverage day with an estimated annual cost of $301,596. The agreement was included in the packet.

An opportunity was provided for public comment and no public comment was received.

MOTION: By Director Hernandez to approve the Professional Services Agreement for Stefan Klein, M.D. for a one-year term at a rate of $2,900 per coverage day, as presented; Second by Director Sanchez.

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

D. Consider Appointment of Mary Casillas as Chief Executive Officer and Approval of the Employment Agreement.

Staff reviewed the proposed appointment of Mary Casillas as Chief Executive Officer, as well as the proposed Employment Agreement effective November 1, 2023, for a one-year term, subject to renewal until November 1, 2027, and with an annual salary of $450,000. Ms. Casillas would be eligible for a 12-month severance package if terminated without cause. Ms. Casillas would also be eligible for a 10% discretionary incentive compensation based on achievement of certain objectives determined by the Board and in consultation with Ms. Casillas. The compensation incentive will be provided at the next Board meeting. An annual performance evaluation near the effective date of the agreement, or as otherwise scheduled by the District, will be performed.
The Staff Report, Compensation of the CEO Policy, Salary Survey, and Employment Agreement were included in the packet.

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

MOTION: By Director Hernandez to approve Appointment of Mary Casillas as Chief Executive Officer, as well as the Employment Agreement as presented; Second by Director Sanchez.

Moved/Seconded/and Unanimously Carried: Ayes: Directors Hernandez, Sanchez, and Shelton. No: Pack. Absent: Johnson. Approved 3-1 by roll call vote, with Director Pack dissenting and Director Johnson absent.

9. **Public Comment**

An opportunity was provided for public comment and no public comment was received.

10. **Closed Session**

President Hernandez announced the items to be discussed in Closed Session as listed on the posted Agenda are Conference with Legal Counsel-Existing Litigation, Government Code §54956.9(d)(1) and Hearings/Reports, Government Code §37624.3 & Health and Safety Code §1461,32155. The Board went into Closed Session at 7:47 p.m.

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

The Board of Directors reconvened into Open Session at 8:00 p.m. District Counsel Quinn reported that in Closed Session the Board discussed Conference with Legal Counsel-Existing Litigation, Government Code §54956.9(d)(1) and Hearings/Reports, Government Code §37624.3 & Health and Safety Code §1461,32155. Information was provided and no reportable action was taken.

12. **Adjournment:**

There being no further regular business or actions, the meeting was adjourned at 8:00 p.m.

The next Regular Meeting of the Board of Directors is scheduled for Thursday, February 22, 2024 at 5:00 p.m.

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SPECIAL MEETING OF THE BOARD OF DIRECTORS
SAN BENITO HEALTH CARE DISTRICT
SUPPORT SERVICES BLDG., 2ND-GREAT ROOM

MONDAY, FEBRUARY 12, 2024
5:00PM
MINUTES
IN PERSON AND BY ZOOM VIDEO CONFERENCE

MINUTES

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

Also Present
Mary Casillas, Chief Executive Officer
Mark Robinson, Chief Financial Officer
Amy Breen-Lema, VP Clinic, Ambulatory, & Phys. Services
Andrea Posey, Interim Chief Nursing Officer
Heidi Quinn, District Legal Counsel
Suzie Mays, Director, Project Management

1. **Call to Order- Roll Call**

   Directors Hernandez, Johnson, Pack, Shelton and Sanchez were present; attendance was taken by roll call.

   A quorum was present and the Special Meeting was called to order at 5:00 pm by Director Hernandez.

2. **Presentation on Fair Market Value**

   Ms. Casillas introduced Jeff Piehl, Partner at Healthcare Appraisers (HCA). Other representatives present from HCA included Nick Janiga, Matt Muller, Jeff Doyle, and Ben Cloutier. Robert Miller of Hooper, Bookman & Lundy and District consultant Richard Peil of B.Riley also attended via zoom in the event the Board had questions.

   HCA performed a fair market valuation of San Benito Healthcare District d/b/a Hazel Hawkins Memorial Hospital. A presentation, which is available online, was provided to the Board of the valuation summary and questions answered.

   An opportunity was provided for public comment and individuals were given three minutes.

3. **Adjournment:**

There being no further business or actions, the meeting was adjourned at 6:09 p.m.

The next Regular Meeting of the Board of Directors in scheduled for Thursday, February 22, 2024 at 5:00 p.m.

Hazel Hawkins MEMORIAL HOSPITAL

Employment Categories

Disclaimer

Revision Insight

Document ID:	12058
Revision Number:	0
Owner:	Drew Tartala, HR Manager
Revision Official Date:	No revision official date

Revision Note:
Policy has been updated uploaded in HTML format.

Policy : Employment Categories

PURPOSE

The purpose of this Policy is to identify and define the employee classifications and Fair Labor Standards Act exemption status for San Benito Health Care District employee positions. These classifications do not guarantee employment for any specified period of time. The right to terminate the employment relationship at will at any time is retained by both the employee and SBHCD.

POLICY

It is the policy of SBHCD to classify all employees for purposes of employee benefits, as well as categorize all employees for wage and hour requirements in compliance with the Federal Fair Labor Standards Act (FLSA). This policy may not apply if the employee union contract stipulates differently.

PROCEDURE

Fair Labor Standards Act Job Classifications

SBHCD employees are designated as either nonexempt or exempt under state and federal wage and hour laws:

- **Nonexempt employees** are employees whose work is covered by the Fair Labor Standards Act (FLSA). They are *not* exempt from the law's requirements concerning minimum wage and overtime. The department must keep accurate records of hours worked for employees in non-exempt positions. Employees in such positions must be paid for hours actually worked, and must receive overtime compensation at a premium rate, when applicable.
- **Exempt employees** are generally executives, managers, professionals, administrative or other staff who are exempt from the minimum wage and overtime provisions of the FLSA. Exempt employees hold jobs that meet the standards and criteria established under the FLSA by the U.S. Department of Labor.

Company Job Classifications

SBHCD has established the following categories for both nonexempt and exempt employees:

- **Regular full-time employees** are regularly scheduled to work the company's full-time schedule at a minimum of 36 hours a week or 72 a pay period. Generally, they are eligible for the full benefits package, subject to the terms, conditions and limitations of each benefit program.
- **Regular part-time employees** are regularly scheduled to work less than the full-time schedule but at least 20 hours each week or 40 hours a pay period. Regular part-time employees are eligible for some of the benefits offered by the company, subject to the terms, conditions, and limitations of each benefit program.
- **Per Diem employees** are scheduled to work below a minimum of 20 hours a week, or below 40 hours a pay period or on an on-call basis. Per Diem employees are not eligible for benefits offered by the company, excluding sick time, which is subject to the terms, conditions, and limitations of that policy. In order to maintain your per diem status, you must be available to work a minimum of six (6) shifts a month, including 1 weekend shift. Failure to provide your availability by the first of each month may result in the termination of your employment.
- **Exempt employees** are part-time or full-time employees who occupy designated positions and are paid on a salaried basis. Exempt employment does not require that a record of hours be maintained. Pursuant to Payroll Based Journal (PBJ) requirement, all SNF exempt employees must punch in to confirm that they have arrived for their scheduled shifts. Exempt employees are eligible for some of the benefits offered by the company, subject to the terms, conditions, and limitations of each benefit program.

Status Change

Changes in employee status are determined by the needs of the district for adequate staffing. Status changes are considered when an employee has worked three consecutive months in a status different from their present classification. Changes in employee status are left to managerial and district discretion as to whether the change is necessary for prolonged periods. In the event any part-time or full-time employee convert to a per diem status, will be paid out all accruals, with the exception of Continue Education and Sick. Continuing Education will be eliminated and sick time will be reduced to 24 hours a calendar year with a maximum accrual of 48 hours.

REFERENCES

Federal Fair Labor Standards Act

Document ID	12058	**Document Status**	In preparation
Department	Human Resources	**Department Director**	Quintana, Mario
Document Owner	Tartala, Drew	**Next Review Date**	
Revised	[11/01/2009], [12/01/2012], [09/01/2019], [03/01/2021], [04/01/2023]		
Keywords	labor, employee		
Attachments: (REFERENCED BY THIS DOCUMENT)			
Other Documents: (WHICH REFERENCE THIS DOCUMENT)			

Hazel Hawkins MEMORIAL HOSPITAL

Competency Determination and Maintenance

Disclaimer

Revision Insight

Document ID:	12059
Revision Number:	0
Owner:	Drew Tartala, HR Manager
Revision Official Date:	No revision official date

Revision Note:
Policy has been updated. Format changed from Word to HTML.

Policy : Competency Determination and Maintenance

POLICY

The objective of this policy is to assure that all employees are informed and capable regarding the knowledge, skills, and abilities necessary to fulfill their professional roles, as delineated in their respective position description duty and criteria statements. Competency moves along a continuum of education and experience, and it varies by position description and included responsibilities. In addition, however, certain knowledge and skills must be demonstrated by all employees.

PRACTICE

Competency Requirements

1. By the end of the probationary period as stated by company policy and union contract, the new employee must demonstrate:
    a. Familiarity with the District mission and vision statement;
    b. Knowledge and competency defined in his/her position description, and presumed as the basis for hiring;
    c. Competency in the use of specific information technology; (hardware/software/procedures) as specified in his/her position description; and
    d. Familiarity and compliance with the standards of punctuality, productivity, proactivity, and professionalism;
2. On an annual basis, the employee must
    a. Complete annual safety training courses;
    b. Obtain a satisfactory rating on his/her performance evaluation; and
    c. Complete position-specific competency requirements, as defined in his/her position description.
3. Continuingly, the employee must maintain competence through one or more of the following;
    a. Participation in District/hospital and department committee and staff meetings;
    b. Participation in department-based projects (continuous quality improvement);
    c. Attendance at outside seminars related to specialty information technology practice or other position-specific topics;
    d. Completion of accredited educational course work;
    e. Attendance at department-based in-service training.

Competency Evaluation:

1. When competency is evaluated;
    a. On an annual basis, in conjunction with performance review, and by random observation; and for new employees: after the probationary period.
2. How competency is evaluated:
    a. Methods for validating competency, to be determined by the evaluator and described to the employee in advance of the evaluation event, may include one or more of the following: direct observation, skills demonstration, and written evaluation.

Age-Specific Competencies:

1. Staff members must demonstrate the knowledge and skills necessary to provide care appropriate to the age of the patient served.
2. The age-specific needs of the patients need to be reflected in the appropriate staff competence assessment.
3. Information sources for evaluating age-specific competencies are:
    a. Staff interviews can provide an overview of what made the employee qualified.
    b. Inservice and continuing education experience.
    c. Observation of daily work.
    d. Peer review of daily work performance.
    e. Patient satisfaction surveys.
    f. Annual evaluations.

Competency Filing

Upon completion of the position-required competencies outlined by The Joint Commission and other regulatory agencies, the Director or designee shall provide a copy to Human Resources.

Document ID	12059	**Document Status**	In preparation
Department	Human Resources	**Department Director**	Tartala, Drew
Document Owner	Tartala, Drew	**Next Review Date**	
Revised	[04/01/1998], [08/01/2000], [05/01/2004], [09/01/2019], [03/01/2021]		
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Keywords	education, probation, knowledge, compliance,		
Attachments: (REFERENCED BY THIS DOCUMENT)			
Other Documents: (WHICH REFERENCE THIS DOCUMENT)			

Paid Time Off Policy

Disclaimer

Revision Insight

Document ID:	12061
Revision Number:	0
Owner:	Drew Tartala, HR Manager
Revision Official Date:	No revision official date

Revision Note:
New policy.

Policy : Paid Time Off Policy

PURPOSE

San Benito Health Care District (SBHCD) provides a flexible bank of paid time off (PTO) to all eligible benefited employees to enable employees to meet both their work and personal needs. SBHCD believes that PTO is valuable for employees not only to make their work experience with the company personally satisfying but also to enhance their productivity.

ELIGIBILITY

All benefited full-time and part-time employees who have successfully completed their introductory period are eligible to participate in the company's PTO program. Employees, who are eligible for PTO, are not to exceed their regularly scheduled hours per day and not to exceed their PTO balance. Request should be made two weeks in advance.

DEFINITIONS

Kin Care: Kin care leave is time provided to employees to take time off work to care for a family member. These family members include:

- A child — biological child, adopted child, foster child, stepchild, legal ward, or a child for which the employee stand's in *loco parentis*;
- A parent — biological parent, adoptive parent, foster parent, stepparent, or legal guardian;
- A spouse;
- A registered domestic partner;
- A grandparent;
- A grandchild;
- A sibling; or
- Designated person — any individual related by blood or whose association with the employee is the "equivalent of a family relationship,"

PROCEDURE

PER DIEM EMPLOYEES

While per diem employees are not eligible for our PTO accruals, they will earn sick time on a prorated basis. Upon successfully completing 90 days of employment, employees may begin to use paid sick time in increments of two hours, up to a maximum of 40 hours, or five days, whichever is greater, per calendar year.

Accrued, unused time under this policy will carry over each year up to a maximum accrual of 80 hours or ten days, whichever is greater.

Leave under this policy may be used in connection with the diagnosis, care or treatment of an existing health condition for, or the preventive care of, an employee or an employee's family member (Kin Care). As defined above, Kin Care allows up to one-half of the annual allotment of sick leave. Leave under this policy may also be used for employees who are the victims of domestic violence, sexual assault or stalking.

Employees requesting time off under this policy should provide as much advanced notice to their director and human resources as practicable, and employees who take more than three days of leave will be required to provide appropriate documentation to human resources in support of the leave taken.

Unused sick time under this policy is not paid out at the time of separation from employment. However, employees who are re-employed with the company within 30 days of separation will have their accrued unused bank of time off under this policy made available to them.

BENEFITED FULL-TIME AND PART-TIME EMPLOYEES

Benefited full-time and part-time employees may use PTO for any reason listed in the per diem section as well as, vacation, family care, and personal business. As defined above, Kin Care allows up to one-half of the annual allotment of PTO, which may be used for an illness of the employee's family member. PTO under this policy may also be used for employees who are victims of domestic violence, sexual assault, or stalking. Full-time employees accrue PTO based on their regularly scheduled workweek and continuous years of service and according to the following schedule:

Years of Service	Accrual Per Pay Period	Annual Accrual (Days)	Maximum Accrual (Days)
1 Year	6.15	20	N/A
2 Years	6.46	21	40
3 Years	6.76	22	40
4 Years	7.08	23	40
5+ Years	9.23	30	40

Part-time employees receive a prorated share of the same benefits based upon the actual hours worked per payroll period.

Once an employee has reached his or her maximum PTO accrual, the employee will not become eligible to accrue any additional PTO until the employee's PTO balance falls below the maximum accrual. In addition, employees taking an unpaid leave of absence or who are on leave receiving disability payments do not accrue PTO while they are on leave.

PTO is provided to employees so that they are better able to perform their job duties. For this reason, the company requires employees to take PTO and does not permit employees to take pay in lieu of PTO, except where an employee has deferred his or her PTO at the company's request. The company also reserves the right to direct employees to take PTO when business conditions make that necessary or appropriate.

Employees who were hired before July 17, 2023 may have a legacy bank of sick, holiday, vacation, and will be required to exhaust those banks prior to using their PTO accruals. Please refer to the Employee Benefits Policy for the accrual use.

SCHEDULING PTO

PTO must be scheduled and approved by the employee's supervisor at least two weeks in advance. The company has the right to refuse an employee's application for PTO if, at the company's sole discretion, scheduling PTO at the time requested would be inconsistent with the smooth operation of the company's business. The company pays all accrued but unused PTO when an employee leaves the company.

UNSCHEDULED PTO

In some instances, it may not be possible for an employee to schedule PTO. Unscheduled PTO is only permitted in cases of medical emergencies or illness, or where otherwise legally required. Employees who need to take unscheduled PTO must comply with the following:

1. Notify their supervisors as soon as possible. Employees must personally contact supervisor and human resources as far in advance as possible, so that proper arrangements can be made to handle the employees' work in their absence. Leaving a message with another employee does not satisfy this responsibility. Employees are also responsible for informing their supervisors and human resources of the anticipated date of their return to work.
2. Provide daily updates. Employees who are using unscheduled PTO are responsible for personally contacting their supervisor each workday and providing updates on their anticipated dates of return, if a medical note is not given.
    1. An employee who is scheduled to miss more than 3 consecutive days of work will be required to submit a medical note to their supervisor and human resources.
3. Supply medical certification. The company may require employees who are absent due to their own illnesses, or to care for an ill parent, child, spouse or domestic partner, to provide appropriate medical documentation from a health care provider. The company may also, in certain instances, require a second certification from another health care provider.

Employees' failure to contact their supervisor or to provide appropriate medical certification when requested may result in denial of PTO benefits and discipline, including termination.

Leave under this policy will run concurrently with leave taken under other applicable policies as well as under local, state or federal law, including leave taken pursuant to the California Family Rights Act (CFRA) or the Family and Medical Leave Act (FMLA). Refer to our Leave of Absence Policy for more information.

For more information regarding leave under this policy, contact human resources.

CASHING OUT PTO

At present, SBHCD does not offer payout options to its staff. However, it reserves the right to periodically notify employees via email about payout options, which will be determined based on the financial status of the district. Any permanent changes to this section will be accompanied by an amendment.

Document ID	12061	**Document Status**	In preparation
Department	Human Resources	**Department Director**	Tartala, Drew
Document Owner	Tartala, Drew	**Next Review Date**	
Attachments: **(REFERENCED BY THIS DOCUMENT)**			
Other Documents: **(WHICH REFERENCE THIS DOCUMENT)**			

Tenecteplase (TNKase) for Thrombolysis Therapy

Disclaimer

Revision Insight

Document ID:	11816
Revision Number:	0
Owner:	Shanell Kerkes,
Revision Official Date:	No revision official date

Revision Note:
No revision note

Policy : Tenecteplase (TNKase) for Thrombolysis Therapy

PURPOSE

To provide guidelines in the administration of Tenecteplase (TNKase) for the management of Acute Ischemic Stroke, Myocardial Infarction/STEMI, and Pulmonary Embolism in adults for the lysis of obstructing thrombi.

DEFINITIONS

TNKase - Tenecteplase

AIS – Acute Ischemic Stroke

MI - Myocardial Infarction/STEMI

PE - Pulmonary Embolism

EHR - Electronic Health Record

eMAR - Electronic Medication Administration Record

POLICY

Patients undergoing tenecteplase therapy must have ongoing assessment of drug tolerance, side effects and efficacy. Initiation of thrombolytic therapy would primarily be in the Emergency Room with transfer to the ICU or a Comprehensive Stroke Center in the shortest time possible. In the event this is an inpatient, initiation should be in the ICU.

Inclusion Criteria:

1. Symptoms suggestive of ischemic stroke that are deemed to be disabling, regardless of improvement.
2. Diagnosis of ischemic stroke causing measurable neurological deficit.
3. Neurological deficit.
4. Onset of symptoms <4.5 hrs of stroke symptoms.
5. Age of 18 years or older.

Exclusion Criteria:

1. Symptoms suggesting subarachnoid hemorrhage.
2. Significant head trauma or prior stroke in the previous 3 months.
3. Arterial puncture at noncompressible site in previous 7 days.
4. History of previous intracranial hemorrhage.
5. Intracranial neoplasm, AVM (arteriovenous malformation), or aneurysm.
6. Recent intracranial or intraspinal surgery.
7. Elevated blood pressure (Systolic >185mmHg or Diastolic > 110mmHg).
8. Active Internal bleeding.
9. Platelet count < 100,000/mm3.
10. Current use of anticoagulant with INR >1.7 or PT>15s.
11. Heparin received within 48 hr resulting in abnormally elevated aPTT above the upper normal limit.
12. Blood Glucose Concentration <50 mg/dL.
13. Current use of direct thrombin inhibitors or direct factor Xa inhibitors.
14. CT demonstrates multilobular infarction.

Relative Exclusion Criteria:

1. Only minor or rapidly improving stroke symptoms
2. Pregnancy
3. Seizure at onset with postictal residual neurological impairments
4. Major surgery or serious trauma within previous 14 days

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5. Recent gastrointestinal or urinary tract hemorrhage (within previous 21 days)
6. Recent acute myocardial infarction (within previous 3 months)

Indication and Dosing:

	STROKE	**Myocardial Infarction**	**Pulmonary Embolism**
Max Dose	25 mg	50 mg	50 mg
Less than 60kg	0.25 mg/kg IV bolus dose over 10 seconds	30 mg single IV bolus dose over 5 seconds	30 mg single IV bolus dose over 5 seconds
60kg to less than 70kg	0.25 mg/kg IV bolus dose over 10 seconds	35 mg single IV bolus dose over 5 seconds	35 mg single IV bolus dose over 5 seconds
70kg to less than 80kg	0.25 mg/kg IV bolus dose over 10 seconds	40 mg single IV bolus dose over 5 seconds	40 mg single IV bolus dose over 5 seconds
80kg to less than 90kg	0.25 mg/kg IV bolus dose over 10 seconds	45 mg single bolus dose over 5 seconds	45 mg single bolus dose over 5 seconds
Greater than 90kg	0.25 mg/kg IV bolus dose over 10 seconds **(>100kg max dose of 25 mg)**	50 mg single bolus dose over 5 seconds	50 mg single bolus dose over 5 seconds
Comments	For patients 18 years of age and older. Administer within 4.5 hours of symptom onset.	Administer within 4.5 hours of symptom onset	Administer within 4.5 hours of symptom onset

EQUIPMENT

1. Tenecteplase (TNKase) 50 mg vial for reconstitution
2. Sterile Water for Injection USP 10mL vial
3. 10 mL syringe (MI and PE)
4. 5 mL syringe (stroke)

PROCEDURE

1. Reconstitution Preparation
    a. Determine the appropriate dose
    b. Remove shield from supplied 10 mL syringe
    c. Withdraw 10 mL of Sterile Water for Injection USP from supplied diluent vial and inject entire contents into TNKase vial to a concentration of 5mg/mL.
    d. Do not shake Reconstituted product;
    e. Gently swirl until contents are completely dissolved
    f. Reconstituted solution should be colorless to pale yellow transparent solution
    g. Withdraw appropriate dose and discard any unused solution
    h. Immediately administer to patient or refrigerate at 2-8 degrees C (36-46 F) and use within 8 hours or discard.
2. Dosing and Preparation for Stroke:
    a. Determine correct dose based on patient weight (0.25 mg/kg)
    b. Using 5 mL syringe withdraw the appropriate volume of solution based on the patient weight (solution concentration 5mg/mL)
    c. Flush line with 10 mL 0.9% Saline Flush
    d. Administer TNKase as an IV Bolus over 10 seconds
    e. Flush line with 10 mL 0.9% Saline Flush
    f. Max Dose- 25 mg

TENECTEPLASE (TNKase) DOSING FOR ACUTE ISCHEMIC STROKE

Weight (kg)	Dose (mg)	Volume (mL)
< 40 kg	Manual Calculation	Manual Calculation
≥ 40 kg to < 41 kg	10 mg	2 mL
≥ 41 kg to < 43 kg	10.5 mg	2.1 mL
≥ 43 kg to < 45 kg	11 mg	2.2 mL
≥ 45 kg to < 47 kg	11.5 mg	2.3 mL
≥ 47 kg to < 49 kg	12 mg	2.4 mL
≥ 49 kg to < 51 kg	12.5 mg	2.5 mL
≥ 51 kg to < 53 kg	13 mg	2.6 mL
≥ 53 kg to < 55 kg	13.5 mg	2.7 mL
≥ 55 kg to < 57 kg	14 mg	2.8 mL
≥ 57 kg to < 59 kg	14.5 mg	2.9 mL
≥ 59 kg to < 61 kg	15 mg	3 mL
≥ 61 kg to < 63 kg	15.5 mg	3.1 mL
≥ 63 kg to < 65 kg	16 mg	3.2 mL
≥ 65 kg to < 67 kg	16.5 mg	3.3 mL
≥ 67 kg to < 69 kg	17 mg	3.4 mL
≥ 69 kg to < 71 kg	17.5 mg	3.5 mL
≥ 71 kg to < 73 kg	18 mg	3.6 mL
≥ 73 kg to < 75 kg	18.5 mg	3.7 mL
≥ 75 kg to < 77 kg	19 mg	3.8 mL
≥ 77 kg to < 79 kg	19.5 mg	3.9 mL
≥ 79 kg to < 81 kg	20 mg	4 mL
≥ 81 kg to < 83 kg	20.5 mg	4.1 mL
≥ 83 kg to < 85 kg	21 mg	4.2 mL
≥ 85 kg to < 87 kg	21.5 mg	4.3 mL
≥ 87 kg to < 89 kg	22 mg	4.4 mL
≥ 89 kg to < 91 kg	22.5 mg	4.5 mL
≥ 91 kg to < 93 kg	23 mg	4.6 mL
≥ 93 kg to < 95 kg	23.5 mg	4.7 mL
≥ 95 kg to < 97 kg	24 mg	4.8 mL
≥ 97 kg to < 99 kg	24.5 mg	4.9 mL
≥ 99 kg	25 mg (MAX DOSE)	5 mL

3. Dosing and Preparation for MI or PE
   a. Determine correct dose based on patient weight
   b. Using a 10 mL syringe, withdraw the appropriate volume of solution based on patient weight (solution concentration is 5 mg/mL; discard remainder)
   c. Flush line with 10 mL 0.9% Saline flush
   d. Administer TNKase as an IV Bolus over 5 seconds
   e. Flush line with 10 mL 0.9% Saline flush
   f. Max Dose- 50 mg

Weight (kg)	Dose (mg)	Volume (mL)
<30 kg	30 mg	6 mL
60 kg to < 70 kg	35 mg	7 mL

	70 kg to < 80 kg	40 mg	8 mL
	80 kg to < 90 kg	45mg	9 mL
	90 kg or greater	50mg	10 mL

4. Dosing Considerations:
    a. Hepatic and Renal adjustments- no specific dose adjustment information available
    b. Geriatric
        i. Consider administering 50% of usual dosage in patients 75 years of age or older.
    c. TNKase is NOT COMPATIBLE with any solution containing DEXTROSE.
    d. Flush IV line with 0.9% Saline BEFORE and AFTER TNKase administration
5. Monitoring Parameters:
    a. CBC
    b. aPTT
    c. signs and symptoms of bleeding
    d. ECG monitoring

DOCUMENTATION

1. Document amount of bolus and amount of medication infused over the hour in the Nursing Documentation on the eMAR.
2. Document vital signs, cardiac rhythm, and modified NIHSS in EHR.
3. Document any side effects in the nursing rounds or notes, such as bleeding, headache, hematuria, Hemoccult test suspected emesis and stool monitor, hallmark signs and symptoms of intracerebral hemorrhage (ICH): neurological deterioration, acute hypertension and/or nausea and vomiting, altered level of consciousness, seizure, etc. Notify MD immediately.
4. Document any teaching in regard to the protocol.

REFERENCES

- Guidelines for the Early Management of Patients With Acute Ischemic Stroke: 2019 Update to the 2018 Guidelines for the Early Management of Acute Ischemic Stroke: A Guideline for Healthcare Professionals From the American Heart Association/American Stroke Association Stroke Volume 50, Issue 12, December 2019, Pages e344-e418; 2018
- Guidelines for the Early Management of Patients With Acute Ischemic Stroke A Guideline for Healthcare Professionals From the American Heart Association/American Stroke Association Stroke. 2018;49:e46–e99
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- Parsons M, Spratt N, Bivard A, et al. A RCT of Tenecteplase versus alteplase for acute ischemic stroke. N Engl J Med.2012;366(12):1099-1107
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- Micromedex Solutions. Greenwood Village, CO: Truven Health Analytics. http://micromedex.com

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Department	Emergency Department	**Department Director**	Kerkes, Shanell
Document Owner	Kerkes, Shanell	**Next Review Date**	
Keywords	TNK, AIS, stroke, STEMI, embolism,		
Attachments: (REFERENCED BY THIS DOCUMENT)			
Other Documents: (WHICH REFERENCE THIS DOCUMENT)			

Hazel Hawkins MEMORIAL HOSPITAL

Intravenous Therapy Infection Control Guidelines

Disclaimer

Revision Insight

Document ID:	10815
Revision Number:	1
Owner:	Michael Hame,
Revision Official Date:	No revision official date

Revision Note:
Formatting, adding missing guidance from CLABSI policy, updating with chlorhexidine bathing guidance

Policy : Intravenous Therapy Infection Control Guidelines

Summary/Intent

PURPOSE:

A. To provide policies for intravascular therapy which insure aseptic technique.

B. To provide mechanisms for recognition of intravascular device use infectious complications.

C. To provide guidelines for maintenance and replacement of intravascular device use catheters.

D. To reduce the infectious complications associated with intravascular device use including central venous catheter associated blood stream infections.

Definitions

DEFINITIONS OF DEVICE USES:

A. Devices used for short-term vascular access

1. Short Peripheral Venous Catheters and Butterflies - usually inserted into veins of forearm or hand, remain most commonly used IV devices.
2. Peripheral Arterial Catheters - used to monitor hemodynamic status of critically ill patients.
3. Mid-line catheters - 3 to 8 inch peripheral catheters inserted via the antecubital fossa into proximal basilic or cephalic veins.
4. Nontunneled Central Venous Catheters - most commonly used central catheter.
5. Central Arterial Catheters - Pulmonary artery catheter (Swan-Ganz Catheters) inserted through an introducer.
6. Pressure monitoring systems - used in conjunction with arterial catheters.

B. Peripherally Inserted Central Venous Catheters

1. Peripherally inserted CVC's (PICC's) provide an alternative to subclavian or jugular vein catheterization and are inserted into superior vena cava via cephalic or basilar vein, often placed in the upper arm.

C. Devices used for long-term Vascular Access

1. Tunneled central venous catheters - surgically implanted central catheters - Hickman, Broviac, Groshong and Quinton. Catheters have a tunneled portion exiting the skins cuff just inside the exit site.
2. Totally implanted intravascular devices (Mediport) - devices tunneled beneath the skin, but has a subcutaneous port or reservoir with a self-sealing septum that is accessed by needle puncture through intact skin.

Affected Departments/Services

1. This is an organization-wide program. It applies to all care settings involved in the insertion and management of vascular access devices.

Policy: Compliance: Key Elements

POLICY:

A. The following guidelines will be followed to reduce infectious complications associated with intravascular device use.

B. It is the policy of San Benito Health Care District to implement practices consistent with evidence-based standards of care to reduce the risk of infection including central venous catheter associated blood stream infections. These practices include, but are not necessarily limited to, the following:

1. Education of Physicians & Staff

    a. Physicians and staff will be educated upon hire (staff) and initial appointment (physicians) and on an annual basis thereafter about healthcare associated bloodstream infections and the importance of prevention.

2. Education of Patients and Family

    a. When possible – consistent with the patient's clinical condition and emergent need of the procedure – the patient and/or family will be educated about central line associated blood stream infections.

3. Equipment and Supplies

    The organization will assure that equipment and supplies are available when a central line is inserted:

    - Central venous catheter
    - Central venous catheter insertion kit
    - Sterile drapes
    - Barrier protection as outlined in this policy
    - Chlorhexidine based antiseptic skin preparation (not required for patients < 2 months of age)
    - Local anesthetic
    - Line maintenance anticoagulant appropriate to the line type and patient age / presentation
    - Site dressing, securement device, chlorhexidine containing sponge dressing for patients older than 2 months of age

PROCEDURAL GUIDELINES:

A. Surveillance for Catheter-Related Infection

1. Palpate the catheter insertion site for tenderness daily through the intact dressing.
2. Visually inspect the catheter site if the patient develops tenderness at the insertion site, fever without obvious source, or symptoms of local or bloodstream infection.
3. In patients who have large, bulky dressings that prevent palpation or direct visualization of the catheter site, remove the dressing, and visually inspect the catheter site at least daily, and apply a new dressing.
4. Record the date of catheter insertion appropriately in Meditech under "IV/Invasive Lines Assessment" for inpatient, and under "IV Therapy for Emergency Department placement.

B. Hand washing

1. Wash hands before and after palpating, inserting, replacing, dressing, or otherwise manipulating any intravascular device.

C. Barrier Precautions During Catheter Insertion and Care

1. Peripheral

    a. Wear gloves when inserting an intravascular device.

    b. Wear gloves when changing the dressings on intravascular devices.

2. Central

    a. Use sterile technique, using maximal sterile barrier including sterile gown and gloves, a mask, cap are to be worn by all healthcare personnel involved in the catheter insertion procedure.

    b. The patient is to be covered with a large sterile drape during catheter insertion and also when exchanging a catheter over a guide wire.

D. Cannula Selection

- Peripheral Venous Catheters

1. Selection of the cannula is influenced by the intended purpose and duration of use, known complications related to the individual patient and experience at the facility.
2. Consider use of midline catheters when the duration of IV therapy is expected to exceed 6 days.
3. Teflon or polyurethane catheters are acceptable for routine peripheral infusions when sites are rotated routinely.

- Central Venous and Arterial Catheters

1. Use a single-lumen central venous catheter, unless multiple ports are essential for the management of the patient.
2. Use a peripherally inserted central venous catheter, a tunneled catheter, or an implantable vascular access device for patients 4 years of age or older, in whom long-term vascular access of greater than 30 days is anticipated. Consider use of totally implantable access devices for younger pediatric patients who require long-term vascular access.

E. Cannula Insertion Site Selection

- Peripheral

1. In adults an upper extremity site is preferred to a lower extremity for catheter insertion.
2. In pediatric patients' scalp, hand or foot sites are preferred to a leg, arm or antecubital fossa site.

- Central and Arterial

1. Weigh risks and benefits of placing a device at a recommended site to reduce infectious complications against the risk of mechanical complications.
2. Use subclavian rather than jugular or femoral sites for central venous catheter placement unless medically contraindicated.

F. Catheter Site Care During Insertion

1. Strict aseptic technique is employed when inserting a cannula.
2. Hand hygiene must be performed by all staff involved in the procedure prior to catheter insertion
3. Hair in the insertion area is cut or clipped rather than shaved, if necessary, to facilitate the adherence of the dressing.
4. Whenever a central venous catheter is inserted, the following shall occur:
    - If possible, the procedure should be explained to the patient and family. Appropriate consent – if required – should be obtained for non-emergent need.
    - NHSN central line insertion practices adherence monitoring and procedure checklist form will be completed.
    - Maximal sterile barrier precautions are to be used including sterile gown and gloves, a mask, cap and eye protection and are to be worn by all healthcare personnel involved in the catheter insertion procedure. The patient is to be covered with a large sterile drape during catheter insertion and also when exchanging a catheter over a guide wire for insertion of central "deep" lines.
    - Catheters should not be inserted into the femoral vein unless other sites are not available
    - Catheters should be secured in place and a sterile occlusive dressing applied following insertion.
    - Confirmation of proper placement (e.g. x-ray or other test) may be performed.
5. A chlorhexidine-based antiseptic skin preparation shall be used on all patients over 2 months of age unless contraindicated. For all other patients, the physician shall determine the appropriate antiseptic skin before the catheter insertion. Allow the antiseptic to remain on the insertion site for the manufactures recommended time before inserting the catheter. When tincture of iodine is used for skin antisepsis, remove it with alcohol prior to inserting the catheter.
6. Do not palpate the insertion site after the skin has been cleansed with the antiseptic.
7. After insertion secure the cannula to prevent movement at the insertion site using a non suture securement device.

G. Accessing and Removal of Central Venous Catheters

1. To reduce the risk of infection, accessing central venous catheters should be limited to necessary use.
2. Catheters will be evaluated daily by a physician and removed as soon as the patient's clinical status and needs will allow. Non-essential catheters should be removed.

H. Disinfection of Catheter Hubs and Injection Ports

1. Catheter hubs and injection ports shall be disinfected prior to each hub or port access. The following steps shall occur:

    a. Staff shall perform appropriate hand-hygiene and wear non-sterile gloves

    b. The hub or injection port shall be wiped thoroughly with a 70% alcohol swab or an alcoholic chlorhexidine preparation and allowed to dry before accessing

    c. Sterile technique will be employed

I. Catheter Site Dressing Regimens

1. Use transparent dressing to cover the catheter site.

    a. Transparent Polyurethane Film may be used on either peripheral or central lines.

    b. The evaluation of the line includes inspection and palpation of the site daily, and assurance that the dressing is intact and occlusive.

    c. The insertion site should be cleansed with a chlorhexidine-based antiseptic solution before application of the dressing. **Antimicrobial ointment is not to be used.**

2. Replace catheter-site dressings when the device is removed or replaced. Change dressing more frequently in diaphoretic patients.
3. Change dressings over the catheter site **every two days for gauze** dressings, or **every seven days for semipermeable dressings**, as well as PRN dressing changes as indicated if the dressing becomes wet, soiled or loose. If the catheter site is erythematous or has exudate the frequency of dressing changes should be increased as required to keep the site dry.
4. CVCs, PICC, hemodialysis catheters replace gauze dressing every 2 days and transparent dressings every 7 days on short-term catheters.
    i. Change dressing a minimum of every 7 days if antimicrobial patch is used; i.e. Chlorhexidine Gluconate (CHG).

    ii. Perform hand hygiene prior to handling the dressing and wear sterile gloves. Avoid touch contamination of the catheter insertion site when the dressing is replaced. Use sterile technique.

    iii. Swab the insertion site with chlorhexidine (unless contraindicated) and allow to air dry before the new dressing is applied.
5. If the patient has an unexplained fever, pain, or tenderness at the IV site, the dressing is removed and the site inspected immediately.
6. The physician shall be notified of any signs or symptoms of possible infection at the insertion site.
7. Bathe all patients with CVC, PICC or hemodialysis catheters daily with a 2% chlorhexidine wash or disposable wipe.

J. Replacement of Intravascular Devices

1. In adults, replace peripheral IV catheter and rotate site at minimum every 96 hours. This recommendation includes cannula inserted by cut down, peripheral cannulas, and heparin lock devices.
2. If the clinical condition of the patient prohibits changing the site, this needs to be documented and site appearance charted.
3. Replace catheters inserted under field emergency situations and from other facilities and insert a new catheter at a different site within 24 hours.
4. In pediatric patients, no recommendation for the frequency of catheter replacement or for the removal of catheters inserted under emergency conditions.
5. Replace peripheral arterial catheters at least every four days, including all components of the system (tubing, flushing devices and flush solutions).
6. Replace pulmonary artery (central arterial catheters Swan-Ganz) at least every 5 days. If feasible, replace arterial catheter introducer sheath every 5 days, even if catheter has been removed.
7. It is not recommended to routinely replace nontunneled central venous catheters as a method to prevent catheter-related infections.

K. Replacement of Administration Sets and Intravenous Fluids

1. Administration Sets

    a. In general, administration sets include the area from the spike of tubing entering the fluid container to the hub of the vascular device. However, a short extension tube may be connected to the vascular device and may be considered a portion of the device to facilitate aseptic technique when changing administration sets. Replace extension tubing when the vascular device is replaced.

    b. Replace IV tubing, including piggyback tubing, stopcock and needles no more frequently than 72 hours unless a problem develops.

    c. Tubing used to administer blood or blood products should be changed after every 2 consecutive units when given back to back without a delay, or after every unit if there is a delay in administration between blood product units.

    d. Tubing used to administer lipids or TPN should be changed every 24 hours.

    e. It is recommended that all administration sets be secured at junctions by luer lock devices.

    f. A single secondary set or piggyback tubing is recommended for all medications except protonix and/or dilatin which require their own line and filter. Use of single set decreases risk of contamination of connection sites to line with multiple manipulations. The piggyback line should be flushed prior to spiking a new medication bag.

2. Parenteral Fluids

    a. **No IV solution containers are hung for more than 24 hours.**

    b. TPN infusions should not hang for more than 24 hours.

    c. When lipid emulsions are given alone, not in conjunction with TPN, complete the infusion within 12 hours of hanging the emulsion.

    d. Administrations sets used consecutively shall be changed every 24 hours and immediately upon suspected contamination.

    e. Complete infusions of blood products within 4 hours of hanging the product.

L. Intravenous Admixtures

1. Strict aseptic technique is used when setting up an admix to the parenteral fluid.
2. All compounded parenteral solutions will be prepared under aseptic technique. When the compounding is not done by Pharmacy under the laminar flow hood, a clean non-congested area will be used. Preparation area and IV ports are cleaned with 70% alcohol.
3. No more than 3 sterile ingredients may be used in a single sterile product preparation made outside of the laminar hood.
4. The administration begins within 4 hour, and is completed within 24 hours of administration.
5. Use incompatibility/stability charts/references/tables appropriately.
6. Label medications properly.
7. Check all containers of parenteral fluid for visible turbidity, leaks, cracks, particulate matter, and the manufacturer's expiration date before use.
8. **Use single-dose vials for parenteral additives or medications whenever possible.**
9. **Single dose**" vials with no preservatives are considered single use and are to be used and discarded immediately.
10. **If multidose vials are used:**

    a. When a multiple use injectable vial **with preservative** is opened, the expiration date for all opened multi-dose vial will be 28 days after opened. Refrigerate multidose vials after they are opened if recommended by the manufacturer.

    b. Cleanse the rubber diaphragm of multidose vial with alcohol and allowed to air dry prior to withdrawing solution.

    c. Use a sterile device each time a multidose vial is accessed, and avoids touch contamination of the device prior to penetrating the rubber diaphragm.

    d. Ensure that only the required amount of solution is withdrawn into the syringe. If there is any excess, do not return solution to the vial; rather, discard excess solution.

    e. All multiple dose vials will contain the date, time opened, and initials of person who opened the vial.

f. Discard multidose vials into pharmaceutical waste containers when empty, when suspected or visible contamination occurs, when break in technique occurs or when the manufacturer's stated expiration date is reached. If no expiration date appears on vial, do not use, contact pharmacy immediately.

11. **Reconstituted multidose vials:** For reconstituted multiple dose vials, the manufacturer's expiration time for the particular reconstituted solution shall be used if less than 28 days. All reconstituted multiple dose vials will contain the date, time opened, and initials of person who reconstituted the vial.

M. Phlebitis

Defined as an inflammation of a vein.

1. An incidence of phlebitis shall be reported as an adverse patient outcome.
2. The nurse shall be competent to assess the access site and determine the need for treatment and or intervention in the event of phlebitis.
3. Cases of phlebitis shall be reported to the physician and the Infection Control Practitioner using the following grading criteria:

Grade	Clinical Criteria
0	No Symptoms
1	Erythema at access site with or without pain
2	Pain at access site with erythema an/or edema
3	Pain at access site with erythema and/or edema streak formation palpable venous cord
4	Pain at access site with erythema and / or edema streak formation, palpable venous cord > 1inch in length, purulent drainage

4. The hospital's incident rate will be calculated and evaluated for trends, clusters, by the Infection Control Committee.

N. Culturing for Suspected IV Related Infections

1. If an IV system is to be discontinued because of suspected IV-related infection such as purulent thrombophlebitis or bacteremia, the **skin at the skin-cannula injunction is cleansed with alcohol and allowed to dry before cannula removal.** For deep lines, the portions of the catheter which lie in the subcutaneous tissue and tip are handled with sterile technique and sent in 2 sterile containers for culture. For peripheral catheters, the entire cannula is sent in a sterile container for culture.
2. If an IV system is discontinued because of suspected fluid contamination the fluid is cultured and the implicated bottle is saved. The incident is reported as soon as possible to the Infection Prevention and Control Department and Risk Management.
3. If contamination of the fluid is confirmed, the implicated bottle and the remaining units of the implicated lot are saved, and the lot numbers of fluid and additives are recorded.
4. If "intrinsic" contamination (contamination during manufacturing) is confirmed, Risk Management shall notify the appropriate authorities (local health authorities, CDC, and the U.S. Food and Drug Administration).

REFERENCES:

- Infection Control and Hospital Epidemiology October 2008, Vol. 29, Supplement 1 SHEA/IDSA Practice Recommendation Strategies to Prevent Central Line-Associated Bloodstream Infections in Acute Care Hospital
- Camp-Sorrello, D. (ED) (2004) Access Device Guidelines: Recommendations for Nursing Practice and Education. ONS Publishing division, Pittsburg.
- Infusion Nursing Society. (2006) Policies and Procedures for Infusion Nursing. (3rd edition), Infusion Nursing Society publishing.
- CDC, (2011) Guidelines for the Prevention of Intravascular Catheter-Related Infections.
- Joint Commission National Patient Safety Goals

Document ID	10815	**Document Status**	In preparation
Department	Infection Control	**Department Director**	Hame, Michael
Document Owner	Hame, Michael	**Next Review Date**	
Original Effective Date	01/01/2010		
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Keywords	catheters, vascular, venous		
Attachments: (REFERENCED BY THIS DOCUMENT)			
Other Documents: (WHICH REFERENCE THIS DOCUMENT)			

RADIOLOGY POLICY APPROVAL PACKAGE

Table of Contents

Hazel Hawkins
MEMORIAL HOSPITAL

Mabie Southside/Northside Skilled Nursing Facility
Board Report – February 2024

To: San Benito Health Care District Board of Directors

From: Dee Cross, RN, MLS, Interim Director of Nursing, Skilled Nursing Facility

1. Census Statistics: January 2024

Southside	2024	Northside	2024
Total Number of Admissions	8	Total Number of Admissions	0
Number of Transfers from HHH	5	Number of Transfers from HHH	0
Number of Transfers to HHH	4	Number of Transfers to HHH	1
Number of Deaths	1	Number of Deaths	0
Number of Discharges	6	Number of Discharges	1
Total Discharges	7	Total Discharges	1
Total Census Days	**1,349**	**Total Census Days**	**1,386**

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: January 2024

Southside	From	Payor	Northside	From	Payor
1	HHMH	Hospice			
1	HHMH/Re-Admit	Medicare			
2	HHMH	Medicare			
1	St. Louise	Medicare			
1	Stanford	Medicare			
1	HHMH/Re-Admit	CCA			
1	SVM/Re-Admit	CCA			
Total: 8			**Total: 0**		

3. Total Discharges by Payor: January 2024

Southside	2024	Northside	2024
Medicare	2	Medicare	1
Medicare MC	0	Medicare MC	
CCA	3	CCA	
Medical	1	Medical	
Medi-Cal MC	0	Medi-Cal MC	
Hospice	1	Hospice	
Private (self-pay)	0	Private (self ay)	
Insurance	0	Insurance	
Total:	**7**	**Total:**	**1**

4. Total Patient Days by Payor: January 2024

Southside	2024	Northside	2024
Medicare	181	Medicare	53
Medicare MC	0	Medicare MC	0
CCA	1,035	CCA	1,146
Medical	91	Medical	93
Medi-Cal MC	0	Medi-Cal MC	0
Hospice	11	Hospice	0
Private (self-pay)	31	Private (self-pay)	93
Insurance	0	Insurance	0
Bed Hold / LOA	11	Bed Hold / LOA	1
Total:	**1,360**	**Total:**	**1,386**
Average Daily Census	**43.87**	**Average Daily Census**	**44.71**

Hazel Hawkins
MEMORIAL HOSPITAL

To: San Benito Health Care District Board of Directors
From: Bernadette Enderez, Director of Diagnostic Services
Date: February 2024
Re: Laboratory and Diagnostic Imaging

Updates:

Laboratory

1. Service/Outreach
   - Main Hospital outpatient laboratory open for limited hours for President's day holiday. Sunnyslope and Mc Cray draw stations closed.

2. Quality Assurance/Performance Improvement Activities
   - Annual reference range verification for coagulation tests in process.

3. Laboratory Statistics

	January 2024	YTD
Total Outpatient Volume	4213	4213
Main Laboratory	1237	1237
HHH Employee Covid Testing	15	15
Mc Cray Lab	973	973
Sunnyslope Lab	409	409
SJB and 4th Street	76	76
ER and ASC	1503	1503
Total Inpatient Volume	208	208

Diagnostic Imaging

1. Service/Outreach
   - Diagnostic Imaging Outpatient (Xray and Ultrasound) open for limited hours for President's day.

2. Quality Assurance/Performance Improvement Activities
   - Procedure charge master review in process

Hazel Hawkins
MEMORIAL HOSPITAL

3. Diagnostic Imaging Statistics

	January 2024	YTD
Radiology	1721	1721
Mammography	773	773
CT	915	915
MRI	135	135
Echocardiography	105	105
Ultrasound	747	747

Hazel Hawkins Hospital
FOUNDATION
Caring for Our Community

TO: San Benito Health Care District Board of Directors
FROM: Liz Sparling, Foundation Director
DATE: February 2024
RE: Foundation Report

The Hazel Hawkins Hospital Foundation Board of Trustees met on February 8 at Noon the in the Horizon Room. Dr. Bogey presented the need for new chairs in the ER, including guest chairs in the patient rooms and Nurse's station chairs.

Financial Report for January

1. Income $ 14,938.49
2. Expenses $ 49,965.49
3. New Donors 0
4. Total Donations 138

Allocations

1. $8100 for ER Chairs - 20 guest chairs for patient rooms and 11 Nurses Station Task Chairs

Directors Report

- We received our audit and it was presented at our Finance Committee meeting. It is a clean audit and will be presented to our Board of Directors in March.
- Our Fundraising Campaign Committee has been very busy meeting with donors and educating the public on the latest information about HHMH.
- We sent out our tax letters to all donors in 2023.
- Working on a FLEX grant for the Hospital, up to $15K available.
- Also looking into some federal seismic compliance grants.

Dinner Dance Committee:

We are planning on an in-person sit down event this year on November 2. The Committee is working on a venue that can hold over 220 people.

Scholarship Committee:

Our Scholarship Application has been posted on our website and is due by April 1. Scholarships are for students perusing their career in the medical field. We strongly encourage current HHMH employees to apply. Criteria is posted on our website: www.hazelhawkins.com/foundation

BOARD OF DIRECTORS
DISTRICT FACILITIES & SERVICE DEVELOPMENT COMMITTEE

Thursday, February 15, 2024
4:00 P.M. – Great Room

MINUTES

I. CALL TO ORDER/ROLL CALL:

The meeting of the District's Facilities & Service Development Committee was called to order by Jeri Hernandez at 4:00p.m.

COMMITTEE MEMBERS:

Jeri Hernandez, Board President	In Attendance
Bill Johnson, Board Vice President	In Attendance
Mary Casillas, VP, Chief Executive Officer	In Attendance
Mark Robinson, VP, Chief Finance Officer	
Andrea Posey, Interim, VP, Chief Nursing Officer	In Attendance
Amy Breen-Lema, VP, Clinics, Ambulatory & Physicians Services	In Attendance
Doug Mays, Senior Director, Support Services	In Attendance
William Pollard, Plant Operations Manager	In Attendance
Tina Pulido, Plant Operations\Construction Coordinator	In Attendance

II. APPROVAL OF MINUTES:

The minutes of the District's Facilities & Service Development Committee of January 18, 2024 were approved with a motion by Jeri H. and second by Bill J. with the following amendments:

1) Members Present on 1/18/2024; Bill Johnson listed as present, but was not in attendance.
2) HHH Pharmacy Pyxis Locker Installation; reported as being scheduled to be installed on 1/3/2024 as scheduled. The information should have been reported on the minutes as being installed on 1/03/24 and commissioned by vendor on 01/18/24.

III. UPDATE ON CURRENT PROJECTS:

- HHH Autoclave Replacement (Will P.)
  Will P. reported that this project is currently under HCAI review and awaiting installation date.

- HHH Boiler Replacement (Will P.)
  Will P. reported that this project is currently under HCAI review and awaiting installation date. Three bids for installation were presented to the Committee. The Committee has approved the bids to be sent to the Finance Committee for review.

- HHH Lab Equipment Replacement (Will P.)
  Will P. reported that this is a phased project. The Committee has requested that each item be listed separately on the agenda. Moving forward, the projects will be listed as follows:

  1) HHH Lab Equipment Replacement (Chemical Analyzers)
     Will P. reported that in order to accommodate the new Analyzers, they will need to consider other locations for them or possibly renovate the current Lab space. He is working with TreanorHL to come up with some ideas for the Committee to review.

  2) HHH Lab TJC POC Case Work
     Will P. reported that they are working with McKesson regarding a modular type of casework system that can be moved as needed or repurposed as needed.

- HHH Respiratory Therapy TJC POC Case Work (Will P.)
  Will P. reported that this project is awaiting installation of new base casework.

IV. UPDATE ON PENDING PROJECTS:

- IT Split System 5T Pkg. Unit (RTU) Replacement (Will P.)
  Will P. reported that they have temporarily fixed the unit, however, once the hotter weather arrives we may still have issues.

- HHH Chiller Motor Installation (Will P.)
  Will P. reported that this project is in the design stage.

- HHH Med Sur Double Door Replacement (Will P.)
  Will P. reported that this hallway door has to be replaced as it's no longer functioning properly. This project is still in the planning stage.

- HHH Radiology RTU Replacement (Will P.)
  Will P. reported that this project is in the planning stage.

V. UPDATE ON MASTER PLAN:

- SPC-4d (Will P.)
  Will P. reported that we are currently working on the following:

  1) Small and Rural Hospital Relief Program Application (PIN 71)
     Will P. reported that we are working with TreanorHL on the grant application and should be submitted to HCAI by 2/16/2024.
  2) AB 1882/OSHPD PIN 75 Signage Requirements
     Will P. reported that Hospitals are required to post their SPC/NPC status at all of the entrances of the buildings that are not in Seismic Compliance. He is working with TreanorHL and HCAI to get the signage posted.

VI. PUBLIC COMMENT:

There was no public comment.

VII. OTHER BUSINESS:

There was no other business.

VII. ADJOURNMENT:

There being no further business, the meeting was adjourned at 4:23 PM. The next Facilities Committee meeting is scheduled for March 21, 2024.

MEDICAL EXECUTIVE COMMITTEE

To be Distributed at the Board Meeting

San Benito Healthcare District,

We have spent the last several weeks wrestling with the best way to align the long-term goals that have been shared with us by both the board members and leaders of SBHD and Hazel Hawkins, and the capabilities that American Advanced Management can bring to the San Benito County market. Over the past 9 months since we first began to get to know each other, American Advanced Management has added 4 additional facilities, 3 in California and 1 in Texas, and was recently selected by Madera Community Hospital board and creditors committee to reopen the 106-bed acute care facility. As our scale continues to grow, our ability to drive value to each market that selects us to provide their care increases. We now have 9 facilities under ownership/management. We continue to pursue other acquisition opportunities in California and beyond. We believe in our experience in the complex California healthcare environment and our experience in growing the beds and volumes of the facilities in our network continue to be a great match for the needs of San Benito County moving forward.

With the primary goal of providing growth and sustainability to Hazel Hawkins Memorial Hospital, we propose the following deal structure that we hope meets the needs of SBHD. We are certainly open to discussion on the terms and structure of how best to move forward.

- American Advanced Management would pay the current value of the non-cash working capital, $7.4M is the most recent figure we have seen, plus an additional sum to bring the total initial payment to an amount equal the revenue bond liability that would be called at the time of a Change of Ownership.
- In addition to the working capital payment, AAM will pay $4,000,000 annually for a period of 10 years for a total payment of $40,000,00M for the assets of Hazel Hawkins Memorial Hospital. Our current understanding of the amount due for the revenue bond is ~$8,500,000. The total value exchanged would be $48,500,000.
- AAM will take responsibility for capital improvements and capacity increase costs, but we propose that the actual expenses incurred in NPC and SPC compliance would be treated as $1 for $1 credits for the total purchase price. This would only be during the 10 year payment period and only required seismic work with due dates during the 10 year period would be included.
- AAM will agree to continue Hazel Hawkins Memorial Hospital operations as a short-term acute care hospital with an emergency department. If AAM is in default of this requirement the assets would transfer back to San Benito Healthcare District.
- SBHD would use payments from AAM plus tax revenues to pay off general obligation bonds, fund pension plan through some debt mechanism, and pay down any other long-term liabilities that we are missing in this list.
- AAM is willing to assume the unused fund balance and future payback that unused portion of the Distressed Hospital Loan Program funds that HHMH has received.

If SBHD believes that this overall approach aligns with the needs of the District, please let us know and we will have our transactional attorney work with Robert Miller to draft deal documents and work through the large list of specific details that will be needed. If the District has specific requirements that they feel are not being met through this proposal, please share those with us so we can work together to see if a solution can be developed.

Sincerely,

AMERICAN ADVANCED MANAGEMENT, INC

Effective Date: August 3, 2023

VIA EMAIL ONLY TO mcasillas@hazelhawkins.com

Mary Casillas, MHA
Interim, Chief Executive Officer
Hazel Hawkins Memorial Hospital
911 Sunset Dr.
Hollister, CA 95023

Re: Potential Business Combination between (i) San Benito Health Care District d/b/a Hazel Hawkins Memorial Hospital ("**HHMH**") and (ii) American Advanced Management Group, Inc. or its affiliate ("**AAMG**")

Dear Ms. Casillas:

This letter (this "**Letter**") is intended to summarize the principal terms of the proposed transaction by which HHMH and AAMG, through one or more steps, would enter into a business combination transaction by which AAMG would operate and assume financial responsibility for certain assets of HHMH, including without limitation a licensed inpatient acute care hospital, outpatient surgery center, skilled nursing facility, various clinics and other properties included on the hospital campus (the "**Proposed Transaction**"). HHMH and AAMG are referred to herein collectively as the "**Parties**." Except as expressly set forth herein, this Letter constitutes a nonbinding expression of the mutual intention of the Parties to pursue the Proposed Transaction on the terms and subject to the conditions described herein.

1. Proposed Transaction. Subject to the satisfaction of the conditions described in this Letter, the structure of the Proposed Transaction is expected to be as described in Exhibit A. Notwithstanding anything to the contrary, the Parties recognize that all of the terms and structure of the Proposed Transaction are subject to the Parties' continuing review and analysis and that it may be necessary or appropriate to restructure the form and the terms of the Proposed Transaction as a result of due diligence investigation or licensing, regulatory, compliance, tax, accounting or other considerations.

2. Definitive Agreements. As soon as reasonably practicable after the execution of this Letter, HHMH shall instruct its legal counsel to draft, and the Parties shall commence to negotiate, one or more definitive agreements relating to the Proposed Transaction (the "**Definitive Agreements**"). The Definitive Agreements would include the terms summarized in this Letter and such other representations, warranties, conditions, covenants, indemnities and other terms that are customary for transactions of this kind.

3. Conditions. The Parties' obligation to proceed with the Proposed Transaction will be subject to: (i) approval of the United States Bankruptcy Court for the Northern District of California (the "**Court**"), under §§ 363, 365, 943, and/or 1123 of title 11 of the United States Code (the "**Bankruptcy Code**"), without limitation and as applicable, in the voluntary bankruptcy case filed by HHMH under chapter 9 of the Bankruptcy Code, captioned *In re San Benito Health Care District dba Hazel Hawkins Memorial Hospital*, Case No. 23-50544-SLJ; (ii) all approvals and actions required under applicable laws, rules and regulations, including without limitation the Local Health Care District Law codified at California Health and Safety Code § 32000 *et seq.* (the "**District Law**"); and (iii) customary conditions, including without limitation the following: (A) the governing bodies of the Parties approving the Proposed Transaction; (B) the Parties' execution of the Definitive Agreements; (C) the receipt of any regulatory approvals and third-party consents, on terms satisfactory to the Parties; and (D) satisfaction of conditions and covenants at the closing as are customary in similar transactions and agreements.

4. Access to Information. During the period from the signing of this Letter through the termination of this Letter pursuant to paragraph 5, the Parties will provide each other and their respective designated officers and employees, and their respective accountants, lawyers, manager, and other representatives, reasonable access during normal business hours, to all information relating to such Party's operations for the purpose of due diligence review. The due diligence investigation may include, but is not limited to, a review of the legal, tax, intellectual property and labor records and agreements relating to a Party, and any other matters as such Party's accountants, tax and legal counsel, and other advisors deem relevant in connection with the Proposed Transaction.

5. Termination. This Letter will automatically terminate and be of no further force and effect upon the earlier of (i) execution of the Definitive Agreements by the Parties; (ii) a Party's delivery of written notice to the other Party that such Party has determined not to proceed with the Proposed Transaction or (ii) mutual agreement of the Parties. Notwithstanding anything in the previous sentence, the preamble and paragraphs 5–10 shall survive the termination of this Letter and the termination of this Letter shall not affect any rights any Party has with respect to the breach of this Letter by another Party prior to such termination.

6. GOVERNING LAW. **THIS LETTER SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH INTERNAL LAWS OF THE STATE OF CALIFORNIA WITHOUT GIVING EFFECT TO ANY CHOICE OR CONFLICT OF LAW PROVISION OR RULE THAT WOULD CAUSE THE APPLICATION OF LAWS OF ANY JURISDICTION OTHER THAN THOSE OF THE AFOREMENTIONED STATE.** Each Party irrevocably and unconditionally agrees that it will not commence any action, litigation, or proceeding of any kind whatsoever against any other Party in any way arising from or relating to this Letter, the Proposed Transaction and all transactions contemplated thereby in any forum other than the Court; provided, that, if the Court does not exercise discretion over such dispute, the Parties irrevocably and unconditionally agree that such dispute shall be exclusively brought before the U.S. District Court for the Northern District of California or the courts of the State of California sitting in the County of San Benito, and any appellate court from any thereof. Each party irrevocably and unconditionally submits to the exclusive jurisdiction of such courts and agrees to bring any such action, litigation, or proceeding only in such courts. Each party agrees

that a final judgment in any such action, litigation, or proceeding is conclusive and may be enforced in other jurisdictions by suit on the judgment or in any other manner provided by law.

7. No Third-Party Beneficiaries. Except as specifically set forth or referred to herein, nothing herein is intended or shall be construed to confer upon any person or entity other than the Parties and their successors or assigns, any rights or remedies under or by reason of this Letter.

8. Expenses. The Parties will each pay their own transaction expenses, including the fees and expenses of legal counsel and other advisors, incurred in connection with the Proposed Transaction. Notwithstanding the foregoing or anything else to the contrary, if any dispute arises between the Parties concerning the enforcement or declaration of any right under this Letter, then the prevailing party shall be entitled to receive from the non-prevailing party any and all of the costs, expenses, and fees incurred by the prevailing party in connection therewith, including, without limitation, reasonable attorneys' fees and all costs and expenses associated with such dispute.

9. No Binding Agreement. Each Party agrees to negotiate the terms and conditions of the Definitive Agreement in good faith, it being understood and agreed that (i) this Letter does not purport to set forth all of the terms and conditions of the Proposed Transaction, (ii) with respect to those terms and conditions of the Proposed Transaction addressed in this Letter, this Letter does not purport to set forth all matters with respect to such terms and conditions, and (iii) the terms and conditions of the Proposed Transaction set forth in this Letter may change as a result of, among other things, the Parties' due diligence review and desire to obtain all licensing and regulatory approvals in an efficient and expeditious manner. This Letter reflects the intention of the Parties, but for the avoidance of doubt neither this Letter nor its acceptance shall give rise to any legally binding or enforceable obligation on any Party, except with regard to the preamble and paragraphs 5–10 hereof.

10. Miscellaneous. This Letter may be executed in counterparts, each of which shall be deemed to be an original, but all of which together shall constitute one agreement. Signature pages transmitted by facsimile or email shall be deemed original signatures for all purposes. The headings of the various paragraphs of this Letter have been inserted for reference only and shall not be deemed to be a part of this Letter.

[End of Text; Signature Page Follows]

This Letter will be void and the terms contained herein revoked unless accepted and returned by 5:00 p.m. (Pacific Standard Time) on August 11, 2023. If you agree with the terms set forth in this Letter and desire to proceed with the Proposed Transaction on that basis, please sign this Letter in the space provided below and return an executed copy to me at the address indicated on the letterhead.

Very truly yours,

AMERICAN ADVANCED MANAGEMENT GROUP, INC.

G Singh

By: GURPREET SINGH MD

Title: President

Agreed to and accepted:

SAN BENITO HEALTH DISTRICT d/b/a HAZEL HAWKINS MEMORIAL HOSPITAL

Mary Casillas

Mary Casillas, MHA
Interim, Chief Executive Officer

Exhibit A

Proposed Transaction

Transaction Structure	Unless impractical based or the results of the Parties' due diligence investigation and desire to obtain all licensing and regulatory approvals in an efficient and expeditious manner, the Parties intend to enter into a lease of certain assets of HHMH to AAMG (the "**Lease**"), including without limitation a licensed inpatient acute care hospital, outpatient surgery center, skilled nursing facility, various clinics and other properties included on the hospital campus (the "**Facilities**").
Fair Market Value	The Parties jointly shall retain an independent third-party valuation consultant (an "**Appraiser**") to determine the fair market value of the Proposed Transaction, including without limitation the Lease and the Purchase Option (as defined below). The Parties each shall pay one-half of the fees of such consultant.
Lease	The Lease would contemplate that HHMH would lease to AAMG, and AAMG would operate and assume financial responsibility for, the Assets, which would include: (i) the Facilities; (ii) all accounts receivable of HHMH; (iii) all current liabilities of HHMH, including without limitation all accounts payable; (iv) all assumed contracts; (v) all prepaid expenses; (vi) all inventory; (vii) all claims; (viii) all tangible and intangible property used exclusively in the operation of the Facilities, including without limitation books and records, medical records, phone numbers, advertising and promotional materials; (ix) to the extent transferable, all governmental authorizations used exclusively in the operation of the Facilities and (x) all intellectual property used exclusively in the operation of the Facilities, in each case subject to the consent or approval of any governmental authority or other person necessary to lease such assets to AAMG (collectively, the "**Assets**"). The Lease term would be between five and ten years as agreed by the Parties and would include quarterly rent payments from AAMG to HHMH in an amount commensurate with fair market value as determined by the Appraiser.
Installment Sale Purchase Option	The Lease would include an option of AAMG to purchase the Assets upon expiration of the term of the Lease (the "**Purchase Option**"). The Purchase Option would provide that, upon AAMG's exercise of the Purchase Option, the

	Parties would characterize the rent payments paid by AAMG to HHMH during the term of the Lease as payments under an installment sale contract. The purchase price under the Purchase Option would be an amount commensurate with fair market value as determined by the Appraiser. In the event that the fair market value of the Purchase Option exceeds the amount of rent payments paid from AAMG to HHMH during the term of the Lease, then AAMG would pay the remainder of the purchase price in cash at the closing of the Purchase Option (the "**Closing**"). At the Closing, AAMG would assume and own all Assets and all liabilities of HHMH in connection with the Assets except as otherwise agreed by the Parties; provided, that AAMG would not assume HHMH's unfunded pension liabilities.
Conditions and Covenants	The Purchase Option would be exercisable only if all bonds and other indebtedness of HHMH has been paid in full. The Lease would include a requirement that at all times during the term of the Lease and for a reasonable period thereafter AAMG shall cause the Facilities to continue to (i) provide all services required to maintain licensure for the Facilities, as well as those other services as agreed by the Parties and (ii) meet reasonable staffing commitments necessary to continue to provide high quality services. The Proposed Transaction would be subject to the approval of (i) the Board of Directors of HHMH and (ii) voters of HHMH, in each case to the extent required under the District Law. The Lease would include a requirement that AAMG fund and complete certain capital improvements as agreed by the Parties.
Staffing and Personnel	The Lease would contemplate that all HHMH employees providing services exclusively in the operation of the Facilities would become employees of AAMG upon commencement of the Lease.

Community Communications	The Parties will cooperate to develop a comprehensive community communications plan regarding the Proposed Transaction; provided, that nothing herein shall restrict or limit HHMH's ability to make public announcements concerning HHMH's operations. AAMG will not make any public announcements regarding the Proposed Transaction until both Parties have agreed to the substance and timing of the communications plan.

NOTE: The terms and conditions set forth in this Exhibit A ***are not binding and remain subject to due diligence and negotiation of the Definitive Agreements, which may contain different terms and conditions.***

January 2, 2024

Hazel Hawkins Memorial Hospital
911 Sunset Drive
Hollister, CA 95023
Attention: President and Chief Executive Officer

Re: Non-Binding Proposal to Purchase the Assets of Hazel Hawkins Memorial Hospital.

Ladies and Gentlemen:

This letter (this "Term Sheet") summarizes the principal terms of a proposed transaction (the "Transaction") between (i) a yet-to-be-formed California nonprofit public benefit corporation that would have Insight Foundation of America, a Michigan nonprofit corporation, as its sole member ("Purchaser") and (ii) Hazel Hawkins Memorial Hospital, a California health care district ("Hospital" or "Seller")[1], pursuant to which Purchaser would acquire certain of the assets of Hospital and continue to operate the Hospital's acute-care hospital and other facilities (collectively, the "Facilities"). For purposes of this Term Sheet, Purchaser and Hospital, as the parties to the Transaction, shall be collectively referred to as the "Parties" and individually referred to as a "Party".

1. **Proposed Principal Terms and Conditions of the Transaction.**

Parties to Transaction:

Purchaser shall be the purchaser and Hospital shall be the seller under one or more definitive agreements with respect to the Transaction, including without limitation an Asset Purchase Agreement (the "Purchase Agreement") which shall be subject to approval, as appropriate, in the Bankruptcy Proceeding.

Purchaser shall provide customary parent guarantees with respect to the obligations of Purchaser in connection with the Transaction, including, but not limited to, the obligations of Purchaser to provide indemnification pursuant to the terms of the Purchase Agreement.[2]

Purchaser will be a California nonprofit public benefit corporation duly incorporated and operated in compliance with state and federal law. Purchaser will provide in writing copies of its conflict of interest policy(ies) and all formation and

[1] Seller is a debtor in a Chapter 9 bankruptcy proceeding currently pending in the United States Bankruptcy Court for the Northern District of California (Case No. 23-50544-SLJ) (the "Bankruptcy Proceeding").
[2] NTD: Seller does not have a parent entity.

governing documents.

Acquired Assets: Subject to compliance with all applicable laws, rules and regulations, Purchaser shall purchase all right, title and interest, free and clear of any liens or liabilities, in and to all of Hospital's properties and assets set forth on Exhibit A, which shall include the buildings themselves and substantially all of the personal property used in the Hospital's operation of the Facilities (the "Acquired Assets").

Real Estate: The Parties would include the Hospital's real property associated with the operation of the Facilities (the "Real Estate") in the Acquired Assets, and Purchaser would post a bond, provide a letter of credit or otherwise provide security acceptable to HHMH to secure performance of Purchaser's obligations under the Purchase Agreement in an amount not less than the fair market value of the Real Estate.

Assumed Liabilities: Purchaser shall only assume (a) liabilities arising out of the acquisition or operation of the Acquired Assets for periods following the Closing Date and (b) the assumption, purchase or other satisfaction of other liabilities of Hospital as determined by Purchaser in its sole and absolute discretion, including designated trade creditor claims, designated vendor arrangements and Designated Contracts (collectively, the "Assumed Liabilities"). For purposes of this Term Sheet, the closing of the Transaction shall be the "Closing" and the date on which the Closing occurs and takes effect shall be the "Closing Date".

Excluded Assets: Purchaser shall not acquire, and Hospital shall retain all asset of Hospital that are not included on Exhibit A (collectively, the "Excluded Assets").

Excluded Liabilities: Other than the Assumed Liabilities, Purchaser shall not assume or otherwise be responsible or liable for or obligated with respect to any debt, liability, taxes, undertaking, expense or other obligation of Hospital or any of its subsidiaries or related to any of the Acquired Assets of any kind, character or description (collectively, the "Excluded Liabilities").

Purchase Price: The parties anticipate that the purchase price for the Acquired Assets shall be between $59,000,000 and $65,000,000. The final purchase price for the Acquired Assets shall be comprised of a cash amount in the range that an independent third party assesses as a fair market value as of the Closing Date, with the

fair market value taking into account the seismic retrofit and the covenants agreed to in the Purchase Agreement. The purchase price for the Acquired Assets shall be paid in cash at the Closing; provided, that in all events the cash at the Closing received by Hospital would be sufficient for Hospital to fund all obligations and liabilities that would become due at the Closing, including without limitation any bond obligations that would be in default if not paid in full at the Closing.

Bankruptcy Approval: The Hospital intends to implement a Plan of Adjustment through the Bankruptcy Proceeding and anticipates including the Transaction as a component of that Plan.

Designated Contracts: Prior to execution of the Definitive Agreements, Purchaser shall designate material executory contracts and unexpired leases of Hospital that Purchaser desires, via the Bankruptcy Proceeding, to be assumed and assigned to Purchaser at the Closing; provided, that the Parties anticipate that Purchase shall assume all such contracts and leases unless the Parties mutually agree to terminate them prior to the Closing (the "Designated Contracts"). To the extent requested by Purchaser, Hospital will use commercially reasonable efforts to obtain the written consent of the non-Hospital counterparty to the Designated Contracts containing restrictions on assignment if the failure to obtain such written consent would result in a breach of the applicable Designated Contract as a result of the consummation of the Transaction.

Regulatory Approvals: The Parties shall use commercially reasonable efforts to obtain all regulatory and governmental approvals and clearances necessary or advisable to consummate the Transaction and for Purchaser to operate the Facilities following the Closing, which approvals and clearances will be set forth in a schedule to the Purchase Agreement and will include all approvals required under the Local Health Care District Law set forth at California Health and Safety Code Section 32000 *et seq.* (the "Required Approvals").

Closing Conditions: The Transaction shall be subject to the satisfaction or waiver of the conditions set forth below.

1) The Parties shall have obtained all Required Approvals.

2) No Material Adverse Effect shall have occurred (as defined below).

The Closing shall not be conditioned on conditions of any other kind, including obtaining financing of any kind or due diligence.

Material Casualty Loss or Condemnation:

"Material Adverse Effect" means, with respect to the Acquired Assets, any event, occurrence, fact, condition or change that is materially adverse to (a) the business, results of operations, financial condition or assets of the Hospital, or (b) the ability of Seller to consummate the Transaction; *provided, however,* that "Material Adverse Effect" shall not include any event, occurrence, fact, condition or change, directly or indirectly, arising out of or attributable to: (i) general economic or political conditions; (ii) conditions generally affecting the industries in which the Hospital operates; (iii) any changes in financial, banking or securities markets in general, including any disruption thereof and any decline in the price of any security or any market index or any change in prevailing interest rates; (iv) acts of war (whether or not declared), armed hostilities or terrorism, or the escalation or worsening thereof; (v) any action required or permitted by the Definitive Agreements or any action taken (or omitted to be taken) with the written consent of or at the written request of Purchaser; (vi) any matter of which Purchaser is aware on the date of execution of the Definitive Agreements; (vii) any changes in applicable laws, rules or regulations or the enforcement, implementation or interpretation thereof; (viii) the announcement, pendency or completion of the Transactions, including losses or threatened losses of employees, customers, suppliers, distributors or others having relationships with the Hospital; (ix) any natural or man-made disaster or acts of God; (x) any epidemics, pandemics, disease outbreaks, or other public health emergencies; or (xi) any failure by the Hospital to meet any internal or published projections, forecasts or revenue or earnings predictions (provided that the underlying causes of such failures (subject to the other provisions of this definition) shall not be excluded).

If there is a Material Adverse Effect prior to the Closing, then Purchaser shall have the right to terminate the Purchase Agreement upon prior written notice to Hospital.

Representations, Warranties and Covenants Generally:	The Purchase Agreement will include appropriate representations, warranties and covenants with respect to the Acquired Assets, all of which will survive the Closing for one (1) year.
Indemnification:	Hospital will indemnify and hold harmless Purchaser, its affiliates and their respective representatives from all losses incurred by them relating to or arising from any Excluded Liabilities, (b) any breaches of or inaccuracies in the representations and warranties of Hospital, and (c) any breaches of any covenants of Hospital. Purchaser will indemnify and hold harmless Hospital and their affiliates and their respective representatives from all losses incurred by them relating to or arising from (a) any Assumed Liabilities and the operation of the Acquired Assets after the Closing Date, (b) any breaches of or inaccuracies in the representations and warranties of Purchaser, and (c) any breaches of any covenants of Purchaser.
Definitive Agreements	The Parties shall enter into, at minimum, the Purchase Agreement. Each definitive agreement would include operating covenants, including without limitation those set forth in Exhibit B.

2. GOVERNING LAW. **THIS TERM SHEET SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH INTERNAL LAWS OF THE STATE OF CALIFORNIA, WITHOUT GIVING EFFECT TO ANY CHOICE OR CONFLICT OF LAW PROVISION OR RULE (WHETHER OF THE STATE OF ILLINOIS, MICHIGAN OR ANY OTHER JURISDICTION) THAT WOULD CAUSE THE APPLICATION OF LAWS OF ANY JURISDICTION OTHER THAN THOSE OF THE STATE OF CALIFORNIA.**

3. Expenses. Purchaser and Hospital will each pay their own transaction expenses incurred in connection with the Transaction, including the fees and expenses of investment bankers, legal counsel and other advisors.

4. **Miscellaneous**. This Term Sheet may be executed in counterparts, each of which shall be deemed to be an original, but all of which together shall constitute one agreement. The headings of the various sections of this Term Sheet have been inserted for reference only and shall not be deemed to be a part of this Term Sheet.

5. **Binding Effect.** Notwithstanding anything to the contrary contained herein, except for the provisions of Section 2, Section 3, Section 4 and this Section 5, which are intended to be legally binding, this Term Sheet shall represent a non-binding term sheet between Purchaser and Hospital. No contract or agreement providing for any transaction, including any transaction involving the

Acquired Assets or Hospital, shall be deemed to exist between Purchaser and Hospital or any of their respective affiliates unless and until final definitive agreements have been executed and delivered.

[*Remainder of page left intentionally blank. Signature pages follow.*]

If you are in agreement with the terms set forth above and desire to proceed with the Transaction on that basis, please sign this Term Sheet in the space provided below and return an executed copy to the undersigned at your earliest convenience.

Sincerely,

PURCHASER

By: _____
Name: Atif Bawahab
Title: Chief Executive Officer

Acknowledged and agreed:

HAZEL HAWKINS MEMORIAL HOSPITAL

By: _____
Name:
Title: President and Chief Executive Officer Interim

Exhibit A

a) all of the Real Estate;

b) all of the plant, buildings, structures, installments, improvements, fixtures, betterments, and additions situated on the real property owned or leased by Hospital;

c) all of the leasehold interests of Seller in all real property that is owned by an unrelated third party and leased to Seller as lessee or tenant;

d) all bank accounts; provided, that Hospital shall retain all current and non-current cash and cash equivalents, securities, investments, endorsements, bond funds and other funds created by bond indentures, financial assurances, and certificates of deposits;

e) all accounts receivable for services rendered prior to the Closing Date;

f) all of the tangible personal property owned or, to the extent assignable or transferrable by Seller, leased, subleased, or licensed, by Seller and used in connection with the operation of the Facilities, including, without limitation, equipment, furniture, furnishings, fixtures, machinery, tools, supplies, telephones, office equipment, and real property improvements;

g) all of the interests of Seller as lessee in and to each lease, sublease, license, or other contractual obligation under which the personal property is used by Seller with respect to the operation of the Facilities;

h) all inventory used in connection with the operation of the Facilities (other than the portions of inventory disposed of, or expended, as the case may be, by Seller in the ordinary course of business);

i) all prepaid expenses;

j) all intangible personal property owned by Seller and solely used in connection with the operation of the Facilities, together with (i) all registrations and applications to register, and all rights to register, any of the foregoing, together with all renewals, extensions, and foreign counterparts of, and other registrations or applications claiming priority to, any of the foregoing, (ii) all royalties, income, and payments now owing or in the future due to the owner of any of the foregoing with respect to any of the foregoing, (iii) all damages and rights to sue and enforce any of the foregoing, including any damages and rights to sue for any past, present, or future infringement, dilution, misappropriation, or violation of any of the foregoing, (iv) all other proprietary rights and interests in any of the foregoing, (v) all data relating to any of the foregoing in any form or medium, and (vi) all copies and tangible embodiments of any of the foregoing, in any form or medium;

k) computer software, programs and hardware or data processing equipment, data processing system manuals and licensed software materials that are used in connection with the operation of one or more of the Facilities;

l) all financial and operational records of the Facilities (including all equipment records, construction plans and specifications, medical and administrative libraries, documents, catalogs, books, records, files, and operating manuals);

m) all medical staff and personnel records relating to medical staff members and employees providing services at or with respect to the Facilities or who accept employment with Purchaser (including, without limitation, peer review materials);

n) all active patient and medical records used in connection with the operation of the Facilities;

o) all insurance proceeds relating to the physical condition of the Purchased Assets, to the extent not expended on the repair or restoration of the Purchased Assets prior to the Closing;

p) the Designated Contracts;

q) to the extent transferable, all permits held by Seller required for the ownership, development, or operation of the Facilities, including the Medicare and Medi-Cal provider agreements for the Facilities;

r) all telephone and facsimile numbers, post office boxes and directory listings used in connection with the Facilities;

s) to the extent transferable, Seller's National Provider Identifiers relating to the Acquired Seller Facilities; and

t) all other rights, properties and assets of Seller that are solely used in connection with the operation of the Facilities

Exhibit B

a) maintain in good standing Purchaser's status as a nonprofit public benefit corporation under the laws of the State of California as in effect from time to time;

b) ensure continuous operation of the Facilities;

c) maintain a board that shall include a majority of its members as individuals who are independent of Purchaser's organization;

d) maintain a compliance with all applicable laws, rules and regulations in all material respects, including without limitation all requirements of any CMS provider agreements;

e) operate the Hospital so as not to illegally discriminate and in accordance with mutually agreeable quality standards and metrics;

f) maintain charity care/financial assistance policies at or above the level as such policies were in effect at the time that the Hospital was operated by San Benito Health District and that that meet or exceed Public Act 094-0885, the Fair Patient Billing Act, effective on January 1, 2007; provided, further, that the Hospital shall administer its financial assistance policy as if it were subject to Section 501(r) of the Internal Revenue Code by: (i) establishing and maintaining a written financial assistance policy ("FAP"), (ii) setting charge limits for FAP-eligible patients and (iii) making reasonable efforts to determine FAP eligibility;

g) maintain in good standing all licenses and permits associated with the Facilities;

h) continue to provide services to Medicare and Medi-Cal patients; and

i) develop and approve an annual capital expenditure budget contemplating investment in operations and capital in the sum of Fifty Million Dollars over the course of the ten- (10-) year period after the Closing.

County of San Benito
ADMINISTRATIVE OFFICE

481 FOURTH STREET, HOLLISTER, CA 95023 (831) 636-4000 FAX: (831) 636-4010 WWW.COSB.US

RAY ESPINOSA, **COUNTY ADMINISTRATIVE OFFICER**

HENIE RING, **DEPUTY COUNTY ADMINISTRATIVE OFFICER / HUMAN RESOURCES**

Ramon Aban	Dulce Alonso	Graciela Rodriguez	Christina Ruiz	Lorena Moreno
Budget Officer	**Prin. Admin. Analyst**	**Assoc. Admin. Analyst**	**Assit. Admin. Analyst**	**Exec. Assist. to CAO**

February 7, 2024

San Benito Health Care District
911 Sunset Drive
Hollister, CA 95023-5602

Re: Letter of Intent Joint Power Authority

The County of San Benito ("County") propose a potential collaboration with the San Benito Health Care District ("District") to form a Joint Powers Authority ("JPA") to capitalize, govern, and oversee the management of Hazel Hawkins Memorial Hospital.

JPAs are authorized under California Government Code § 6500, et seq., and provide a mechanism for one or more public agencies to jointly exercise powers in common to the members. In the formation of the JPA, a specific purpose is established, in this case will be focused on the operation and financing of healthcare services. JPA's have the authority to issue bonds or to enter into contracts with outside agencies, to ensure fulfillment of stated goals.

It is understood that in 2022, the District experienced significant challenges related to its cash flow, and, as a result, the District engaged with and hired a third-party, B. Riley, to improve the performance of the hospital, medical clinics, and skilled nursing facilities. B. Riley assisted in stabilizing operations and, more recently, the District experienced positive cash flow and positive net income on a consolidated basis. Notwithstanding these recent successes, which are to be commended, the District has declared Chapter 9 bankruptcy, and the County shares the concern expressed by the District board that continued operation under the current structure may not a viable way to assure our sizable and growing community that our citizens' future healthcare needs will be met.

As you are aware, the County engaged the healthcare management consulting firm, ECG, to provide an analysis of our local healthcare market, the future demand for services, the financial performance of HHMH, the clinics, and the SNFs, and to provide advice on strategic challenges, opportunities, and potential solutions. ECG subsequently developed a detailed business plan for the future operation of the hospital and clinics. The plan is focused on the establishment of a new medical group and restructuring of existing clinics. Additionally, the plan assumes that the JPA will establish partnerships with larger regional provider organizations to better meet local needs in areas such as cardiovascular medicine, stroke care, and others. A summary of this business plan is attached as Exhibit A.

The business plan demonstrates that the hospital could improve its operating margin and rebuild cash reserves, while gradually funding the now-frozen pension plan and investing in capital improvements. If effectively executed, the business plan will build the organization's cash reserves to over $100 million in year 10.

In consideration of this work and ECG's advice, the County proposes the formation of a JPA that will oversee and establish a broader community governing structure the hospital, medical clinics, and skilled nursing facilities.

The purpose of the JPA will be to:

- To foster and capitalize on the further development of and expansion of a local healthcare system to deliver high-quality healthcare services to the residents of the County and the District
- To ensure a sufficient foundation of local support and long-term financial stability
- To provide mechanisms for expanding access to care by recruiting and building a local sustainable group (>25) of medical providers.
- To maintain a locally operated healthcare delivery system focusing on a mission to serve the healthcare needs of our community versus equity shareholders.
- To operate efficient health care services by eliminating unnecessary duplication of services and resources.
- To establish a formal structure for business discussions and decision-making leading to collaborative activities.
- To oversee the additional capitalization required by the District.

The JPA will appoint an operating board to include representation by each member of the JPA. The County and the District will propose a slate of representatives to be approved by the other JPA member(s). Additionally, we are suggesting that the operating board include 3-5 additional members to include healthcare experts, community members with needed skills, and physicians.

Significant components of the County's proposal are outlined below:

1. The assets of the District will remain assets of the District, and the long-term and current liabilities will remain. The District will continue to receive supplemental tax revenue, and public bonds will be repaid as specified in current indentures.
2. The County and the District will create a JPA for the purpose of operating the hospital, skilled nursing facilities, and physician clinics owned by the District. The JPA will drive collaboration, provide financial support, and set strategic direction for the organization, enabling the community to maintain locally owned, controlled, and governed healthcare. A locally controlled health system under the JPA will allow members of our community to determine how the healthcare needs of our community are met, which serves we support and need, and what investment meets the needs of our community versus those of a private, third-party organization, particularly one that is based out-of-state.
    a. The JPA will develop an operating board, consisting of representation by the member organizations, but adding new members with different expertise, bringing

essential skills and perspectives (e.g., physicians, finance experts, healthcare administrators). A 9 to 11-member board is recommended.

b. The JPA board will be responsible for selecting the Chief Executive Officer "CEO."

3. The JPA will enter into strategic partnership agreements for various clinical services with academic organizations, such as Stanford Healthcare, or larger regional hospitals, such as Salinas Valley Health, to bolster the ability of the hospital to offer complex care, such as stroke, cardiology, neurosciences, etc.
4. The JPA will provide $12-15 million of new capital for hospital operations, consisting of a minimum of $5 million from the County and $7-10 million of public debt issued to the JPA (not the District). JPA debt is not an obligation of the JPA members unless the members choose to become liable. The incurrence of JPA debt is not subject to a public vote. This new capital will support growth and any immediate liquidity concerns. Additional capital available to the organization may also include a ~~~$7 million receivable under the federal Employee Retention Tax Credit program and $10 million previously committed by HCIA under California's Distressed Hospital Loan program. This capital will be used to fund the following:
    a. Development of a new medical group consisting of 25 physicians over a period of 5 years. These physicians will fill an increasing gap in physician capacity in the area and will drive growth to the hospital. San Benito County currently has a shortage of over 50 physicians.
    b. Funding of currently deferred capital projects, growth capital (including a cardiac catheterization lab), and future routine capital.
    c. Funding of an Electronic Medical Records ("EMR") system to replace the hospital's current antiquated system at a cost of $10 million.
    d. Funding of the unfunded employee pension liability overtime at the rate of $1-2 million per year
    e. Increasing days cash on hand (reserves) from 53 days in year 1 to 113 days in year 10. Business plan projections include:
        i. The 2023-2024 reduction of costs in employee benefits;
        ii. An increase in the severity and complexity of hospitalized patients (Case Mix Index or "CMI") from 1.15 to 1.30;
        iii. 2% growth in revenue per service; and
        iv. Volume increases of 3-5% per year.
5. The District board will have the following reserve powers:
    a. Approval of the JPA's annual operating and capital budget;
    b. JPA capital projects approval if over $5 million;
    c. Approval of strategic plan or business plan; and
    d. Approval of new services or service discontinuation.
6. The County of San Benito may adopt new development fees or other appropriate fees under the existing Community Services District (CSD) to supplement hospital revenues. These funds for <u>future</u> development are not included in the ECG business plan, <u>and financing of the business plan is not contingent on these fees</u>. The City of Hollister and the City of San Juan Bautista could choose to impose similar fees as well.

8. The District will file a Plan of Reorganization with the U.S. Bankruptcy Court in San Jose that includes the terms and capitalization plan for the JPA, and essential components outlined in the ECG business plan.

Completion of this transaction will require the approval of the San Benito County Board of Supervisors, the District Board, and the U.S. Bankruptcy Court in San Jose. It also requires the execution of the JPA Agreement, the JPA Loan Agreement, and the adoption of Articles and Bylaws for the JPA.

We propose that over the next 60-90 days the County and the District work collaboratively to (1) codify the business plan and JPA formation as the centerpiece of the District's Plan of Reorganization and (2) agree on a finalized JPA Agreement and Loan Agreement, and (3) begin the process of selecting candidates for the JPA operating board.

This letter is meant to express the County's general intent only and does not constitute an offer which may be binding or create any legal rights or obligations between the parties. The parties are free to negotiate the terms of any agreement which may be reached between them with respect to the hospital.

The County looks forward to engaging in discussions around the hospital and the formation of a JPA which the County believes to be the best path forward for the community, retaining local control of the hospital and clinic and ensuring that resident needs are met for generations.

Sincerely,

By: _____
Ray Espinosa
County Administrator
County of San Benito

By: _____
Mary Casillas
Chief Executive Officer
San Benito Health Care District

Enclosures:

a. Draft JPA Agreement
b. Timeline
c. Summary of ECG Business Plan
d. Full Narrative – Business Plan

DRAFT
FOR DISCUSSION

JOINT POWERS AGREEMENT ESTABLISHING A COORDINATED SYSTEM FOR HEALTH CARE SERVICES

This Joint Powers Agreement establishing a Community Collaborative for Health Care Services (hereinafter, the "Agreement") is entered into by and between the San Benito Healthcare District and the County of San Benito ("Parties") as of _____, pursuant to the provisions of Title I, Division 7, Chapter 5, Article I (Sections 6500, et seq.) of the California Government Code (hereinafter, the "Act") relating to joint exercise of powers by public agencies.

Recitals

A. The Parties are a local healthcare district organized pursuant to the Local Health Care District Law (California Health and Safety Code sections 32000 et seq., hereinafter referred to as "District Law") of the State of California, and a County government. The District owns and operates a licensed acute care hospital, two skilled nursing facilities, related ancillary services and a number of physician clinics (the "Facilities") in the geographic boundaries of the San Benito Health Care District and the County of San Benito, California (herein referred to as "the Region")

B. The Parties wish to form a joint powers authority entity (hereinafter, "JPA') pursuant to the Act to assist in pursuing the joint mission of providing healthcare services in the Region. The Parties desire to establish this cooperative relationship for the following purposes:

i. To oversee the management and operations of the Facilities, and to oversee the development and implementation of a business plan;
ii. To create a broader governance structure for the health care operations that would include board members with needed expertise to guide the future of health care services in the Region;
iii. To foster and capitalize the further development and expansion of a local healthcare delivery system to provide high quality services to residents of the Region;
iv. To ensure a sufficient foundation of local support through a transparent governance model with participation of residents who may have disparate ideas.
v. To ensure long-term financial stability for the organization;
vi. To provide mechanisms for expanding access to care through the formation of a new, sustainable, multi-specialty group (>25) of medical providers;
vii. To increase public confidence in the local healthcare delivery system, increasing the likelihood that patients will choose to receive their care locally; and

viii. To maintain a locally operated health care delivery system focusing on serving the healthcare needs of the residents in the Region, and to preserve and enhance access to the broadest range of services possible to all residents, regardless of their ability to pay.

NOW, THEREFORE, THE PARTIES HEREBY AGREE TO THE TERMS AND CONDITIONS SET FORTH BELOW.

Agreement

1. Recitals. The Recitals set forth above are true and correct.

2. General Purpose of Agreement. The purpose of this Agreement is to establish a cooperative relationship by and among the Parties through the creation of a joint powers agency (JPA) that is able to operate healthcare services efficiently and effectively in the Region. The JPA shall seek to expand services and to improve the financial viability of the organization. The Parties intend that additional public agencies within the Region, such as cities, may join the JPA in the future subject to the applicable terms and conditions stated in this Agreement.

3. Joint Powers Authority Created. Pursuant to Section 6506 of the Act, the Parties create a public entity, separate and apart from the Parties to this Agreement, to be known as the San Benito Health Care Authority (hereinafter, the "Authority"). The debts, liabilities, and obligations of the Authority shall not constitute the debts, liabilities, and/or obligations of any of the Member Parties.

6. Governance.

A. Operating Board ("Operating Board"). The JPA shall be governed by an Operating Board. The Operating Board, as the governing and administrative body of the JPA, shall formulate and set policy, and shall exercise the powers set forth in this Agreement to accomplish its purpose. Appointments to the Operating Board shall be made through the following process:

(i) Each JPA Agency shall recommend a slate of two board members to represent that Agency on the Operating Board. Each party's slate shall be subject to the approval of the other Agency. Any subsequent Agency that joins the JPA may be given one additional seat on the board;

(ii) The four board members appointed by the JPA Agencies shall serve as the nominating committee for all remaining community board members. There shall be no fewer than three and no more than seven appointed community members.

B. Term of Office of Directors. Each Director shall serve a two (2) year term of office. All Directors shall serve at the will and pleasure of their respective Agencies and may be replaced at any time and without cause by the member Agency that initially appointed the Director. Any replacement Director shall serve out the balance of the term of the Director being replaced.

7. Meetings of the Operating Board.

A. Conducting Meetings. The Board shall hold regular meetings at least monthly and shall adopt bylaws for conducting their meetings and other business. All meetings of the Board, including without limitation regular, adjourned regular, and special meetings, shall be called, noticed, and conducted, in accordance with the provisions of the Ralph M. Brown Act (commencing with Section 54950 of the California Government Code).

B. Quorum and Decision-Making Methods. A majority of voting members of the Board shall constitute a quorum. Each Director, or alternate, shall be entitled to one vote. Decisions shall be made by supermajority votes of at least seventy-five percent (75%) of the voting members present, except where otherwise required by law or established by Board bylaws or other provisions of this Agreement.

C. Board Officers. The Board shall have a Chair to preside over and conduct all meetings, and a Vice Chair who shall succeed the Chair and preside in the absence of the Chair. The offices of Chair and Vice Chair shall rotate through each of the seats on the Board annually in a manner to be determined by the bylaws.

8. Limitation on Powers. Nothing in this Agreement shall authorize activities that corporations and other artificial legal entities are prohibited from conducting by Section 2400 of the California Business and Professions Code.

9. Appointed Officers. Pursuant to section 6505.6 of the Act, the Operating Board shall appoint an Auditor and a Treasurer for the JPA to perform the duties required by law, as well as provide any other services that may be desired by the JPA. Should the County Auditor and County Treasurer be willing to serve, they may serve the JPA as Auditor and Treasurer, or the JPA may select another eligible Auditor and Treasurer to perform such duties. Such officers shall receive no compensation for holding the appointed office but shall be compensated for the cost of providing services per written agreement with the Authority. Under general authority provided by Government Code sections 6505 et seq, the Operating Board may appoint an executive officer to manage the operations of the Authority.

10. **<u>Activities of the JPA</u>.** The activities of the JPA shall include the following:

A. **Operational and Strategic Oversight.** The Operating Board shall oversee the management of the healthcare Facilities.

B. **Financial Management and Oversight.** Except for assets and liabilities specifically excluded from the scope of this agreement, all financial activities related to the Facilities shall be overseen by the JPA.

C. **Business Planning.** The Operating Board of the JPA shall develop and approve a business plan for the health care system and shall oversee its implementation. The business plan shall be subject to the reserve approval rights specified in Section 5(C) of this Agreement.

D. **Budget.** The Operating Board of the JPA shall approve an annual budget each year subject to the reserve approval rights specified in Secon 5(C) of this agreement.

E. **Medical Staff Oversight.** The operating board shall receive reports and credentialling recommendations from the medical staff and shall approve all physician privileges.

F. **Quality.** The Operating Board shall oversee quality and shall seek improvement where needed.

G. **Medical Group Development and Provider Employment.** The Operating Board shall oversee the development of a new multi-specialty medical group and shall have the authority to re-structure existing rural clinics.

H. **Other Activities.** The JPA shall also be responsible for the following other activities under this Agreement:

iv. Labor management, employment policies and benefit programs;
ix. Pooled financing, issuance of bonds and other funding vehicles (revenue, general obligation and other short term and long term);
x. Fundraising-philanthropy in partnership with the Hazel Hawkins Hospital Foundation;
xi. Contracting negotiations with various third party and government payers inclusive of Medical, managed care, commercial PPO, HMO, existing medical groups, and IPA's;
v. Regulatory compliance and accreditation;
xii. Such other projects which may be added in the future by agreement among the Parties;
xiii. Joint venture activities relating to inpatient and outpatient services;
xiv. Management activities;
xv. Development and implementation of insurance/provider networks; and
xvi. Sharing and crossover of managed care contractual rates.

5. Powers and Duties.

A. Authority. The JPA shall have the powers specified in Section 4 and other powers that are set forth in section 32121 of the District Law. Such powers shall be exercised in the manner provided in the Act subject only to the restrictions set forth in this Agreement. The. JPA is authorized in its own name to perform all acts necessary for the exercise of common powers.

B. Assessments. Pursuant to Section 6504 of the Act, the JPA is empowered, and by this Agreement required, to assess the Parties to finance the entire operation of the JPA as specified below:

(i) The County of San Benito shall contribute $5 million of initial capital to the JPA.

(ii) The San Benito Health Care District shall delegate management all of the Assets and Liabilities associated with the Facilities, except for those specified in Exhibit A. Specifically excluded from the JPA's scope of financial management shall be a fund of $500,000 each year, which shall be exclusively managed by the District in furtherance of wellness and preventive care for residents in the Region.

(iii) All administrative expenses of the JPA shall be paid from the operating budget of the Facilities.

(iii) All supplemental tax payments, grants, and income and expense related to Federal Disproportionate Share ("DSH") and Quality Assurance Fee ("QAF") programs shall be managed by the JPA.

(iv) The County of San Benito may serve as a credit facility to the JPA for the purpose of providing capital during the first ten (10) years of this Agreement. The current estimated need for such capital is between $7-10 million. The JPA may, at its sole discretion, issue municipal debt instruments to fulfill the need for this capital.

(v) The County of San Benito may, at its sole discretion, adopt new development fees to provide an additional source of capital for the facilities.

C. Reserve Powers. The San Benito Health Care District shall have the right to approve (i) the JPA business plan, (2) JPA expenditures greater that $5 million, (iii) agreement to enter into partnership with third party health systems, and (iv) any discontinuation of service.

10. Fiscal Year and Annual Budget/Financing.

A. Fiscal Year. The JPA's fiscal year shall be the twelve (12) month period commencing each _____, except if the effective date of this Agreement is other than _____, the first fiscal year shall be the short year commencing the effective date and ending the following _____.

B. Annual Budget. The JPA shall operate only under an approved fiscal year budget. Once adopted annually for each fiscal year, the total annual expenditure budget may only be increased by unanimous vote of the Operating Board. The JPA will adopt a preliminary annual budget no later than _____ for the following fiscal year and will adopt a final budget prior to _____.

C. Budget Elements. The budget policy shall include, but is not limited to, the following components:

i. **Operation and Maintenance Expenses**. The costs of operating and maintaining Facilities and the equipment housed therein shall include, but will not be limited to, personnel salaries and benefits, office and computer supplies and other consumables, payments for lease facilities, medical equipment, and expenses necessary to repair facility equipment due to normal wear and tear from ordinary usage.

ii. **Capital Expenditures.** Capital expenditures shall include the costs of Facility improvements, medical equipment, strategic growth investments as approved in the business plan, and the original purchase of equipment, hardware, software, and other fixed asset type items typically having a useful life of more than one (1) year. All costs associated with capital purchases, such as installation, shall be capitalized. Replacement of such equipment at the end of its useful life shall be a capital item. Capital expenditures shall be paid in accordance with a budget established in the business plan and shall be paid for through available cash or JPA debt.

11. Funding and Cost Allocation. The JPA's annual budget shall include a reasonable provision for contingencies as well as financing for the maintenance, upgrade, or ultimate replacement of key fixed assets and structures. The JPA shall endeavor to provide its services in the most cost-effective manner available without compromising quality standards. For the first ten years of this Agreement, the JPA shall contribute $2 million per year to the San Benito Healthcare District's now-frozen employee pension fund. Additional contributions to the pension fund shall be made based on annual actuarial studies and professional advice.

12. Appeals to the Operating Board. Any member agency shall have the right to appeal any implemented or recommended policy or procedure to the JPA's Operating Board for final determination should, in the opinion of the member agency, such policy or procedure pose a significant adverse impact on the member agency. In such cases, a unanimous vote of the JPA's Operating Board (excluding the Directors from the appealing agency) shall be required to approve the policy or recommendation.

13. Term of Agreement and Termination Provisions. This Agreement shall be deemed to go into effect on _____ (the "Effective Date") and shall continue in full force and effect until rescinded or terminated, as set forth below.

A. Termination of Individual Membership. Any member may terminate its participation in this Agreement by giving written notice to the JPA Operating Board not less than eighteen months before the start of the fiscal year, which termination shall be effective only on the beginning of the next fiscal year. If a member terminates its participation in this Agreement any and all assets and liabilities of the JPA shall become assets and liabilities of the San Benito Healthcare District, except for debt issued to the JPA under Section 5(B)(iv) of this agreement, shall become assets and liabilities of the San Benito Healthcare District. The member requesting Termination shall bear any expenses specifically related to termination.

B. Rescission of Agreement by All Parties. At any time, this Agreement may be rescinded and terminated, and the Authority may be dissolved, by a unanimous vote of all Parties.

15. Membership. Membership in the Authority shall be open to all cities, independent districts, and other public agencies which have an interest in providing healthcare services in the Region.

A. Admission of New Members. The Operating Board has the authority to admit new members to the Authority, after noticing existing members and an opportunity for them to be heard at a public meeting. The Board shall set the terms and conditions for admitting new members (either individually or generally) that it deems appropriate.

B. Cost of Admitting New Members. The Operating Board shall determine the cost of admitting any new members to the JPA, such as on-going assessments or charges that new members will be required to pay to the JPA.

C. New Member Obligations. Each agency accepted as a new member shall be required to pay any assessments established by the Operating Board, and sign a copy of this Agreement, or an acknowledgement that it is bound to all the terms and conditions herein (at the discretion of the JPA).

16. Amendments to Agreement. This Agreement may be amended or modified only by a unanimous vote of the Member Agencies that are Parties to this Agreement. Any amendments to this Agreement shall be in writing and signed by all members.

17. Severability. Should any part, term, portion or provision of this Agreement, or the application thereof to any person or circumstances, be in conflict with any State or Federal law, or otherwise be rendered unenforceable or ineffectual, the validity of the remaining parts, terms, portions, or provisions or the application thereof to other persons or circumstances, shall be deemed severable and shall not be affected thereby, provided such remaining portions or provisions can be construed in substance to continue to constitute the Agreement that the Parties intended to enter into in the first instance.

18. **Insurance.** The JPA shall be required to obtain insurance or join a self-insurance program in which one or more of the Parties participate, appropriate for its operations. Any and all insurance coverages provided by the JPA shall name each and every Party to this agreement as an additional insured for all liability arising out of or in connection with the operations by or on behalf of the named insured in the performance of this Agreement. Minimum Levels of the insurance or self-insurance program shall be set by the JPA in its ordinary course of business. The JPA shall also require all contractors and subcontractors to have insurance appropriate for their operations.

19. **Indemnity.** The JPA shall indemnify, defend and hold harmless the Parties their officers, agents, servants, employees, and volunteers from any and all claims, losses, costs or liability resulting to any person, firm, or corporation, or any other public or private entity for damages of any kind, including, but not limited to, injury, harm, sickness, or death to persons and/or property from any cause whatsoever arising from, or in any way connected with, the performance of its operations and exercise of its powers, except from any such claim arising solely out of acts or omissions attributable to the member Party or its officers, employees, volunteers, or agents.

20. **Successors.** This Agreement shall be binding upon and shall inure to the benefit of the successors of the Parties hereto.

21. **Notice of Creation.** A notice of the creation of the JPA by this Agreement shall be filed by the Authority with the Secretary of State pursuant to Section 6503.5 of the Act.

22. **Other Notices.** Notices to the JPA required or permitted to be given under this Agreement shall be in writing. Delivery of such notices shall be conclusively taken and sufficiently given forty-eight (48) hours after deposit in the United States Mail, return receipt requested, with the postage thereon fully prepaid, addressed to the Authority as follows:

[Insert address of principle place of business]

Notices to the Parties shall be provided in the same manner as above, addressed as set forth in the signature page hereto. The JPA may change its address above for notices by giving written notice as described above to all Parties. Any Party may change its address for notices by giving written notice as described above to the Authority.

23. **Counterparts.** This Agreement may be executed in any number of counterparts, each of which shall be deemed an original, but all such counterparts together shall constitute but one and the same instrument.

24. **Entire Agreement.** This Agreement contains the final and entire agreement of the Member Parties and supersedes all other agreements, written or oral, heretofore made by the parties. The parties shall not be bound by any terms, conditions, statements, or representations, oral or written, not contained herein.

IN WITNESS WHEREOF, the Parties hereto have caused this Agreement to be executed and attested by their proper officers thereunto duly authorized, as of the day and year first above written.

Dated: _____ [PARTY NAME]

By: _____

_____

Address: _____

_____

Dated: _____ [PARTY NAME]

By: _____

_____

Address: _____

_____

Dated: _____ [PARTY NAME]

By: _____

_____

Address: _____

_____

**

EXHIBIT A

TBD

Timetable for Operationalizing the JPA

Assumes SBHD is deemed eligible for Chapter 9 bankruptcy

Deemed Eligible

- Determination that the San Benito Healthcare District is eligible for Chapter 9 bankruptcy protection

Negotiation of Definitive Agreements

- JPA Agreement
- JPA Loan Agreement

Approval of the U.S. Bankruptcy Court

- Plan of Reorganization
- JPA-related Agreements

Establish Operating Board

- Slates created by Healthcare District and County
- Outside Directors nominated

Commence Operations

- JPA Operating Board begins overseeing implementation of the business plan
- JPA Operating Board selects management

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San Benito County

Summary Strategic Analysis and Business Plan Recommendations

February 6, 2024

ECG MANAGEMENT CONSULTANTS

A Siemens Healthineers Company

Contents

Contents *(continued)*

Overview

Background

ECG is pleased to submit our strategic recommendations for Hazel Hawkins Memorial Hospital (HHMH) and the future of healthcare in San Benito County. It is our perspective that the County of San Benito (COSB) and the San Benito Health Care District (SBHCD) can partner to create a viable path HHMH. In this report, we provide our recommendations for actionable strategies that will set the foundation to keep HHMH a locally controlled hospital.

In November 2022, HHMH declared a fiscal emergency with inflation, insurance reimbursement declines, and the pandemic as leading factors. By May 2023, HHMH voted to file chapter 9 bankruptcy. Given HHMH's current state and as it seeks partners (including out-of-state operators and for-profit entities), San Benito County leadership became concerned that the county could possibly lose its only locally controlled full-service hospital, skilled nursing facilities, and rural clinics.

As a result of the healthcare district exploring partnership options, COSB wanted to ensure that the future strategic direction of the hospital best met the needs of the community. As a result, the county engaged ECG to evaluate its strategic options and perform an assessment of HHMH. ECG has been working with COSB and its advisers (who have both legal and investment banking backgrounds) since July 2023 to provide a strategic analysis on future options for HHMH.

Overview of ECG and Engagement Objectives

ECG is a leading national consulting firm with a more than 50-year history of advising health systems, hospitals, medical groups, payers, and providers on a range of issues, including finance, strategy, hospital facilities, operational performance improvement, and interim leadership. COSB hired ECG to advise on the following key questions:

- Can a community the size of San Benito County support a Critical Access Hospital?
- Is there a future path to financial sustainability for HHMH?
- What core strategies are needed to ensure a financially sustainable future for the hospital?
- What options does the county have to support the hospital?

ECG's engagement with COSB had the following key objectives in two phases:

1. Phase One

    a. Meet with COSB executives to discuss the engagement objective, scope, timeline, and deliverable.

    b. Collect publicly available information about HHMH, including regional and national Critical Access Hospital benchmarks.

    c. Identify a range of strategic and operational scenarios for financial evaluation.

    d. Prepare and summarize the financial impact of the scenarios identified above.

    e. Prepare a brief assessment of the strategic considerations associated with each scenario.

    f. Prepare an executive summary of the results from the financial and strategic impact of the scenarios.

2. Phase Two

    a. Develop a preliminary strategic financial feasibility forecast with scenario sensitivities as well as a strategic business plan.

    b. Develop capital assumptions and financial forecast scenarios based on feedback from county leadership.

    c. Develop a detailed physician provider workforce assessment throughout San Benito County.

    d. Provide a strategic business plan summary report to meet long-term financial sustainability objectives.

ECG is extremely grateful to be hired to advise county leadership on HHMH's future viability. We are honored to work with the county's committed leadership team and the Board of Supervisors to help protect locally controlled and locally led healthcare for the residents of San Benito County. Thank you for trusting us with this ever-important task.

HHMH's Current State

HHMH Background

HHMH is a 25-bed critical access hospital located in Hollister, California, and has served San Benito County for more than 100 years. The organization converted to a Critical Access Hospital in March 2020 and serves a critical healthcare need for the community in San Benito County. The hospital provides primary and specialty care, orthopedics, obstetrics (OB), skilled nursing, surgical services, diagnostic imaging, laboratory services, emergency services, multiple rural health clinics, and more. HHMH in addition to the 25-bed critical access hospital, is composed of five rural clinics, two specialty centers, a home health agency, four satellite lab/draw stations, and two skilled nursing facilities (119 beds of SNFs). The organization is operated, and all assets are owned by the SBHCD and receives annual tax revenue support for locally controlled healthcare from the taxpayers of San Benito County.

Factors Contributing to HHMH'S Current Position

For the last 100 years, HHMH has been an essential community hospital providing care to its residents and has served as a leading employer in San Benito County. However, given circumstances outlined in the previous sections, HHMH is at an inflection point. A multitude of factors have contributed to HHMH's current vulnerable position, including the following:

- **Challenging Payer Mix:** San Benito County has proven to be a difficult healthcare payer environment to operate in, with a high percentage of Medi-Cal patients.
- **1099 Physician Contract Model:** HHMH does not employ or align physicians, and the lack of an integrated medical group, physicians who live and work full time in San Benito County have created staffing difficulties at HHMH and made local patient access to physicians extremely difficult. It appears over the years, SBHCD leadership prioritized investment in physical facilities and has not pursued the development of a locally supported physician and medical groups. The current 1099 model is less sustainable because providers are not fully integrated with the health system and some do not even live in the region full time. It is ECG's opinion that not investing in physicians and building a locally supported medical group has been a significant strategic failure. Building an aligned physician group or network has been one the more significant strategies that all hospitals in the U.S. have been deeply involved in over the past two decades. The State of California has even created special support for district hospitals to form and operate medical groups (e.g., 1206B exemption).
- **Out-Migration:** Due to lack of local physicians in multiple specialties, patient out-migration is a significant issue for HHMH, with 57% of inpatient (IP) cases leaving San Benito County for care

in 2021 (source: HCAI data). Both low acuity and higher-acuity cases are leaving the county. Leading factors of out-migration include the following:

- **Physician shortages** in the market are prevalent. Based on an analysis of provider supply in San Benito County, ECG estimates a current shortage of over 50 physicians in the county (source: ECG independent research through ECG's Provider Network and Community Planning practice).
- **A lack of local physician access** is leading patients to go elsewhere for both ambulatory and inpatient care. Appointment wait times for crucial services are too long. ECG's Provider Network and Community Planning Practice reached out to various provider offices in the region and found long wait times for third next available appointment that included (source: ECG independent research) the following:
  - Obstetrics/Gynecology: 39 days
  - Hematology-Oncology: 90 days
  - Psychiatry: 120 days
  - Cardiology: 52 days
  - Urology: 52 days
  - Adult Primary Care: 26 days

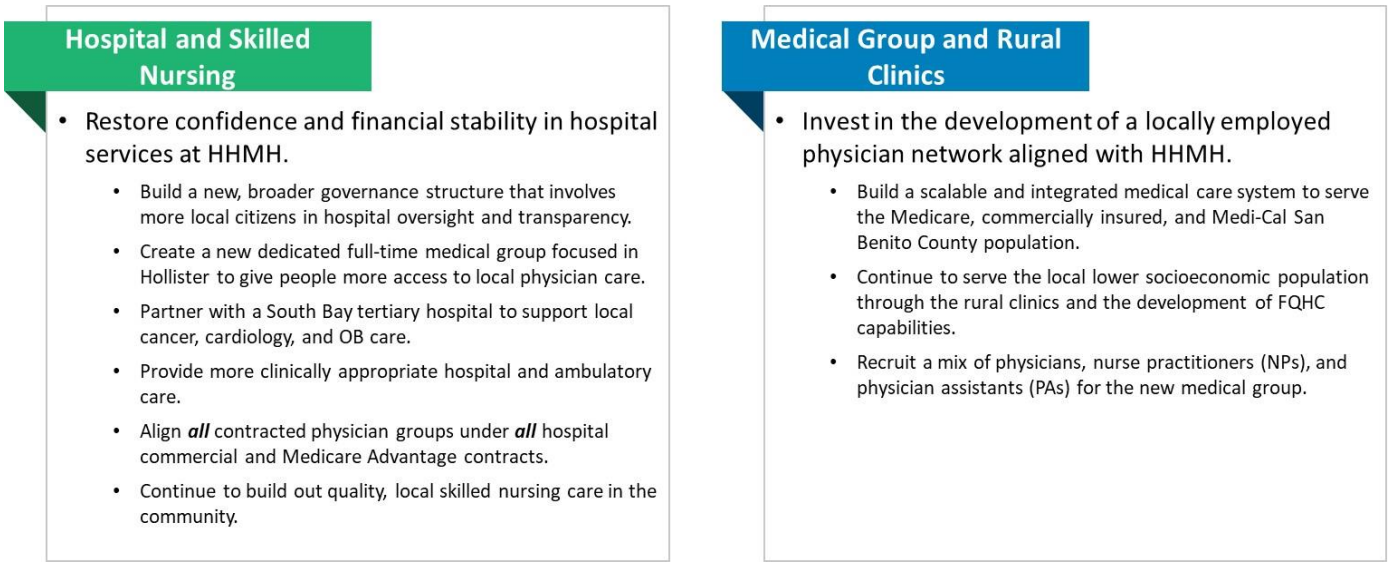
- **No Significant Clinical Partnership:** Without clinical program partnerships with other South Bay tertiary providers or other larger programs, people leave for care and have few alternatives to return for more routine care. Care is not kept local and integrated, causing patients to leave the county for care.
- **Hospital Reputation:** Issues regarding hospital reputation, district financial difficulties, issues with medical billing for some members of the community cause distrust in healthcare for San Benito County residents.

Proposed Business Plan Strategies

The Future of Healthcare at HHMH

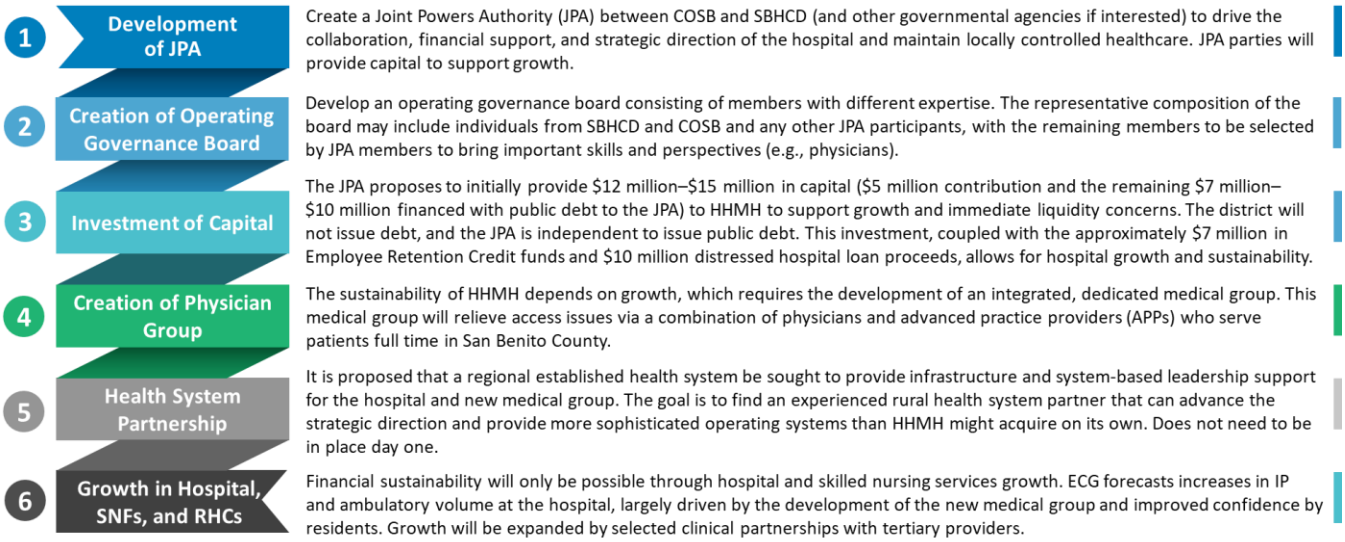
As part of this process, ECG outlined the vision (figure 1) for HHMH to remain a viable community hospital. This vision is anchored in the HHMH staying locally controlled and expanding the quality of healthcare and access to all residents of San Benito County. Perhaps most importantly, a key driver of this concept is further investing in medical providers or a medical group who are aligned and integrated with HHMH to keep care more local and to increase volume of healthcare served locally.

FIGURE 1: Proposed Vision for Healthcare in San Benito County



To achieve this vision, ECG is advising the county to develop six critical strategies summarized in figure 2.

FIGURE 2: Core Strategies for HHMH to Remain a Viable Hospital



With the necessary investment, governance and oversight, ECG believes HHMH has a path to financial sustainability under local control. Just reducing operating expenses is not a viable option for long-term sustainability; there must be a strategy of growth built on physician recruitment, clinical program partnerships, the expansion of clinical services, an infusion of capital, and instilling in the community that safe and effective healthcare can be delivered by HHMH.

Strategy One: Development of a Joint Powers Authority (JPA)

ECG and other county advisers are recommending a JPA among the district, San Benito County, and any other governmental agencies to oversee decision-making, strategic thinking, and control of HHMH. JPAs are exercised when the public officials of two or more agencies agree to create another legal entity or establish a joint approach to work on a common problem, fund/invest in a project, or act as a larger broader representative body for a specific important activity. JPAs offer another way for governments to deliver services (source: Government's Working Together, California State Legislature Senate Local Government Committee). As part of this proposed JPA, the district will maintain ownership of all assets relating to the hospital, SNFs, and rural clinics and will continue to collect all current and future tax revenue. ECG believes that a JPA will benefit the community by:

- Creating better channels of communication between the district and COSB and the community.
- Improving real-time collaboration between the district and COSB on strategic planning and decision-making.

- Maintaining local control and local input assuring that a broad array of healthcare services remains in the community through HHMH (as opposed to the district selling hospital assets to an out-of-state operator and/or for-profit entity to determine local healthcare services).
- Improving financial support for HHMH. COSB being more invested and directly involved in supporting the long-term future of HHMH, the county will have a clearer sense on the overall direction of the hospital and be more comfortable to providing incremental funding support for growth strategies.

Strategy Two: Creation of a Community-Based Operating Governance Board

ECG recommends creating a community-based operating governance board composed of a broader spectrum of community members. Via the JPA, there will be an elected county board of supervisors and elected district members serving on the JPA board. ECG also recommends creating an operating governance board similar to most non-profit community hospitals by adding nonelected members. These nonelected members will have the best interest of the hospital and be able to add specific expertise to oversee hospital operations. These boards will bring more local citizens to oversee and guide HHMH, they build trust among varying factions of the community, will be closer to patients and employees of the hospital, and can build solid expertise to govern a complex entity.

For example, a local prominent physician can serve on the board to guide the expansion of the medical group. Having a community governing board for not-for-profit hospitals is very common and allows hospitals to be nimbler and more focused on strategy. Also, having a larger board of nonelected community-based members allows for greater continuity as district- and county-elected officials are at the behest of election cycles.

Strategy Three: Investment of Capital

As the JPA executes on the strategies outlined in the report, along with investment in capital from JPA members, free cash flows will be improved. Sources of this improved liquidity include the following:

- Distressed Hospital Loan: $10 million
- Employee Retention Credit: $7 million
- JPA Funding: $12 million–$15 million ($5 million contribution and remaining $7 million-$10 million financed with public debt to the JPA)

In addition to the funding sources above, ECG projects that by year five (assuming the JPA executes on the other five strategies), the hospital will have 93 days cash on hand (DCOH) ($47 million) to maintain liquidity and invest in growth and other commitments.

If invested correctly, this additional cash can make a significant difference at HHMH. Figure 3 outlines potential uses of this capital.

FIGURE 3: Potential Uses of Capital

Medical Group Development	In addition to the cash generation projected from operations, the capital investments will be toward developing the medical group to serve local citizens and drive growth.
Deferred Capital Expenditures	HHMH management has outlined the immediate need for infrastructure upgrades within the hospital, which can be funded through the influx of cash.
EHR Funding	Additional capital will be used to fund HHMH's new and enhanced EHR, possibly through the health system management company. This will help attract physicians and improve patient care.
Pension Liability Funding	SBHCD has an unfunded pension liability that over time will be addressed with the additional cash and growth initiatives.
Reserves to Assist with Liquidity Concerns	While HHMH has immediate capital needs to address, a portion of the added cash can be used to build up reserves and curb DCOH concerns in the future.

Strategy Four: Creation of a Physician Group

ECG believes that to create a sustainable growth future for HHMH, it is crucial that the organization has an integrated local medical staff that is committed full time to the San Benito County residents. As noted previously, HHMH's lack of an employed network of physician providers has led to issues with staffing, specifically in the SNFs, and additional billing nuances create difficulties for patients.

The current physician strategy at HHMH is to not employ physicians but to use a 1099 model to staff physicians in the rural clinics and new providers to the community often join an independent practice. This is resulting in many providers working part time in Hollister and the other time in communities north of San Benito County. In ECG's view, this does not take into account the realities of a rural/small town medical practice in 2024. District hospitals in California have alternative models (e.g., HHMH, as a district hospital, is exempt from California Health and Safety Code Section 1206 and is legally permitted to employ physicians via 1206b clinics) to employ physicians and allied providers to build solid, committed, self-perpetuating medical communities in smaller communities and more rural areas. Ongoing financial subsidies for these providers will be required, but without a change in physician strategy, it is unlikely HHMH's financial situation will improve.

ECG recommends, beginning immediately and continuing over the next five to seven years, for the JPA to develop a medical group with 25 to 30 dedicated providers from a range of specialties, with the

inclusion of advanced practice providers (APPs) to support physicians. Though recruiting and retaining providers to smaller communities will be difficult, San Benito County and the city of Hollister is home to a fast growing market, comparatively lower-cost-of -living, moderate housing costs. These factors makes Hollister and San Benito County an attractive location (when compared to high-cost-of-living areas like Salinas Valley, Monterrey or San Jose – South Bay) for young medical professionals interested in rural practice. Young physicians today are largely seeking employment in a supported medical group situation. Very few young physicians are seeking independent practice opportunities or working in independent groups. They prefer employment in supported medical groups.

A reimagined medical staff at HHMH is crucial to ensuring high-quality care to members of its community, growth of inpatient and ambulatory services, and improvement to its reputation from residents. As part of this strategy, ECG recommends that a 25 to 30 provider group can consist of the following:

- **28.5 providers over next seven years**
    - **9.0 primary care (MDs, APPs)**
        - 3.0 in community
        - 6.0 net new
    - **9.5 surgical (e.g., General Surgery, OB/Gyn, Orthopedics)**
        - 3.0 in community
        - 6.5 net new
    - **10.0 medical (e.g., Oncology, Cardiology, Gastroenterology, Pulmonology)**
        - 2.0 in community
        - 8.0 net new

Strategy Five: Health System Partnership

As a part of the county's proposal for a JPA, ECG recommends that the JPA could partner with a larger health system to provide operating systems support and other expertise to HHMH. ECG recommends that HHMH finds an experienced not-for-profit and mission-aligned health system in California to provide expertise and support in the following areas:

- Support development of new medical group by providing expertise.
- Provide experience in strategic deployment of large amounts of capital.
- Potentially enable medical record use. HHMH management has stressed the important of an EHR upgrade within the organization. Through a partnership, HHMH has potential to join the

EHR of a local system. An upgraded EHR will help integrate care and provide a better patient and provider experience.

- Drive progress at HHMH, and execute the strategic business plan. The systems with which the JPA has been in contact have a track record of success and are familiar with the local healthcare landscape. Their experience in the state and expertise with California rural hospital turnarounds is crucial to growth at HHMH.

Additionally, looking for tertiary health systems that will not operate or invest in HHMH, but offer varying levels of support to local healthcare, ECG and The County of San Benito have reached out to tertiary health systems to vet their interest. Stanford Health Care as one such prestigious academic health system expressed interest in an opportunity to partner with Hazel Hawkins Memorial Hospital on supporting clinical care. Stanford offers a Second Opinion Program that provides access to expertise to their vast expertise network for care without patients having to leave their community (source: Stanford Health Care).

During these conversations, clinical partnerships have been discussed for high acuity specialties such as cancer, high-risk obstetrics, and cardiology. Similar discussions have been held with multiple health systems in the region relating to similar partnerships. These partnerships will help to enhance care offerings to San Benito County residents who would otherwise seek care elsewhere.

Strategy Six: Growth in the Hospital, SNFs, and RHCs

ECG believes that the JPA will position HHMH for improved financial outlook at the hospital largely driven by growth resulting from capital investments in medical group development, and improved community reputation. Given these factors, ECG believes HHMH has further opportunity to improve financial operations for the hospital, SNF, and RHCs. Key strategies include:

- **Clinical Service Line Expansion at Hospital:** By expanding on the clinical services offered at HHMH and keeping more cases local, case mix index (CMI; which measures patient acuity) at HHMH is expected to increase to a level in line with other California Critical Access Hospitals. This increase in CMI will correspond to increases in revenue. With a new physician base, ECG has forecasted a 10% increase in overall market share driven by the following:
    - **Cardiology:** Develop a cath lab at HHMH to help keep more cardiology cases in the community.
    - **OB:** In 2021, HHMH delivered 412 births, 49% of the San Benito County total. This market share of births is low in relation to the clinical capability and facilities available at the hospital. Based on the growth rate of births in the county from 2017 to 2021 (3.2% CAGR), ECG estimates over 1,000 births by 2027. This creates significant opportunity to

keep more births at HHMH for a service that residents should not have to out-migrate for. Obstetric clinical partnerships are a way to further support local care.

  - **General Surgery/Orthopedics:** Adding more dedicated general and orthopedic providers allows for lower-acuity surgeries to stay local. Given favorable rates for these surgeries, HHMH will be able to serve these patients locally.

- **Clinic Strategy:** ECG recommends continuing to serve the local lower socioeconomic population through the rural clinics and by converting two rural clinics to FQHCs in the long term. FQHCs offer a vehicle to serve Medi-Cal patients in a more efficient and sustainable manner.
- **SNF Strategy:** The SNFs remain one of the most profitable components (and serve as a critical mission to the local community) of HHMH, but there is capacity to grow volume here and use the HHMH provider base and improved reputation to reach capacity (recommend target of 85%–90%).

Financial Summary

ECG conducted multiple sensitivity analyses to determine the future financial sustainability of HHMH. This included the testing of various volume and expense growth levels, medical group development of different sizes, FQHC conversion and various financial impacts, the inclusion of capital commitments such as a new EHR, and much more. Two final financial forecast scenarios were ultimately developed: the status quo (baseline) and a growth scenario. An overview of each scenario and the resulting outlook is seen in figure 4.

FIGURE 4: Financial Scenario Overview

Status Quo (baseline)	Growth Scenario

• Assumes that no material changes are made to the hospital and its operations
  • Minimal volume growth aside from the already high-performing SNFs
  • No development of a medical group
  • Expenses growing at inflationary levels
  • Less revenue growth than growth scenario due to a lack of a medical group
  • No FQHC conversion of rural clinics
  • No JPA development/funding
  • $3 million downward pro forma adjustment to labor expense
  • Employee Retention Credit
  • Distressed hospital loan
 	
Outlook: In the absence of outside assistance or substantial changes, ECG forecasts HHMH's financial position to continue deteriorating as expenses outpace revenue.
	• Increase hospital IP occupancy to roughly 90% by year 10
	• SNF to reach capacity (90%) by year 2
	• Development of a medical group leading to increases in volume/revenue
	• Conversion of two rural clinics to FQHC status
	• $3 million downward pro forma adjustment to labor expense
	• Inclusion of the following items:
	  • Employee Retention Credit
	  • Distressed hospital loan
	  • Gradual pension payment
	  • EHR funding
	
	Outlook: In the growth scenario, ECG forecasts net income margin to increase from 4% to 8% in the 10-year period, largely led by increased IP and ambulatory services volume at the hospital, with increasing liquidity.

The following additional items were also included in ECG's analysis:

- Status Quo (baseline)
  - Employee Retention Credit: $7 million favorable pro forma adjustment to 2023 financials
  - Distressed hospital loan: $10 million favorable pro forma cash adjustment, $10 million associated liability
- Growth Scenario (the same additions mentioned above, in addition to those below)
  - Gradual pension payment: $2 million annual pension payment, $2 million associated cash decrease annually
  - EHR funding: $2 million annual capital commitment in years one to five

- JPA funding: $12 million–$15 million ($5 million contribution and remaining $7 million–$10 million financed with public debt to the JPA)

The resulting summary-level financial projections for each scenario are seen in figure 5.

FIGURE 5: Financial Summary of Scenarios

	Historical		Forecast									
	2023	Nov. 2023 TTM	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Status Quo (baseline)												
Operating Income	$(1,018,530)	$2,933,447	$154,948	$(1,869,879)	$(3,929,619)	$(5,226,364)	$(5,918,239)	$(6,017,683)	$(6,441,472)	$(6,716,398)	$(7,193,800)	$(7,866,222)
EBIDA	$6,239,017	$10,340,818	$8,327,304	$6,443,359	$4,437,707	$3,207,846	$2,595,260	$2,587,141	$2,261,361	$1,720,793	$1,028,782	$242,480
EBIDA Margin	4.1%	6.9%	5.5%	4.1%	2.8%	2.0%	1.6%	1.5%	1.3%	1.0%	0.6%	0.1%
Operating Cash	$14,441,825	$18,849,384	$35,909,306	$35,114,765	$32,309,491	$28,003,195	$22,807,680	$19,233,907	$15,310,911	$11,642,345	$8,066,653	$3,646,778
Operating DCOH	35.0	48.4	88.6	83.4	74.0	62.4	49.7	41.1	32.0	23.8	16.1	7.1
Growth Scenario												
Operating Income	$(1,018,530)	$2,933,447	$2,091,338	$2,298,824	$2,077,104	$3,734,047	$5,204,917	$7,265,337	$9,129,696	$10,969,987	$12,881,716	$14,689,706
EBIDA	$6,239,017	$10,340,818	$12,163,693	$12,212,062	$12,244,430	$14,168,256	$15,418,416	$17,070,161	$19,032,529	$20,407,179	$21,904,298	$23,398,409
EBIDA Margin	4.1%	6.9%	7.6%	7.2%	6.9%	7.6%	7.9%	8.5%	9.1%	9.4%	9.8%	10.1%
Operating Cash	$14,441,825	$18,849,384	$37,183,402	$39,285,752	$40,402,326	$42,994,648	$46,651,951	$54,004,258	$63,281,722	$74,769,823	$88,510,924	$103,678,867
Operating DCOH	35.0	48.4	89.1	89.0	87.1	89.0	93.0	104.7	119.1	136.4	157.3	179.4

Under the growth scenario, there is a path to long-term financial sustainability that depends on executing the strategic plan. However, under the status quo scenario, inflationary expense increases will outpace revenue and erode margins. Under the status quo scenario, days cash on hand (DCOH) increases initially as a result of the Employee Retention Credit and the distressed hospital loan. However, without significant changes to operations, ECG forecasts DCOH to decline substantially as margins erode. On the other hand, the growth scenario forecasts DCOH to be over 150 days by year 10. ECG tested a variety of scenarios to analyze the impact on liquidity. This included additional pension funding (both scenarios assume a $2 million pension payment for the first 10 years), EHR investment, and medical group subsidy. In addition, ECG assumed HHMH will exit bankruptcy and salaries will increase to a level in line with historical amounts. Under reasonable assumptions relating to these items, the growth scenario continued to show substantial improvements in DCOH.

Conclusion

Given the approaches outlined in this document, ECG believes a community hospital in this growing market, with JPA support and relatively good facilities, can be successful and can stay under local control and not be sold to a for-profit provider. A future path must be about growth of services, which inherently is about developing a dedicated medical staff. As such, we recommend that district and county leadership continue to explore options to collaborate.

Appendix A
Market Assessment

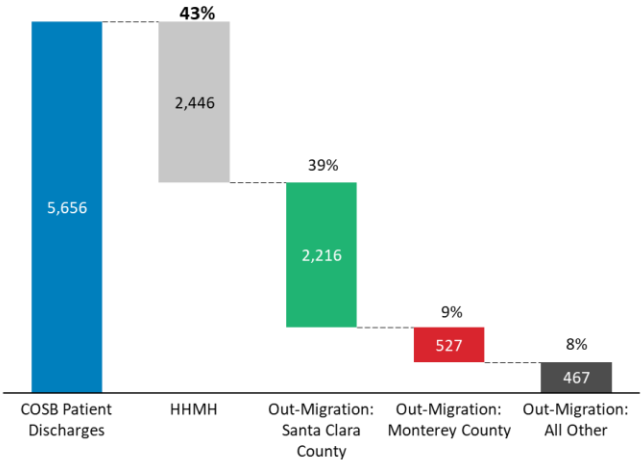
APPENDIX A

Market Assessment

Based on ECG's assessment, San Benito County is a growing market that can support a Critical Access Hospital like Hazel Hawkins Memorial Hospital (HHMH). From 2019 to 2022, San Benito County grew at a rate more than 2.5% higher than that of Monterey County and California. ECG expects this trend to continue as new developments are arising in the county and housing remains more affordable than that of surrounding areas.

Out-migration is an issue that needs to be addressed at HHMH, as 57% of inpatient (IP) cases are occurring outside of San Benito County (source: HCAI). In 2021, 39% of San Benito County residents sought IP care in Santa Clara County, led by Stanford Health Care and Good Samaritan Hospital–San Jose. Just under 10% of San Benito County residents received IP care in Monterey County, led by Salinas Valley Health Medical Center and Community Hospital of the Monterey Peninsula. HHMH's low CMI—over 0.50 less than that of Salinas Valley, Good Samaritan–San Jose, and Stanford Health Care—suggests that higher-acuity cases are often leaving the county (source: HCAI).

IP Discharges of Patients Living in San Benito County (2021)



Top-Five Out-Migration IP Discharge Destinations (2021)

Facility	Out-Migration Discharges (2021)	Discharge Market Share
Stanford Health Care	422	7%
Good Samaritan–San Jose	422	7%
Kaiser Permanente San Jose Medical Center	350	6%
St. Louise Regional Hospital	323	6%
Salinas Valley	232	4%
All Other	1,461	26%

Provider Shortage

Based on an analysis of provider supply in San Benito County, ECG estimates a current shortage of over 50 physician FTEs in the county.

Specialty	Current Shortage	Growth Need	Physician Succession Risk
Core Specialties			
Adult Primary Care	8.8	2.1	2.4
Pediatrics	4.2	0.6	1.7
Obstetrics/Gynecology	4.4	0.6	-
Psychiatry	4.2	0.5	0.4
Core Specialties Total	**21.6**	**3.8**	**4.5**
Medical Specialties			
Allergy/Immunology	1.0	0.1	-
Cardiology	2.4	0.4	0.8
Dermatology	2.0	0.2	0.2
Endocrinology	0.5	0.1	-
Gastroenterology	2.2	0.2	0.3
Hematology-Oncology	2.0	0.2	0.2
Infectious Disease	1.5	0.2	-
Interventional Radiology	0.8	0.1	-
Nephrology	1.1	0.1	0.2
Neurology	1.9	0.2	-
Physical Medicine/Rehab	1.8	0.2	-
Pulmonology/Critical Care	2.3	0.2	-
Rheumatology	1.1	0.1	-
Medical Specialties Total	**20.6**	**2.3**	**1.7**
Surgical Specialties			
General Surgery	3.6	0.4	-
Ophthalmology	1.4	0.3	-
Orthopedic Surgery	3.0	0.3	-
Otolaryngology	1.2	0.2	-
Urology	1.5	0.2	0.1
Surgical Specialties Total	**10.7**	**1.4**	**0.1**
Grand Total	**52.5**	**7.4**	**6.3**

This shortage stresses the need for a committed medical group in San Benito County that can attract young professionals to the region.

Appendix B
Financial Assumptions

APPENDIX B

Financial Assumptions

Key Operating Assumptions: Status Quo (baseline)

Hospital

- **Annual inpatient (IP) volume increases, years 1–10**
  - Medicare: 0.5%
  - Medi-Cal: 0.5%
  - Commercial: 0.5%
- Year 1 acute IP discharges: 2,141
- Year 10 acute IP discharges: 2,238
- **Annual IP revenue per discharge increases, years 1–10**
  - Medicare, Medi-Cal, and commercial: 1.25%
- **CMI remaining consistent**
- **Outpatient**
  - Visit growth of 0.5% annually; year 1: 111,574; year 10: 116,697
  - Revenue per visit growth of 1.5% annually
- **Labor expense decrease:** $3 million pro forma adj.

SNF

- **3.0% discharge growth in year 1, tapering off to 0% in year 5**
- **Revenue per patient day growth**
  - 2% annually
- **Inflationary expense projections**

Rural Clinics

- **No conversion of clinics to FQHC**
- **RHC visit growth**
  - 0.5% annually
- **RHC revenue per visit growth**
  - 1.0% annually
- **Inflationary expense projections**

Medical Group

- **n/a**

Key Operating Assumptions: Growth Scenario

Hospital

- **~10% market share increase from 2023 to year 10**
- **Annual IP volume increases, years 1–5**
  - Medicare: 3%
  - Medi-Cal: 3%
  - Commercial: 5%
- Year 1 acute IP discharges: 2,202
- Year 10 acute IP discharges: 2,749[1]
- **Annual IP revenue per discharge increases years 1–10**
  - Medicare, Medi-Cal, Commercial: 1.5%
- **CMI increase: 1.15 to 1.30**
- **Outpatient**
  - Visit growth in line with aggregate IP growth; year 1: 114,905; year 10: 145,572.
  - Revenue per visit growth: 2% annually
- **Labor expense decrease:** $3 million pro forma adj.

SNF

- **90% occupancy in year 2,** assume SNFs can be staffed at this level
- **Revenue per patient day growth**
  - 2% annually
- **Inflationary expense projections**

Rural Clinics

- **Conversion of two largest rural clinics to FQHCs**
  - 4180 Sunset
  - 4187 Fourth Street
- Increased revenue per visit growth at the two FQHCs
- **RHC visit growth**
  - 2% annually

Medical Group

- **28.5 providers over seven years**
  - **9.0 primary care (MDs, NPs, and PAs)**
    - 3.0 in community
    - 6.0 net new
  - **9.5 surgical**
    - 3.0 in community
    - 6.5 net new
  - **10.0 medical**
    - 2.0 in community
    - 8.0 net new
- **MGMA West Region median compensation benchmarks**
- **Additional annual overhead**
  - Physician: $175,000
  - APP: $100,000

[1] Growth is predicated on general surgery, OB/GYN, cardiology, and other focused specialties.

Appendix C
About ECG

APPENDIX C

About ECG

ECG has organized a team of professionals with an extensive background in strategic planning, competitive market analysis, advanced demand modeling, and comprehensive merger and acquisition planning. We are forward thinking; we challenge ourselves and our clients to plan for the health systems of tomorrow, envision the evolution of care delivery, foresee breakthroughs in treatment and technology, and imagine a care environment that will dramatically change health outcomes for our clients' communities.

ECG is a national healthcare consulting firm composed of approximately 240 consultants, with nine offices nationwide: Atlanta, Boston, Chicago, Dallas, Minneapolis, San Diego, Seattle, St. Louis, and Washington, DC.

Since our founding in 1973, ECG has specialized in providing consulting assistance exclusively to healthcare providers. We have completed nearly 17,700 major consulting projects for more than 3,100 leading healthcare organizations. Our clients include hospitals and health systems, children's hospitals, health sciences centers, faculty practice plans, physician group practices, and research organizations. More than 80% of our clients ask us to lead additional projects—a statistic that we believe underscores the high quality and value of our work.

The evolution of the US healthcare market toward value-based care is creating unprecedented change—in clinical services, payment reforms, organizational structures and leadership, technology enablers and disruptors, and patient expectations. Further, the pace of this change continues to accelerate. ECG's seasoned consultants help organizations navigate the country's ever-changing healthcare delivery system and have the experience and insight to address the most difficult challenges.

Tackling today's complex and interconnected healthcare problems requires knowledge and expertise across multiple disciplines, and that is what we deliver to our clients every day. ECG believes it is crucial to understand how the various strategic, clinical, operational, financial, and technological components of the successful 21st-century healthcare organization interact. Therefore, we take a strategic approach and bring an integrated perspective to every project, recognizing how each component is informed by an understanding of its consequences for the other areas.

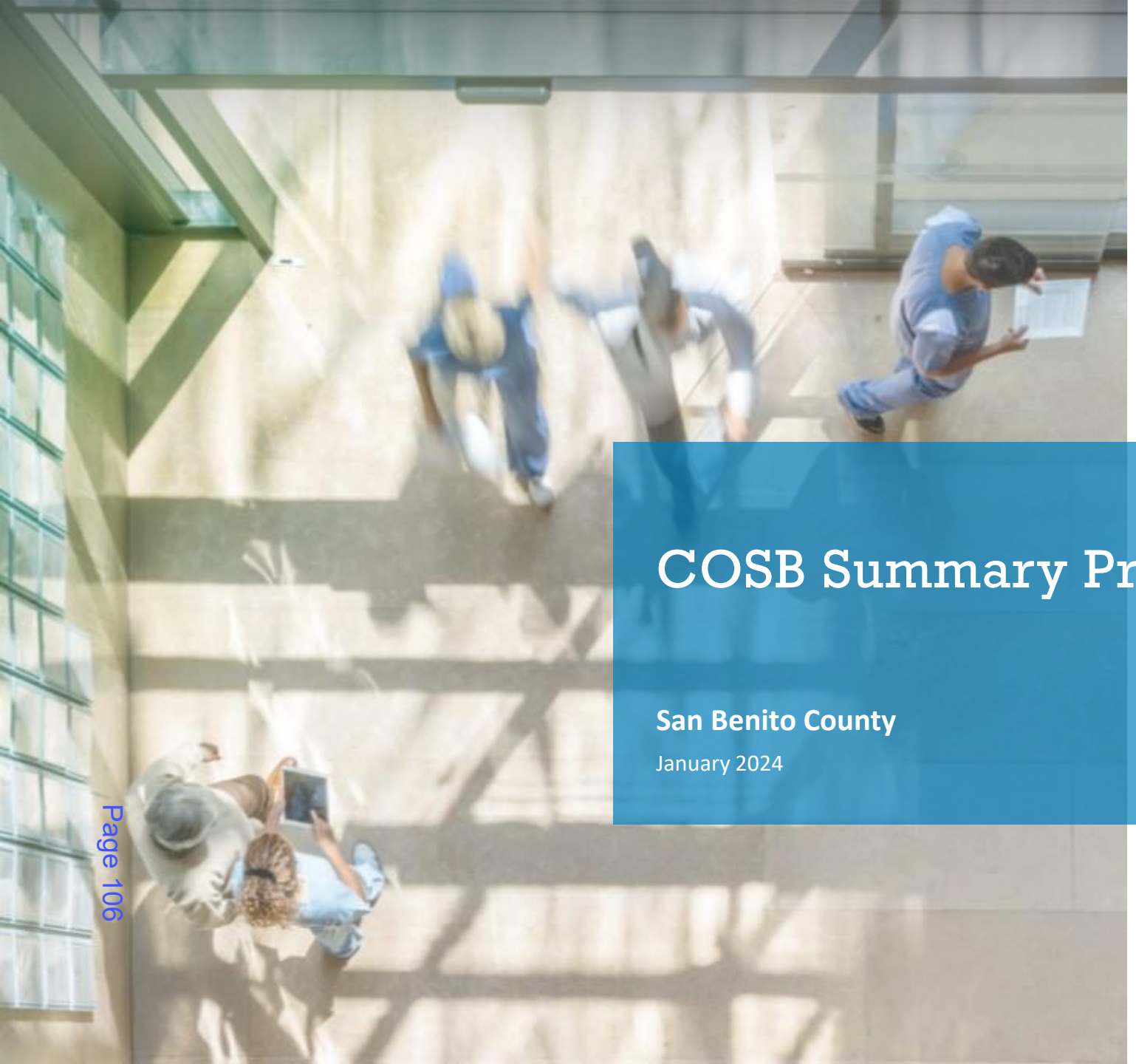
ECG has a long history of assisting healthcare providers and organizations to better understand their environments and craft the transformational strategies and tactics needed to achieve their strategic, business, and mission objectives. We know there is no "one size fits all" approach and pride ourselves on our ability to tailor recommendations based on local market dynamics, strategic strengths, financial realities, and leadership objectives. Successful planning requires deep industry knowledge and expertise, rigorous data and analytics, strategic foresight, political and organizational savvy, and most important of all, practical solutions that can be implemented.

ECG was named top overall healthcare management consulting firm in a *2021 Best in KLAS* report.

ECG has worked with: 17 of the 20 members of *U.S. News & World Report*'s Best Hospitals Honor Roll

85 of 100 Great Hospitals in America as ranked by

PRELIMINARY PROPOSAL FOR DISCUSSION



COSB Summary Proposal

San Benito County

January 2024

Agenda

1. Meeting Objectives
2. Summary of Proposal – County of San Benito (COSB) to San Benito Health Care District (SBHCD)
3. Vision, Strategies, and Funding
4. Financial Analyses
5. Next Steps

Our Objectives

1. Discuss the County of San Benito's (COSB) proposal to work with San Benito Health Car District (SBHCD) and support Hazel Hawkins Memorial Hospital (HHMH)

2. Present our vision, strategies, and funding options for HHMH

3. Discuss the process to work together to reach an optimal option for locally contr healthcare for San Benito County citizens

Summary of Proposal to SBHCD

Development of JPA	Create a Joint Powers Authority (JPA) between COSB and SBHCD (and other governmental agencies if interested) to drive collaboration, financial support, strategic direction of the hospital, and maintain locally controlled healthcare. JPA parties will provide capital to support growth.
Creation of Operating Governance Board	Develop an operating governance board consisting of members with different expertise. The representative composition of the Board may include individuals from SBHCD and from COSB, any other JPA participants with the remaining members to be selected by JPA members to bring important skills and perspectives (e.g., physicians).
Investment of Capital	The JPA proposes to initially provide $12-15M in capital ($5M contribution and remaining $7-$10M will be financed with public debt to the JPA) to HHMH to support growth and immediate liquidity concerns. The district will not issue debt and the JPA is independent to issue public debt. This investment, coupled with the ~$7M in Employee Retention Tax Credit funds, and $10M distressed hospital loan proceeds allows for hospital growth and sustainability.
Creation of Physician Group	Sustainability of HHMH is dependent on growth, which requires the development of an integrated, dedicated medical group. This medical group will relieve access issues via a combination of physicians and APPs who serve patients full-time in San Benito County.
Health System Partnership	It is proposed that a regional established health system is sought to provide infrastructure, and system-based leadership support for the hospital and new medical group. The goal is to find an experienced rural health system partner that can help advance the strategic direction and provide more sophisticated operating systems that HHMH might acquire on its own. Does not need to be in place day one.
Growth in Hospital, SNF, & RHCs	Financial sustainability will only be possible through hospital and skilled nursing services growth. ECG forecasts increases in inpatient and ambulatory volume at the hospital, largely driven by the development of the new medical group and improved confidence by residents. Growth will be expanded by selected clinical partnerships with tertiary providers.

Hazel Hawkins – Health System Vision

Hospital & Skilled Nursing

- Restore confidence and financial stability in hospital services at Hazel Hawkins.
  - Build new broader governance structure that involves more local citizens in hospital oversight – transparency
  - Create new dedicated full-time medical group focused in Hollister to give local people more access to local physician care
  - Partner with South Bay tertiary hospital to support local cancer, cardiology care and OB care
  - Provide more clinically appropriate hospital and ambulatory care
  - Align ALL contracted physician groups under ALL hospital commercial and Medicare Advantage contracts
  - Continue to build out quality, local skilled nursing care in the community

Medical Group & Rural Clinics

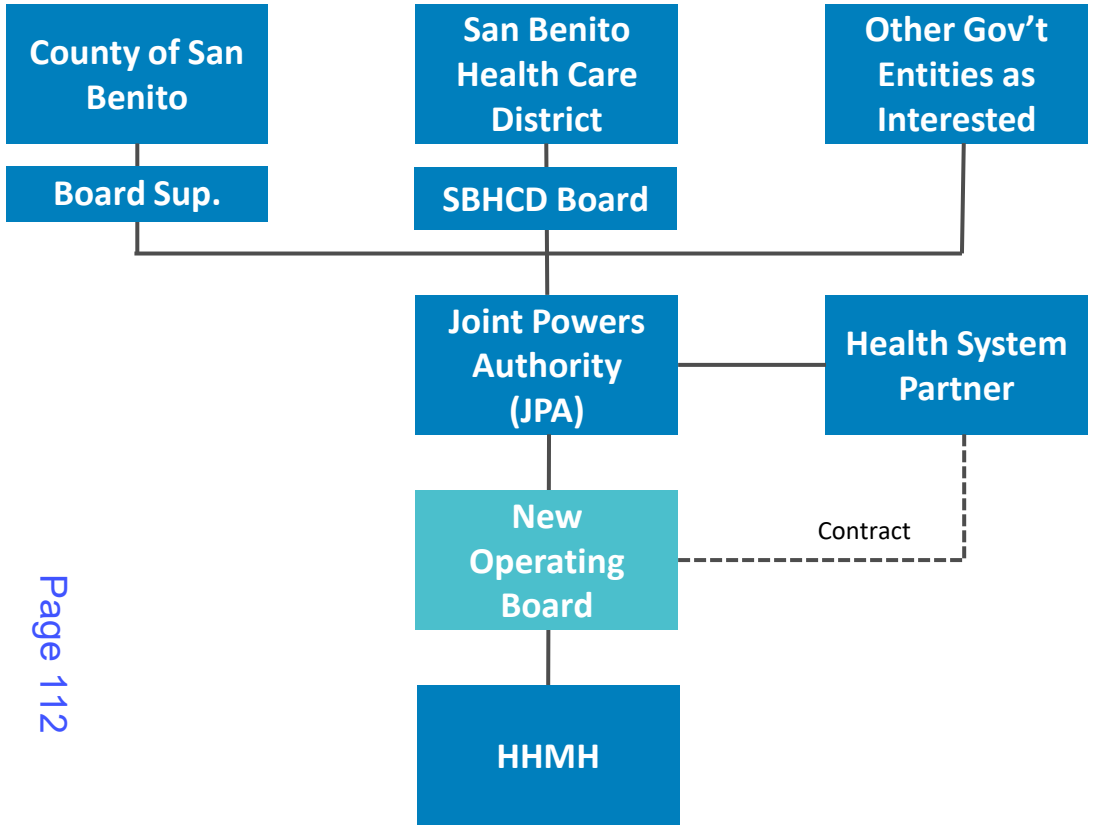
- Invest in the development of a locally employed physician network aligned with Hazel Hawkins
  - Build a scalable and integrated medical care system to serve the Medicare, commercially insured, and Medi-Cal San Benito County population
  - Continue to serve the local lower socio-economic population through the rural clinics and through the development of FQHC capabilities
  - Recruit a mix of physicians, nurse practitioners and physician assistants for the new medical group

Strategies and Funding

Development of JPA

The County proposes a Joint Powers Authority (JPA) to govern HHMH, with Board seats offered to each involved party. The JPA will enter into a contract with a local system to support the operations of HHMH.

JPA Governance Structure



Proposal Overview

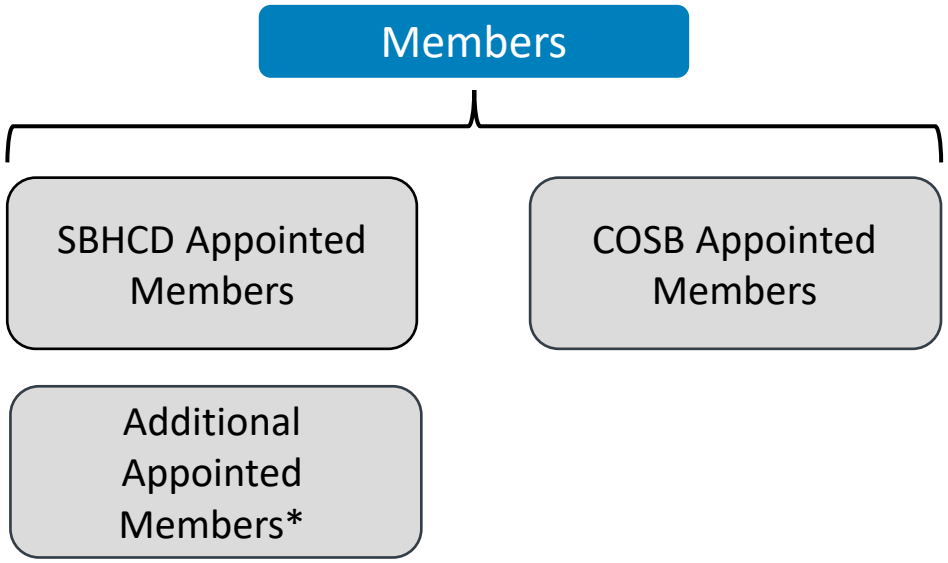
- The Joint Powers Authority (JPA), **consisting of the San Benito Healthcare District, the County of San Benito, and possibly others as interested,** will come together to support a new vision to invest, grow, and manage HHMH.
- The District will continue to own all assets relating to the hospital, SNF, and rural clinics, and will continue to collect all current and future tax revenue.
- The County of San Benito proposes the possibility of adopting of an ongoing fee for any new Community Facilities District "CFD" (a special tax district formed when property owners within a geographic area agree to impose a tax) on the property to fund hospital services.
- The JPA will enter into a contract with an experienced rural health system providing HHMH with oversight, operating systems, and functional expertise.
- The JPA will delegate specific operational and governance authorities to the new local community board selected by the JPA.

Meeting Date: 1-17-2024

Creation of Operating Governance Board

The County proposes the creation of an operating governance Board made up of local community members to help guide hospital strategy and operations.

Potential Operating Governance Board Composition



- **Physicians, nurses, and other providers** will be ideal options for new operating governance board members.

Key Characteristics and Implications

- The operating governance Board is to be **comprised of local community members**, starting with four appointments from both the San Benito Health Care District and the County of San Benito, as well as additional members.
- The JPA partners will jointly select the additional members, potentially **including healthcare providers** and others to help drive the strategic mission of HHMH.
- All Board members will be **local San Benito County residents** with varying backgrounds and areas of expertise.
- To ensure the success of HHMH going forward, this operating governance **Board made up of community members is imperative.** To improve the reputation of the organization, provide broader input into strategic and operational decisions, as well as support quality developments. Residents must feel that the governing body has additional skills necessary to drive change for people of San Benito County.

Investment of Capital

With the combination of the distressed hospital loan, employee retention tax credit, and JPA funding, HHMH will be provided with a substantial influx of cash that can be deployed within the new organization under new broader public governance and experienced rural hospital management.

2024 HHMH Capital Additions

Capital Items	Amount ($M)
Distressed Hospital Loan	$10M
Employee Retention Tax Credit	$7M
JPA Contribution	$5M
Public Debt Issued to JPA	$7M-$12M
Total Additional Capital in 2024	**$29-32M**

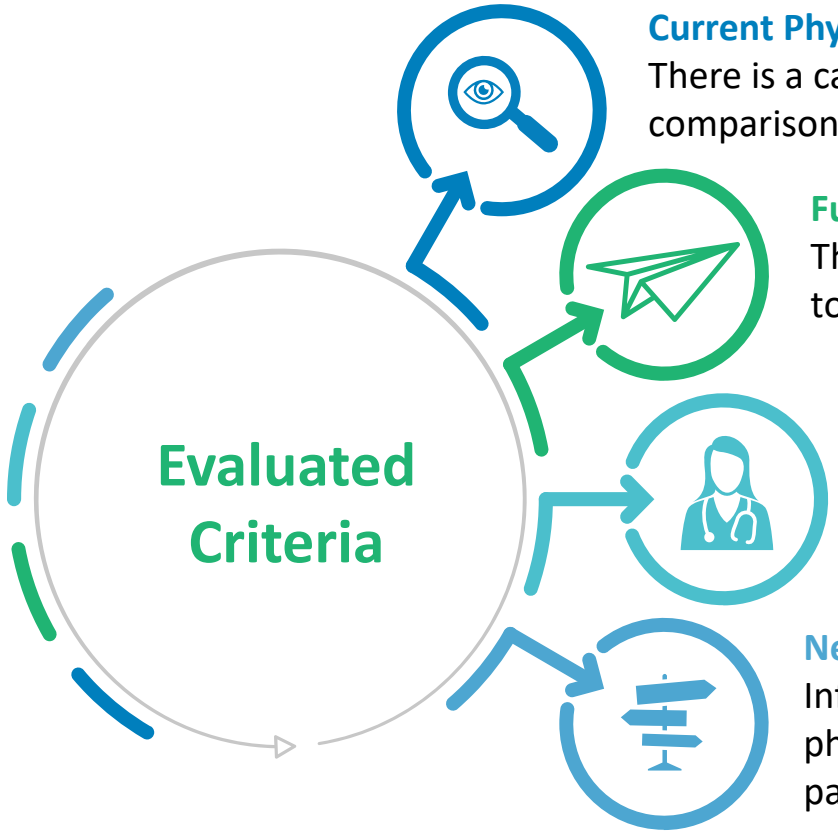
These potential uses of capital have been included in financial sensitivity analyses and forecast a financially sustainable organization when doing so.

Potential Uses of Capital

Medical Group Development	In addition to the cash generation projected from operations, the capital investments will be invested in developing the medical group to serve local citizens and drive growth.
Deferred Capital Expenditures	HHMH management has outlined the immediate need for infrastructure upgrades within the hospital which can be funded through the influx of cash.
EMR Funding	Additional capital will be used to fund HHMH's new and enhanced EMR, possibly through the health system management company. This will help attract physicians and improve patient care.
Pension Liability Funding	SBHCD has an unfunded pension liability that over time will be addressed with the additional cash and growth initiatives.
Reserves to Assist with Liquidity Concerns	While HHMH has immediate capital needs to address, a portion of the added cash can be used to build up reserves and curb days cash on hand concerns in the future.

Creation of Physician Group

ECG performed an analysis of overall physician needs in the County of San Benito. The physician need analysis for the County of San Benito was summarized into four categories.



Current Physician Shortage/(Surplus)

There is a calculated shortage of physicians in the community based on a comparison of physician demand less verified physician supply.

Current Shortage
52.5 Physician FTEs

Future Incremental Growth Need

There is an additional projected demand for physician services due to anticipated population growth over the next five years.

Future Incremental Growth Need
7.4 Physician FTEs

Known Succession Risk

There are physicians in the service area over age 60 who will eventually require succession replacement.

Known Succession Risk
6.3 Physician FTEs

New-Patient Access Barriers

Information gathered during primary source verifications indicates physicians have long average days to third next, non-urgent new-patient appointment.

Creation of Physician Group *Cont.*

The development of an integrated medical group is critical to support the local population and combat the physician shortages in the market. In addition, medical group development is needed to grow local healthcare services.

Medical Group Development: Key Assumptions

- **28.5 providers over 7 years**
  - **9 Primary Care (MDs, NPs, PAs)**
    - 3 in community
    - 6 net new
  - **9.5 Surgical**
    - 3 in community
    - 6.5 net new
  - **10 Medical**
    - 2 in community
    - 8 net new
- **MGMA West Region median compensation benchmarks**
- **Overhead costs:**
  - One-time EMR cost per provider: $20,000
  - Additional annual physician overhead: $175,000
  - Additional annual APP overhead: $100,000

Total annual support costs per provider and staffing ratio of physicians to APPs is assumed in all financial analyses.

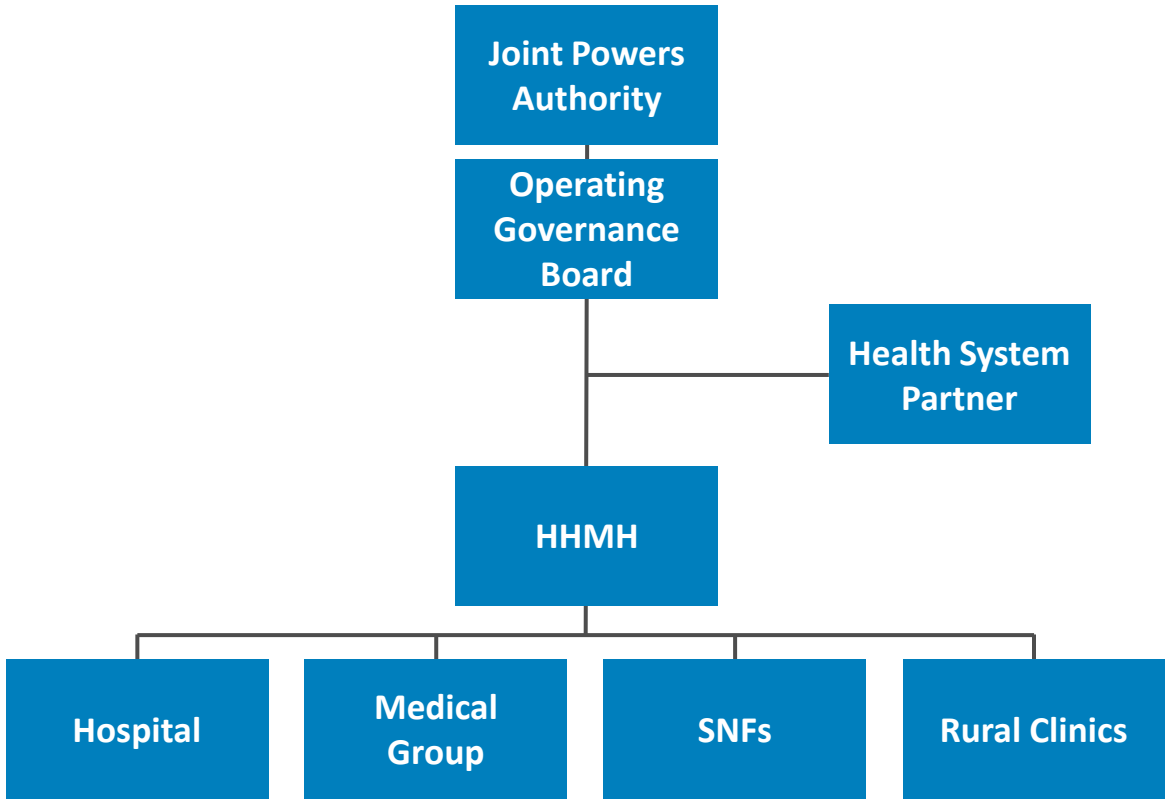
Key Insights

- To create a sustainable future for HHMH, **it is crucial that the organization has an integrated medical staff that is committed full time to the County of San Benito residents**.
  - HHMH's lack of an employed network of providers has led to issues with staffing, specifically in the SNF, and additional billing nuances creating difficulties for patients.
- Over 5 to 6 years, ECG forecasts the development of a **medical group with 25-30 dedicated providers from a range of specialties**, with the inclusion of APPs to support physicians.
- ECG has included **substantial overhead for providers in its analyses, including EMR funding**, and projects a financially sustainable future through overall growth
- Though recruiting and retaining providers will be difficult, a growing market and comparatively affordable living **makes Hollister and the County of San Benito an attractive location for young professionals interested in rural practice.**
- A reimagined medical staff at HHMH is crucial to ensuring high quality care to members of its community, growth of inpatient and ambulatory services, and **improving its reputation in the eyes of local residents.**

Health System Partnership

As a part of the County's proposal for a JPA, it is proposed that the JPA would partner with a health system to provide operating systems and other expertise to HHMH.

HHMH Management Structure



Management Initiatives

- As a result of HHMH's bankruptcy, declining volumes, and shrinking service profile, it is proposed that the JPA brings in a comprehensive and experienced health system to partner with the enterprise operating a community-based hospital.
- Partnering with a local health system will help grow HHMH's scope as a critical access hospital**. This could also evolve into clinical partnerships with the selected system or others, including academics.**

Contract Rationale

- Expertise in new medical group development
- Experience in strategic deployment of large amounts of capital
- Potential for new EMR development
- Drive progress at HHMH and execute the strategic business plan
- Expertise in CA rural hospital turn-arounds

Growth in Hospital, SNF, & RHCs

ECG forecasts an improved financial outlook at the hospital largely driven by growth resulting from reduced outmigration, medical group development, and improved community reputation.

Hospital: Strategic Initiatives & Goals

Volume Growth (IP and OP)	Financial sustainability at the hospital is contingent upon growth in patient volume, specifically Medicare and Commercial payers. As a result of consistent staffing and improved reputation, occupancy is forecasted to increase from ~70% to ~90%.
Revenue Increase (IP and OP)	As higher acuity cases remain local and CMI increases, revenue per unit of service in both the inpatient and outpatient setting is forecasted to slightly increase, specifically for Medicare and Commercial payers.
Service Line Expansion	HHMH has the opportunity to partner with regional tertiary systems on certain specialties such as cancer, OB, and cardiac. Through preliminary discussions, multiple organizations have expressed interest in discussions.
CMI Increase	By expanding on the services offered at HHMH and keeping more cases local, CMI at HHMH is expected to increase to a level in line with other California critical access hospitals. This increase in CIM will correspond to increases in revenue.
Improved Community Reputation	Growth in the hospital is dependent on an improved reputation of the hospital within the community. To reduce outmigration, specifically with higher acuity cases, the County of San Benito population must have trust and confidence in its local healthcare provider. This will be done by investing in a medical group with high quality providers dedicated to San Benito County.

Key Assumptions – Growth Scenario

- **~10% market share increase from 2023 to Year 10**
- **Annual inpatient volume increases Y1-Y5**
  - Medicare: 3%
  - Medi-Cal: 3%
  - Commercial: 5%
- **Annual inpatient revenue per discharge increases Y1-10**
  - Medicare, Medi-Cal, Commercial: 1.5%
- **CMI Increase: 1.15 to 1.30**
- **Outpatient**
  - Visit growth in line with aggregate IP growth
  - Revenue per visit growth: 2% annually
- **Labor expense decrease:** $3M pro forma adj.
- **Inclusion of the following additional items:**
  - Employee retention tax credit: $7M
  - Distressed hospital loan: $10M
  - Gradual pension funding: $2M annually
  - EMR funding: (initial) $10M

Financial Analysis

Financial Sensitivity Analysis Overview

ECG has developed preliminary financial sensitivity analyses for the following scenarios:

Status Quo

- Assumes that no material changes are made to the hospital and its operations.
  - Stable volume declines with minimal volume growth aside from the already high performing SNF
  - No development of a medical group
  - Expenses growing at inflationary levels
  - Less revenue growth than baseline scenario due to lack of medical group.
  - No FQHC conversion of rural clinics.
  - No JPA development/funding
  - $3M downward pro forma adjustment to labor expense
  - Employee retention tax credit
  - Distressed hospital loan

» **Outlook:** In the absence of outside assistance or substantial changes, ECG forecasts HHMH's financial position to continue deteriorating as expenses outpace revenue.

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Growth Scenario

- Increase hospital inpatient occupancy to roughly 90% by year 10
- SNF to reach capacity (90%) by year two
- Development of a medical group leading to increases in volume/revenue.
- Conversion of two rural clinics to FQHC status.
- $3M downward pro forma adjustment to labor expense
- Inclusion of the following items:
  - Employee retention tax credit
  - Distressed hospital loan
  - Gradual pension payment
  - EMR funding

» **Outlook:** In the growth scenario, ECG forecasts net income margin to increase from 4% to 8% in the 10-year period, largely led by increased inpatient and ambulatory services volume at the hospital, with increasing liquidity.

Key Operating Assumptions – Status Quo

Four status quo financial forecast models were developed using the following key assumptions for the hospital, SNF, rural clinics, and medical group financials:

Hospital

- **Annual inpatient volume increases Y1-Y10**
  - Medicare: 0.5%
  - Medi-Cal: 0.5%
  - Commercial: 0.5%
- **Annual inpatient revenue per discharge increases Y1-10**
  - Medicare, Medi-Cal, Commercial: 1.25%
- **CMI remains consistent**
- **Outpatient**
  - Visit growth of 0.5% annually
  - Revenue per visit growth of 1.5% annually
- **Labor expense decrease:** $3M pro forma adj.

SNF

- **3.0% discharge growth in Y1, tapering off to 0% in Y5.**
- **Revenue per patient day growth**
  - 2.0% annually
- **Inflationary expense projections**

Rural Clinics

- **No conversion of clinics to FQHC**
- **Rural Health Clinic visit growth:**
  - 0.5% annually
- **Rural Health Clinic revenue per visit growth:**
  - 1.0% annually
- **Inflationary expense projections**

Medical Group

- **N/A**

Note: Status quo model also assumes no JPA development/funding, or cath lab development.

Key Operating Assumptions – Growth Scenario

Growth scenario was developed using the following key assumptions for the hospital, SNF, rural clinics, and medical group financials:

Hospital

- **~10% market share increase from 2023 to Year 10**
- **Annual inpatient volume increases Y1-Y5**
  - Medicare: 3%
  - Medi-Cal: 3%
  - Commercial: 5%
- **Annual inpatient revenue per discharge increases Y1-10**
  - Medicare, Medi-Cal, Commercial: 1.5%
- **CMI Increase: 1.15 to 1.30**
- **Outpatient**
  - Visit growth in line with aggregate IP growth
  - Revenue per visit growth: 2% annually
- **Labor expense decrease:** $3M pro forma adj.

SNF

- **90% occupancy in year 2,** assume SNFs can be staffed at this level
- **Revenue per patient day growth**
  - 2% annually
- **Inflationary expense projections**

Rural Clinics

- **Conversion of two largest rural clinics to FQHC**
  - 4180 Sunset
  - 4187 4th Street
- Increased revenue per visit growth at the two FQHC clinics
- **Rural Health Clinic visit growth:**
  - 2% annually

Medical Group

- **28.5 providers over 7 years**
  - **9 Primary Care (MDs, NPs, PAs)**
    - 3 in community
    - 6 net new
  - **9.5 Surgical**
    - 3 in community
    - 6.5 net new
  - **10 Medical**
    - 2 in community
    - 8 net new
- **MGMA West Region median compensation benchmarks**
- **Additional annual overhead:**
  - Physician: $175k
  - APP: $100k

Additional Key Operating Assumptions by Scenario

The status quo and growth scenarios also include the following items:

Status Quo – Additional Items Included

- **Employee retention tax credit**
  - $7M favorable pro forma adjustment to 2023 financials
- **Distressed hospital loan**
  - $10M favorable pro forma cash adjustment, $10M associated liability. Principal payments

Growth – Additional Items Included

- **Employee retention tax credit**
  - $7M favorable pro forma adjustment to 2023 financials
- **Distressed hospital loan**
  - $10M favorable pro forma cash adjustment, $10M associated liability. Principal payments
- **Gradual pension payment**
  - $2M annual pension payment (could be greater)
- **EMR funding**
  - $2M annual capital commitment in years 1-5
- **JPA Funding**
  - $12-15M - $5M contribution $7-10M in long-term debt issued to JPA.

Scenario Analysis Comparison: Financial Summary

Under the growth scenario, there is a path to long-term financial sustainability that is dependent on execution of the strategic plan. However, under the status quo scenario expenses will outpace revenue and erode margins.

	Historical		Forecast									
	2023	Nov 2023 TTM	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Status Quo												
Operating Income	($1,018,530)	$2,933,447	$154,948	($1,869,879)	($3,929,619)	($5,226,364)	($5,918,239)	($6,017,683)	($6,441,472)	($6,716,398)	($7,193,800)	($7,866,222)
EBIDA	$6,239,017	$10,340,818	$8,327,304	$6,443,359	$4,437,707	$3,207,846	$2,595,260	$2,587,141	$2,261,361	$1,720,793	$1,028,782	$242,480
EBIDA Margin	4.1%	6.9%	5.5%	4.1%	2.8%	2.0%	1.6%	1.5%	1.3%	1.0%	0.6%	0.1%
Operating Cash	$14,441,825	$18,849,384	$35,909,306	$35,114,765	$32,309,491	$28,003,195	$22,807,680	$19,233,907	$15,310,911	$11,642,345	$8,066,653	$3,646,778
Operating DCOH	35.0	48.4	88.6	83.4	74.0	62.4	49.7	41.1	32.0	23.8	16.1	7.1
Growth												
Operating Income	($1,018,530)	$2,933,447	$2,091,338	$2,298,824	$2,077,104	$3,734,047	$5,204,917	$7,265,337	$9,129,696	$10,969,987	$12,881,716	$14,689,706
EBIDA	$6,239,017	$10,340,818	$12,163,693	$12,212,062	$12,244,430	$14,168,256	$15,418,416	$17,070,161	$19,032,529	$20,407,179	$21,904,298	$23,398,409
EBIDA Margin	4.1%	6.9%	7.6%	7.2%	6.9%	7.6%	7.9%	8.5%	9.1%	9.4%	9.8%	10.1%
Operating Cash	$14,441,825	$18,849,384	$37,183,402	$39,285,752	$40,402,326	$42,994,648	$46,651,951	$54,004,258	$63,281,722	$74,769,823	$88,510,924	$103,678,867
Operating DCOH	35.0	48.4	89.1	89.0	87.1	89.0	93.0	104.7	119.1	136.4	157.3	179.4

Next Steps

- Develop a plan for collaboration discussions moving forward
- Schedule additional follow-up meetings if interested

Appendix

Medical Group Development - Physician Shortages & Succession Risks

There is a shortage of almost 60 physician FTEs in the San Benito County in the evaluated specialties based on the current physician supply plus projected incremental demand due to population growth.

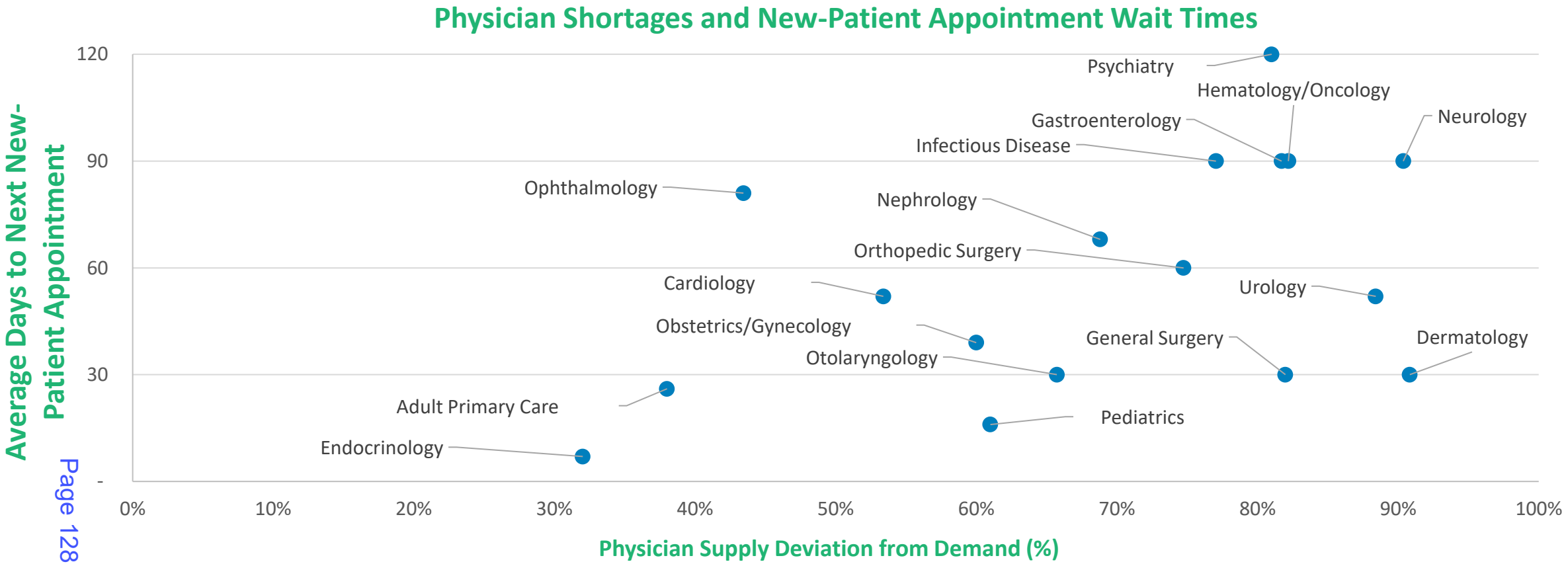
Specialty	Current Shortage[1]	Growth Need[2]	Physician Succession Risk[3]
Core Specialties			
Adult Primary Care[4]	8.8	2.1	2.4
Pediatrics	4.2	0.6	1.7
Obstetrics/Gynecology	4.4	0.6	-
Psychiatry	4.2	0.5	0.4
Core Specialties Total	**21.6**	**3.8**	**4.5**
Medical Specialties			
Allergy/Immunology	1.0	0.1	-
Cardiology	2.4	0.4	0.8
Dermatology	2.0	0.2	0.2
Endocrinology	0.5	0.1	-
Gastroenterology	2.2	0.2	0.3
Hematology/Oncology	2.0	0.2	0.2
Infectious Disease	1.5	0.2	-
Interventional Radiology	0.8	0.1	-

Specialty	Current Shortage[1]	Growth Need[2]	Physician Succession Risk[3]
Medical Specialties *(continued)*			
Nephrology	1.1	0.1	0.2
Neurology	1.9	0.2	-
Physical Medicine/Rehab	1.8	0.2	-
Pulmonology/Critical Care	2.3	0.2	-
Rheumatology	1.1	0.1	-
Medical Specialties Total	**20.6**	**2.3**	**1.7**
Surgical Specialties			
General Surgery	3.6	0.4	-
Ophthalmology	1.4	0.3	-
Orthopedic Surgery	3.0	0.3	-
Otolaryngology	1.2	0.2	-
Urology	1.5	0.2	0.1
Surgical Specialties Total	**10.7**	**1.4**	**0.1**
Grand Total	**52.5**	**7.4**	**6.3**

1 Represents the average current specialty demand, based on 2023 San Benito county demographics, less the current supply of physician FTEs.
2 Represents the projected incremental demand due to demographic changes from 2023 to 2028.
3 Physician FTEs age 60 or greater are considered potential succession risks.
4 Adult primary care includes family medicine and internal medicine.

Current Shortages and New-Patient Wait Time Magnitude

Specialties with the largest deviations between current physician supply and demand also have among the longest new-patient appointment wait times. These specialists have lengthy referral backlogs that impede timely access to care.



Note: Allergy/immunology, interventional radiology, physical medicine/rehabilitation, pulmonology/critical care, rheumatology are not included on the scatter plot as there are no physician FTEs in San Benito County.

Physician Supply Verification

ECG's primary source verification methodology quantifies time spent in clinical practice for individual physicians at all locations, confirms specialty/subspecialty, and measures new patient access.

Physicians were initially identified through various sources:

- State licensure database
- Hospital staff and large group provider listings in the region
- Third-party provider databases
- Provider directories

Additional research was necessary when calls did not yield accurate data or sources are not cooperative:

- Noncooperative practices
- Physicians who cannot be located as listed

A physician had a presence in the defined market. → **The physician was verified either by phone . . .** → **. . . or via other research methods.** → **A clinical FTE was assigned.**

Calls were made to most practices to determine the following:

- Specialties and subspecialties
- Clinical practice locations
- Time spent in clinical practice in each location (by zip code)
- Acceptance of new patients (any new patient, Medicare, and Medicaid)
- Wait time for new patient appointment (third available baseline)

Clinical FTEs were preliminarily assigned based on the following:

- Any physician with a 0.1 or greater FTE for clinical practice in the defined market area
- With an FTE based on 0.1 for each half day of practice up to a maximum FTE of 1.0
- Regardless of age

SBHA-Ovation Collaboration
440 San Benito Street
Hollister California 95023

Thursday 25 January 2023

Jeri Hernadez, President
San Benito Health Care District
911 Sunset Drive
Hollister, California 95023

Via email and US mail

Dear President Hernadez:

The San Benito Healthcare Alliance (SBHA) and Ovation Healthcare (Collaboration) are pleased to provide their letter of intent for (LOI) as an innovative collaborative approach with the San Benito Healthcare District Board of Directors and Hazel Hawkins Leadership. The Collaboration is proposing an alternative to divesting the assets of Hazel Hawkins, to allow the District Board to maintain its local ownership, governance, and control by executing an operating agreement similar to the one Marin County created to enjoin the Collaborative as the operating entity governed by the San Benito County Healthcare District. The Collaborative's proposal will not incur the costs and public outcry by the Sale of Hazel Hawkins. Is our belief our collaboration will generate improved community support and appreciation with our efforts to keep Hazel Hawkins in local ownership and control of one of San Benito County's most treasured institutions.

Below are our responses to the criteria the Board has established for entertaining letters of interest proposals.

Criteria One: Demonstrate a long-standing history and experience of hospital administration.

The Collaboration proposes the District contract with the SBHA whose joint venture partner Ovation Health to provide the daily management, and operational oversight to establish the path of success and sustainability for Hazel Hawkins for the generations to come.
The SBHA is a community member organization made up of physicians, nurses, medical support staff, and business, financial, and community members to provide a diversified level of medical, operational, and financial experience not typically associated with a hospital operation.

Ovation Health is a healthcare-focused management company with a forty-five-year operating history. Ovation currently successfully manages forty-five hospitals nationwide of which twenty-seven are Critical Access. Ovations Leadership Team has eight specialty practices to afford the communities we serve the most comprehensive management tools and operational talents draw from to overcome the constantly changing landscape the healthcare industry is facing. Be it a recession, pandemic, and the constant regulatory challenges we have effectively maintained our client's ability to receive quality healthcare. And specifically to Hazel Hawkins the ability to mentor and guide the turnaround, operational and financial expertise, seismic compliance strategies, and capital needs, facility upgrades to ensure financial sustainability and most importantly restore the trust, patronage, reputation, and legacy of Hazel Hawkins.
This collaboration will provide the District with an enhanced and experienced leadership team positioned to ensure Hazel Hawkins remains the community healthcare provider.

Criteria Two: A proven history of maintaining quality of care.
The collaboration will establish its path of providing proactive vs. reactive healthcare by establishing new and improved relationships with the community's core physicians, nursing, and support colleagues. This effort will set the foundation for attracting additional primary and specialty care providers to facilitate the expansion and much-needed advanced care opportunities. Ovation's track record of improved healthcare scores, and community involvement through its best practices has achieved national recognition from its stroke certifications, Heart Beta tier awards, leapfrog, and Magnet recognition Joint Commission accreditation, all while achieving the healthcare industry's coveted CMS five-star ratings. However, Ovation's performance and delivery of quality care are best documented by the support and patronage we receive from the communities we serve.

Criterial Three: Able to mitigate some of the risks and liabilities while further developing assets, (clinics) and expansion of Care.

The Collaboration capitalizes on guidance from its specialty care teams in addition to its multi-state network of healthcare districts and community-owned and non-profit hospitals where Ovation has been successful in overcoming obstacles and challenges as they arise.

Ovation's leadership track record of facilitating and successfully overcoming the changing insurance, drug, and government regulation landscape while expanding its delivery of quality healthcare by building vertically and horizontally integrated networks in primary and specialty care practices, urgent care, and rural health clinics and outreach programs meet each local communities unique needs has achieved the financial outcomes for superior delivery of healthcare services are provided to our clients and their its communities.

Criteria Four: Provide proof of funds necessary to meet the bidder's purchase price. In addition, must provide evidence of adequate liquidity and financing to meet all post-transaction obligations to HHMH, such as future lease payments, etc.

Given the Collaboration proposal will not necessitate a sale. The process of negotiating a sales price and incurring a public vote to approve the transaction will be less costly or necessary.

The Collaboration has assembled a group of private funding sources who upon review and approval of the Collaboration business and improvement plans will fund the financial projections identified in its business plan to gain the sustainability and success Hazel Hawkins has the potential to achieve. Available funding includes the operational capital to effectively improve the operations, revenue generation to restore the financial sustainability of the organization, expansion of medical staff and programs, needed capital equipment replacement and upgrades, bankruptcy settlements and debt servicing, contact administration for long-term viability and completion of the substantial deferred maintenance issues that the hospital is facing. The most crucial task affecting the culture change required engaging the staff and community to support Hazel Hawkins as they emerge as a destination medical provider. With this structured success, strategically develop additional community support, grants, and funding to ensure Hazel Hawkins will be there for future generations.

The Collaboration will provide verifiable proof of funding after completing its business plan.

Criteria Five: A proven record for the turnaround of distressed rural hospitals.

As noted, the Collaboratives partner Ovation Health currently successfully manages approximately 45 hospitals throughout the United States of which 27 of them are Critical Access Hospitals. Ovation's history of coming in and returning ailing facilities to sustainable and successful operations will be shared with the Board upon the formal presentation of our LOI. The offer will include inviting members of the District Board, the hospital leadership, Physicians, Nurses, and support staff and include members of the community to visit one or more of our existing clients to see firsthand our abilities. Seeing is believing.

Criteria Six: No track record of rapid asset liquidation

The collaborative core mission of vision and values is essential in preserving assets, enhancing technology, and applying best practices to stabilize and grow an organization. Depleting or selling off assets is not any part of any business plan the Collaboratives will employ.

Criteria Seven: Understand specific terms and conditions, as well as the general obligation bond and payoff.

The Collaboration is well-versed and experienced with the various public and private funding mechanisms throughout the United States including California. Since the Collaboration's LOI will not require the immediate payoff of the District's structured debt. Its business plan will uniquely address the servicing and accelerated payoff of the district's obligations to further demonstrate Hazel Hawkins's ability to borrow and pay back its debts to facilitate future capital needs to remodel or replace the existing hospital.

Moving forward, the Collaboration will be having Ovation's leadership, operational, accounting, and facility evaluation teams come to Hollister to complete their full assessment needed to complete their business and funding plans. Given the complexity, the Collaboration expects it will need sixty days or more to complete its tasks and will provide monthly progress reports to the District's Board. .

Given the Collaboration's proposal is currently the only viable entity to allow local ownership and control, it is expected the Board will allow this timeline given the importance to the community and its taxpayers.

The Collaboration by its name set our approach to save Hazel Hawkins, which will mean a collaboration of ourselves, the District Board, Hazel Hawkins leadership, medical and operational colleagues, and most importantly the community to implement the most transparent organization to protect and preserve quality healthcare will always be available to San Benito County.

Madam President, the Collaborative is looking forward in discussing this opportunity in person with the entire Board at their first availability. As noted, we will be requesting a visit to allow Ovation's leadership teams to complete its comprehensive evaluation of Hazel Hawkins to enable us to provide a successful path of sustainability for the District.

Please do not hesitate to reach out to me if you have any questions or concerns,

Very Truly Yours

Dr. Ariel Hurtado, MD
President
San Benito Healthcare Alliance (SBHA).

Hazel Hawkins
MEMORIAL HOSPITAL

CEO Report
February 2024

Financial Emergency Update

- Site visit to Flint, Michigan and Chicago to visit Insights properties with Director Pack and President Hernandez. A verbal report will be given at Board Meeting by the Ad Hoc Committee.
- Met with Ad Hoc committee to go over County's new proposal.
- Virtually attended Bankruptcy court where our attorney's gave a status update to the Court letting the know we have received 4 Letters of Intent/Interest.
- Received second report from court-appointed Ombudsman. Please see attached report.

CEO Activities

- Attended the District Hospital Leadership Forum meeting. Main topics of discussion were; MCO Tax, Office of Health Care Affordability, CHFFA Bridge Loan repayments, DHDP Program. Please see attached presentations from the meeting for more detail.
- Started work with CHA on the Rural Seismic Workgroup. First meeting was February 15 where we discussed strategy and advocacy. A deeper conversation will take place the Rural Health Symposium in San Diego at the beginning of March.

HR

- Turnover rate for January 2024 is at 1%. Please see attached report for more detail. We will be reporting this on a monthly basis going forward.

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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 SECOND INTERIM REPORT**

Jerry Seelig, in his capacity as the Patient Care Ombudsman (the "**PCO**")[1] and under 11 U.S.C. § 333(a)(1), files this Second Interim Report (the "**Second Report**"). Pursuant to Bankruptcy Code § 333, the PCO is monitoring the quality of patient care for any significant decline or material compromise. The PCO employed the standards set by **11 USC§333**[2] to:

- Determine to the best of their ability 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.

[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.

[2] 11 USC § 333. Appointment of patient care ombudsman, (B) (3)

- Determine to the best of their ability, 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 nor compromise to care.
- Determine to the best of their ability the potential compromises to care, which in summary the PCO has identified specific instances where there is potential for compromise to care.

The **First Interim Report [Doc #95]** (hereafter the **"Report"**), which employed these standards, was filed on October 11, 2023. To complete to the best of their ability an in-depth monitoring effort, the PCO has prior to filing this Second Report, completed a second visit to 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.

An initial visit by Mr. Seelig, two subsequent visits by all three professionals, the interviews conducted on and off premise, review of key patient care and safety reports and the PCO's experience and qualifications have enabled the 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

II. EXECUTIVE SUMMARY

III. UPDATED REPORT ON EACH OPERATING UNIT

IV. THE POTENTIAL FOR COMPROMISE TO CARE

V. NEXT STEPS FOR THE PCO

I. THE PCO's MONITORING METHODOLOGY and SCOPE

A. Methodology

The PCO has continued a cost-effective plan to monitor on and off premises the Debtor's patient care and safety at the Debtor's dispersed facilities. The PCO continues to receive 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. In the period post filing the Report, the PCO interviewed the following: (i) the Debtor's CEO, (ii) the CFO, (iii) the Director of Provider Services & Clinic Operations; (iv) the newly employed corporate Chief Nursing Officer ("**CNO**"); (v) the Clinic Operations Manager; (vi) the appointed 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 performs 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, Dietary & Facilities, (xii) the Directors of Laboratory, Radiology, Physical Therapy; and (xiii) other knowledgeable parties. At each facility, the PCO attended clinical care and revenue cycle meetings. Ms. Knox, an experienced clinical nurse, and hospital administrator observed surgical procedures, interviewed the person that performed the sterilization of instruments, and observed other activities in support of safe surgical operations.

2. Shaped by the prior monitoring effort, at each facility, the PCO reviewed internally prepared documentation of patient care and incidents ("incident reports") to identify patients harmed and then research specific patient charts and care components. With cooperation of the Debtor, the PCO was able to examine cases identified in prior cases as having potential for compromise to care and/or failing to meet required clinical and regulatory standards. The PCO continued both their review of the specific incident reports, as well as examining both the specific-facility and system-wide efforts regarding peer review and performance improvement programs.

3. With the cooperation of the Debtor and their counsel, the PCO established a secure "Data Room," that enabled the Debtor's team to provide the PCO with necessary

documents and material. Key documents secured in the Data Room and reviewed by the PCO include:

- Liability-risk, staffing, compliance, and contracting for clinical and nonclinical, materials/supplies/temporary staffing documents at the facility and corporate level.
- Reported state and federal quality measures, including each facility's Joint Commission Surveys3 and any federal or state agency Statements of Deficiencies and Plans of Corrections for the past two-years.4
- Facility-specific reports and distilled all that into the PCO's reports to the Court.
- 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.

As promised in The Report, the PCO has continued off and on site to review and analyze the above and other requested reports/materials/data over the past 10 weeks.

II. EXECUTIVE SUMMARY

A. The Debtor's Operating Units

The PCO references The Executive Summary Chapter in the Report, which offered the court an overview of each of the Debtor's operating units, which are:

[3] 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.

[4] 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 following 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.

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

2. **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[5].

3. **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.

B. The PCO Assessment of Patient Care and Safety

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

We respectfully remind the Court that 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 is an indicator of the ongoing quality of care. Prior to completing the Report, patient medical records were sampled to test for the existence and timeliness of required medical records, forms, and statements. Using remote access granted by the debtor, the PCO selected medical records from all three of the Debtor facilities to include the

[5] Casillas Declaration para 31 pp 8-10

hospital, clinics, and nursing homes.

The PCO stated, based on their review of the records, that the Debtor is using the three electronic health information systems effectively. In that Report, the POC stated based on employing remote access and interviews with the medical records' staff that the Debtor has good compliance with their medical record maintenance obligations.

On site visits prior to the Report and the second visit conducted in November allowed the PCO to sample patient medical records from all various hospital units, the clinics, and the skilled nursing facility. This on-site sample of medical records enabled the PCO to test for the existence and timeliness of required medical records, forms, and statements.

These tests, further chart review, and observation by the PCO led to the PCO stating in the Report ***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. The PCO's post Report efforts on and off premise support that the Debtor continues to meet the requirements for providing information/documents needed for patient continuity of care.***

2. Assessment the Key Factors Preventing Compromises to Care

a) The PCO's assessment of the Debtor's leadership continues to be that they are ***qualified and experienced professional***s who are serving in a competent manner. The Debtor recently employed a Chief Nursing Officer, with strong qualifications, who based on our initial review is doing an excellent job addressing quality assurance and clinical care issues addressed in the Report.

b) As reviewed in detail in the Report: ***Medicare certification, accreditation by Joint Commission, and other regulatory bodies*** established standards of patient care and safety and conduct frequent on-site surveys[6] [7]. We stated in the Report that the Debtor's hospital, Laboratories and Clinics have maintained their accreditation with comparatively few deficiencies to correct. With the continued full cooperation of the Debtor, the PCO to the best of

[6] op cite at note 2
[7] op cite at note 3

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, accreditation by Joint Commission documents, and other regulatory bodies established standards of patient care and safety on-site surveys; the PCO believes that appropriate action is being taken to correct deficiencies cited in the surveys[8] [9].

c) The Debtor is scheduled for a Joint Commission accreditation survey in April 2024. The PCO, in their role as hospital executives engaged in intensive "survey readiness" review and consultative position in the months prior to this most important accreditation of both the Hospital and Clinics. Best practices are to employ in-house and/or external consulting resources to trial or test the survey readiness of the organization and the current quality of patient care and safety in an effort to define a focused plan of correction for any deficiencies if found in the mock survey. Based on our interviews and limited review of materials, we believe that the Debtor's management has initiated a survey preparedness effort. The PCO will in their planned early February site visit, will engage in an in-depth review of this effort and report to the Court in a timely manner.

d) As reported in the Report, all Hospitals, SNFs, and Rural Clinics are required to attempt to complete a ***Standardized Patient Satisfaction Survey*** at the time of the

[8] "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.

[9] 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 following 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.

patient's discharge.[10] On its second site visit, the PCO reviewed survey results at each of the Debtor's operation units and will report to the Court in their next 60-Day Report. The PCO's sampling of ***Standardized Patient Satisfaction Surveys*** and their on-premises interviews with patients contributes to its analysis that patients have reported satisfaction with the care they received.

e) Based on the PCO's continued interviews and an extensive on-site review, the PCO continues to believe 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 Chapters that follows 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 specific instances in each operating unit that offer the potential for compromise to care that need remediation identified and reviewed in the First Report were the focus of the PCO on and off premise monitoring post the filing of the Report. In the Chapters that follow, the PCO offers the Court their assessment of the Debtor's efforts to prevent and a compromise to care.

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, continues to be led by Jody Knox MHA, BS, RN, who is a highly skilled health care administrator. Ms. Knox has served as a hospital CEO, senior manager in large health care provider organizations, and who

[10] 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.html

has extensive experience in clinic operations.

On and off premises, the PCO continued both their review of documents and zoom interviews with the Hospital's leadership team. Soon after the filing of the Report, the PCO hosted a zoom meeting with the hospital operating unit leaderships, the Debtor's CEO, the Rural Clinic manager and the SNF director executives to review those policies, procedures, and practices that the PCO determined could lead to a decline in or compromise to 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 second campus tour that included patient care areas as well as many, if 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.). Concurrently they review any equipment issues, which is both good practice and an excellent communication mechanism.

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

e) During the second visit as in the first, the PCO randomly reviewed patient care supplies and medications for expiration dates and those reviewed were found to be compliant.

During the Second Site visit, the PCO made rounds in the following departments:

OB/Women's Health:

- PCO had the opportunity to observe a Cesarean section, (with appropriate and documented consent from all participating parties). During which time, PCO observed the appropriately timed and verbalized 'time-out(s)' were performed and documented. As well as appropriate sponge, medication, and needle and other such 'counts' as per policy and required surgical procedures. It should be noted that PCO did not stay for the entire procedure, therefore PCO cannot validate that there were the required closing count(s) as required of the sponges, needles, instruments, and materials employed in the procedure.

Surgery

- PCO had the opportunity to observe a wound debridement, (with appropriate and documented consent from all participating parties). During which time, PCO observed the appropriate timing of antibiotic administration prior to incision, the appropriately timed and verbalized ' time-out(s)' were performed and documented. As well as appropriate sponge, medication, and needle and other such 'counts' as per policy and required surgical procedures. It should be noted that the PCO did not stay until the end of the procedure to validate that closing count(s) were performed per policy.

Sterile Processing

- PCO interviewed the agency staffing personnel who described in detail how the sterilization process is done. The organization uses the 3M Attest system, a universally widely accepted practice. A review of the records and a cursory review of the instruments was completed. Although it does not use an Event Related Sterility practice, instead it remains using expiration dates. A sample policy was provided at the time of visit. Event Related Sterility means that an item is sterile until an event occurs to make the sterility of the product questionable (i.e.: dropping the item on the floor, moisture detected on the packaging or a tear or other compromise to the package. AORN's 2010 Recommended Practices for Sterilization in the Perioperative Practice Setting state that "the shelf life of a packaged sterile item should be considered event-related."[11] It appropriately suggested to the CNO and the Infection Control practitioner at the time that the organization move to Event Related Sterility practice.

Contract Review

- PCO reviewed with the clinical contract responsible person that the organization does process vendors through a purchased software system known as 'VendorMate,' a widely used system in the healthcare environment for the required OIG reviews. The organization uses this for both clinical and non-clinical contracts. The medical staff uses a different software program called "Simpler" for the required Office of the Inspector ("OIG") review of vendors to prevent contracting with parties not approved by OIG and other regulating bodies.

[11] OR Manager, Vol 26, No 5, May 2010

Materials

- PCO conducted a further session with this director as a follow up to first visit. During this time it was determined that the organization will be moving to another vendor for linen supply. This is estimated to save this organization in excess of ~$500k/year. This should be monitored monthly for financial, service, quality and infection control parameters and reported through the appropriate committees.
- During this follow up session the Director acknowledged that the Safety Committee was being enhanced as an invitation had been extended to all department managers to participate. There has been sporadic participation but much work will be ongoing to increase this, especially in the areas of OR and SNF.
- Effective November 1, 2023, the organization has taken the stance regarding flu vaccinations and any employee that has not received a flu vaccination will be wearing an appropriate mask in clinical areas.

During the next site visit the PCO will review:

- GI Scope and Processing area
- Registration
- Case Management
- Covid Preparedness in light of the increase in cases as well as participation in region-wide committees/meeting/calls
- Meet with Clinics Medical Leadership
- Conduct In-Depth Review Clinic and other Ambulatory Financial Information

2. The Hospital's Remediation of Deficiencies Cited in Report

As cited in the Report, the PCO identified at the Hospital Operating Unit specific clinical practice and system issues that could lead to potential or actual compromise to care. In the Report

we stated the PCO would monitor and report to the Court on the Debtor's effort to remediate issues that could contribute to a decline in care. In person and at Zoom meetings, led by the Chief Nursing Officer, the Debtor's leadership team presented what actions were taken to remediate the problems identified. The Hospital Unit team provided the PCO with patient charts, requested documents, and performance data to support the PCO's review efforts.

Based on the information provided on and off premise and other monitoring efforts the PCO assessment is that:

a) The Debtor's Hospital Unit Leadership responded to the PCO's reporting on potential compromises to care in the Hospital Operating Unit. The PCO believes based on the information presented that the Hospital Operating Unit is making a strong effort to remediate the problems and issues presented in the Report.

b) The Hospital Operating Units continue to provide high quality patient care and safety with staff and leadership exhibiting a strong commitment to provide cost efficient and effective care.

B. THE SKILLED NURSING FACILITIES' SYSTEM REVIEW

The SNF assessment effort was led by Lisa Grod Ph.D. a licensed nursing home administrator with extensive experience in skilled nursing operations and regulatory compliance. As reminder, 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. 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."

To continue their monitoring, PCO requested and received key documents from the Skilled Nursing Leadership and conducted zoom interviews with the leadership team of the SNF operations. The Interim SNF Director of Nursing (the senior administrator) participated in the PCO led zoom meeting with the hospital operating unit leaderships, the Debtor's CEO, and the Rural Clinic manager to review those policies, procedures, and practices that the PCO determined

could lead to a decline in or compromise to care. During the three-day November SNF site visit, meetings were held with the executive and senior leadership teams daily and multiple interviews were conducted with resident-facing staff.

1. The November on-site Interviews and Expert Observations included:

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 SNFs during the onsite visit.

a) **Facility Rounds** were made with The Infection Preventionist and Interim SNF DON 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 emergency disaster supplies.

b) **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. Bed-bound resident activity programs were reviewed as well as incidents, theft and loss, and grievances with social services.

c) **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 California Department of Public Health ("CDPH")[12] survey to review.

d) **Meetings** were held with Interim DON, staff, and Registered Dietician, Director of Rehabilitation, Billing and Collections, and via telephone with the

[12] The California Department of Public Health ("CDPH") "The California Department of Public Health (CDPH) works to protect the public's health in the Golden State and helps shape positive health outcomes for individuals, families, and communities. The Department's programs and services, implemented in collaboration with local health departments and state, federal and private partners…Through its monitoring-inspection "survey" programs, CDPH "protects patient safety in hospitals and skilled nursing facilities, maintains birth and death certificates and prepares for, and responds to public health emergencies." At: https://www.cdph.ca.gov/Pages/About.aspx

Pharmacy Consultant and SNF Medical Director. Meetings included discussions of the patient tracking and Minimum Data Set ("MDS")[13] 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[14], QAPI, Care Plans, catheters, wounds, and a Prospective Payment System/Payment Driven Payment Model ("PPS/PDPM")[15] billing review. Rounds with the Infection Preventionist included reviews of the antimicrobial stewardship program, and Emergency Disaster Preparedness and triage processes, and vaccination rates of residents and staff.

e) **Billing and Financial Review:** P & Ls were reviewed along with collections. The PCO 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. The January 1, 2024, transition to Central Coast Alliance and timely authorizations and completion of TARS for billing and collections was discussed.

f) **Policies on** theft and loss, grievances, sanitation rounds of kitchen, and incidents were provided to the PCO along with Internet Quality Improvement & Evaluation

[13] "The Minimum Data Set (MDS) is a powerful tool for implementing standardized assessment and for facilitating care management in nursing homes (NHs) and non-critical access hospital swing beds (non-CAH SBs). Its content has implications for residents, families, providers, researchers, advocates, stakeholders, and policymaker."MDS data reporting summarizes information for residents currently in nursing homes by calendar quarter…The MDS assessment information for each active nursing home resident is consolidated to create a profile of the most recent standard information for the resident." At: https://www.cms.gov/medicare/quality/nursing-home-improvement/minimum-data-sets-swing-bed-providers

[14] 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.

[15] 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.

System ("iQIES") Reports on Quality Measures for the SNF. [16] Policies need to be reviewed annually, revised, and updated as necessary, and signed off by key managers and then provide training to staff to keep them aware of new changes.

g) **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 is the added work created due to limited interoperability between systems and therefore there is not a clear communication of what information is entered into the multiple EMRs and supporting systems and in what detail. The outpatient Rehab department is on Web PT, an EMR system to capture Therapy minutes.

h) **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. The Rehabilitation department noted that hiring additional staff is difficult and results in delaying referrals for discharged patients to obtain Outpatient therapy services.

i) **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

[16] 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

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.

j) **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. The Centers for Disease Control's (CDC) National Health Safety Network's (NHSN)[17] reporting continues to identify potential COVID cases, and vaccination rates.

k) **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.

l) **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. The PCO was unable to review transfer agreements at this time, however there were transfer agreements for transportation in place. Rounded with the Director of Infection Prevention and the Infection Preventionist included reviews of the antimicrobial stewardship program which include rates of infections due to indwelling catheters, respiratory infections, hand hygiene and more, and Emergency Disaster Preparedness and triage processes, and vaccination rates of residents and staff. Recommend continued mentorship for the new IP nurse at this time to enhance her knowledge of her role and reporting requirements.

[17] CDC's National Healthcare Safety Network is the nation's most widely used healthcare-associated infection tracking system. NHSN provides facilities, states, regions, and the nation with data needed to identify problem areas, measure progress of prevention efforts, and ultimately eliminate healthcare-associated infections. See at: https://www.cdc.gov/nhsn/index.html

m) The Medical Director was informed of a new requirement that all medical directors begin working on their Certified Medical Director (CMD) training and have five years to complete the process. CDPH is currently tracking all Medical Directors and will determine if deficiencies are warranted if the MD has not engaged in a training program. The Medical Director stays abreast of the current requirements on antipsychotics and dementia related psychoses and resident care. Since COVID, he is concerned that new "grad staff" (licensed and CNA) need longer onboarding and training and mentorship.

n) The Consultant Pharmacist is providing concurrent audits of residents on psychotics and antidepressants, as well as dementia related psychosis or mental health issues and is providing training and education to licensed staff on accurate diagnoses. Monthly audits continue for both SNF's with feedback to the Interim and Assistant DON's.

o) Safety Committee Meetings will be handled by Plant Operations Manager and will incorporate all department managers. Safety minutes were not available for the past 2 quarters.

p) A Midas review was held to review the protocol process for entering and following up on incidents with the PCO, and the CNO. Incident cases were randomly chosen and reviewed for all departments within the health system.

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:

a) The Debtor's SNF Leadership responded to the PCO's reporting on a limited number of potential compromises to care in the Hospital Operating Unit. The PCO believes based on the information presented that the Hospital Operating Unit Leadership are making a strong effort to remediate the problems and issues presented in the Report.

b) The SNFs continue to provide high quality patient care and safety with staff and leadership exhibiting a strong commitment to provide cost efficient and effective care.

c) Based on interviews, document review, a brief visit to some of the clinics, the Rural Clinics continue to provide high quality patient care and safety with staff and leadership exhibiting a strong commitment to provide cost efficient and effective care.

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

A. Financial Factors Shaping the Debtor's Operations

The PCO stated in the Report that "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." Based on review of financial reporting and other information available to the PCO and interviews with the CFO and his key executives, the PCO believes:

- As to: The District's limited access to working capital also presents significant challenges when addressing short-term fluctuations in cash flow[18] . The Debtor has reduced operating expenses significantly while maintaining and, in some instances, increasing revenues across the units bringing an increase in cash reserves.
- As to: 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[19]. The Debtor has achieved an increase in revenues, negotiated a

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

deep reduction second party payer's recapture of Medicare funds, accelerated the payment of special funds and grants, and as above reduced operating expenses significantly while maintaining and in some instances increasing revenues across the unit.

As to the above challenges, the Debtor has prevented to this date negative impact on patient care and continues to obtain needed supplies and adequate staffing. Accordingly, these factors are and will continue to be a component in the PCO's ongoing monitoring and reporting efforts.

B. Community Involvement and Support

In the Report, the PCO stated that the Hospital's Leadership were engaged in addition to the usual management, community relations and clinical care tasks engaged "in the time consuming and complex effort to maintain financial support from multiple boards and funding authorities." In addition, the PCO reported that the in contrast to the PCO professionals extensive past experience as interim managers, "today the Debtor's 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 interviews and the information available to them, the PCO believes that Hospital leadership, although doing a competent job in managing these issues, they are continued to be plagued by unfounded complaints both on social media and in the community.

Based on the PCO's November site visit interviews, continued review of data/documents/material; and analysis of Emergency Room, Hospital, Clinics, the SNFs,' and other Debtor services' data the *PCO has continues to believe 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

In explaining to the Court in the Report the need for a viable and vital Quality Assurance Performance Improvement ("QAPI") program, the PCO quoted then and respectfully repeats a quote from The National Institutes of Health ("NIH"): "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."[20] Furthermore, as we stated in the Report "The Debtors' constant compliance efforts within and across the Hospitals offers the PCO a road map of the quality of 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."

In following up on the prior visit's chart review, during the November site visit the PCO reviewed six patient charts. The PCO identified three care and practice issues that demanded remediation and reviewed those with the Chief Nursing Officer and the QAPI Director. Confidentiality requirements demand that the PCO not make further identification of the specific issues, yet the PCO assures the Court that they have and will continue to monitor the Debtor's efforts at correction and mediation on these and any additional issues identified.

In the Sections that follow we revisit each component of the QAPI Program. In the Report and below we summarize each component and how those components support the integrated QAPI effort. For each component we reported that "the *PCO has determined that there are deficiencies in (the specific component), 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***

[20] 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

therein the QAPI program." We briefly summarize the QAPI Program and its components and offer the Court our assessment based on our November site visit and supporting monitoring efforts.

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. 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).
- ***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.
- ***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.
- ***Meeting the demand and requirement for clinical care meetings.***

Based on the PCO's interviews and review of documents/materials; the *PCO has determined that the* **Debtor, led by its Chief Nursing Officer has defined a plan of correction for the deficiencies cited in the report and is making a concerted effort to improve the Debtor's QAPI program.**

2. Incident Reporting

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."[21] 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 the* **Debtor, led by its Chief Nursing Officer has defined a plan of correction for the deficiencies in Incident Reporting cited in the report and is making a concerted effort to improve the Debtor's 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."[22] The Risk Management department increases patient safety by encouraging confidential and voluntary reporting of adverse events, which can lead to the prevention and recurrence of medical errors.[23]

Based on the PCO's interviews and review of documents/materials; the *PCO has determined that the* **Debtor, led by its Chief Nursing Officer has defined a plan of correction for the deficiencies in Risk Management cited in the report and is making a concerted effort to improve the Debtor's QAPI program.**

4. Compliance-Ethics Program[24]

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 "Compliance Program. The

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

[22] 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.**

[23] 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/#

[24] "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.

Compliance 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.
- 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 the* **Debtor, led by its Chief Nursing Officer has defined a plan of correction for the deficiencies in the Compliance Program cited in the report and is making a concerted effort to improve the Debtor's QAPI program.**

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

In the Report the PCO defined and elaborated on the challenges that the Debtor, as do all hospitals face in maintaining and operating multiple electronic medical patient care record systems. As a reminder we quote again the **HealthIT.gov** who states that a hospital "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." "Interoperability"[25] is therefore demanded of the Debtor's Electronic Medical Record Systems as well as its multiple special applications and reporting systems. The EMR and supporting reporting systems include for the hospital "**Meditech**" EMR; for the Clinics "**EClinicalWorks**" EMR; for the SNFs "**PointClickCare**" EMR, the **Midas Incident Reporting** program, the **Lightworks** toolset for

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

Training, **PIXYS** system for pharmacy, **Web Pt** for the outpatient Rehab Center, and multiple other laboratory, radiology, and data integration systems.

The PCO has **continued to assess the Debtor's ability to both operate multiple EMR/Reporting systems that meet interoperability requirements and standards. to assess and report on the Debtor's interoperability issues.** Based on the PCO's interviews, their access on and off premise to the systems, and review of documents/materials; the *PCO has determined that the* **Debtor is meeting the reporting and interoperability requirements.**

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 § 333, the PCO and his team will continue both on and off premises their interviews with management, caregivers, and patients. The next phase of the monitoring function will focus 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. Review and assess the Debtor's efforts toward preparing for the anticipated Joint Commission Accreditation review of the Hospital and Clinic.

4. Appropriately monitor the recently employed SNF Director of Nursing and other new senior clinical management.

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

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

7. 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.

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

9. 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: January 29, 2024

By:

JERRY SEELIG
In his capacity as the Patient Care Ombudsman

Miscellaneous:

23-50544 San Benito Health Care District dba Hazel Hawkins

Type: bk	Chapter: 9 v	Office: 5 (San Jose)
Assets: y	Judge: SLJ	Case Flag: Salinas, CLMAGT

U.S. Bankruptcy Court

California Northern Bankruptcy Court

Notice of Electronic Filing

The following transaction was received from Louis J. Cisz entered on 1/29/2024 at 9:35 AM PST and filed on 1/29/2024

Case Name: San Benito Health Care District dba Hazel Hawkins
Case Number: 23-50544
Document Number: 189

Docket Text:
Ombudsman Report for the period of 10/11/23 through 01/29/24 Filed by Health Care Ombudsman Jerry Seelig (Cisz, Louis)

The following document(s) are associated with this transaction:

Document description: Main Document
Original filename: Second PCO Report Signed by PCO.pdf
Electronic document Stamp:
[STAMP bkecfStamp_ID=1017961465 [Date=1/29/2024] [FileNumber=39082717-0] [334dbd0ff6718c0ef9ef7582765e9fb7548ab6353ca8db2f040f97affac0c80116 4fa9d6690acf5d4a8ffc9a79454ada4195c4fbc06498ce50c5e8235727e842]]

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Medi-Cal Supplemental Funding Update

Ryan Witz & Nathan Davis
February 7, 2024

DISTRICT HOSPITAL LEADERSHIP FORUM

Significant Areas of Focus in 2024

- Managed Care Organization Tax – Protection & Distribution Methodology
- Office of Health Care Affordability (OHCA)
- CHFFA Bridge Loan – Year 2 Loan Extension
- District Hospital Directed Payment (DHDP) Program – Operational & Programmatic Improvement

Managed Care Organization Tax

- ***AB 119 (Statutes 2023)*** authorized DHCS to seek approval of a new MCO Tax structure that would be effective Apr 2023-Dec 2026.
- Over the 3 ¾ years, the tax will raise ***$19.4 billion*** in non-federal share funding.
- On Dec 15th, 2023, CMS approved the tax.
- Due to the significant budget deficit, DHCS will propose to amend the approved tax to raise another ***$1.5 billion***.

DHCS NEWS RELEASE

CALIFORNIA'S MANAGED CARE ORGANIZATION (MCO) TAX RECEIVES FEDERAL APPROVAL

SACRAMENTO — Governor Gavin Newsom and the State of California received federal approval from the Centers for Medicare & Medicaid Services (CMS) of its MCO tax federal waiver application.

"For the first time ever, we are using MCO tax revenue to augment Medi-Cal provider rates to drive greater Medi-Cal provider participation, especially in underserved areas and in primary and preventive care," said **Department of Health Care Services (DHCS) Director Michelle Baass**. "These dollars will drive access, quality, and equity in our program. This investment will have meaningful impact and demonstrates our commitment to Medi-Cal members."

WHY THIS IS IMPORTANT: This approval paves the way for DHCS to move forward with targeted provider rate increases and additional health care system investments that will advance access, quality, and equity in care and services for millions of Californians using Medi-Cal. These rate increases also promote provider participation in the state's Medi-Cal program, helping to shore up the health care workforce.

Managed Care Organization Tax

- Highlighting the proposed distribution areas

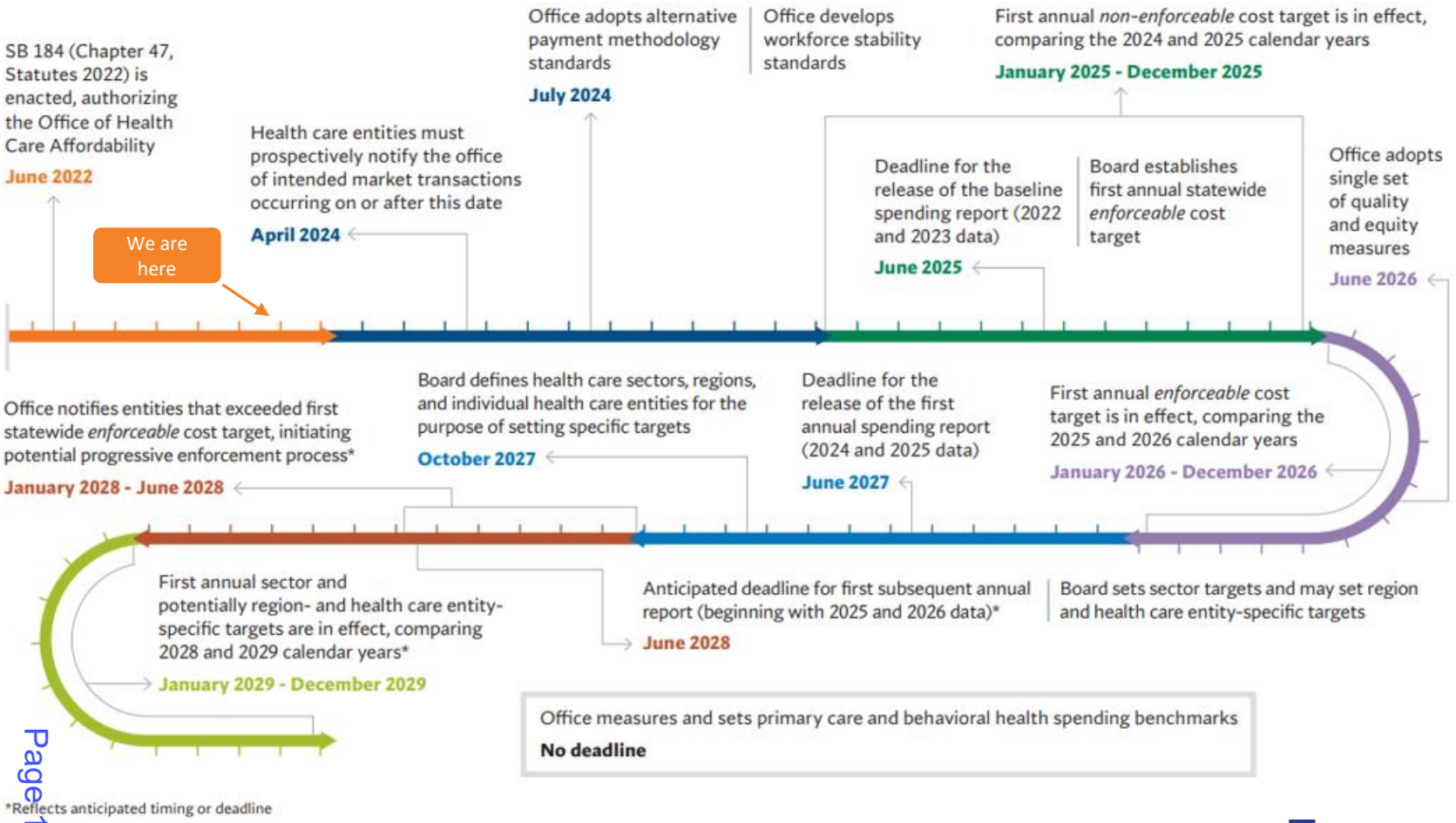
- Over the next couple of months, the Legislature and Administration will work on refining the final budget plan.
  - ***Critically important to stay engaged to protect commitments made***

Spending Plan: Calendar Year 2024 through Fiscal Year (FY) 2027-28

Category[2]	Estimated MPPRF ($millions) [3]	% of Annual Spend
Primary Care and Specialty Care		**62%**
Primary Care, Maternal Care, and Mental Health[4] *(started 1/1/24)*	$291	11%
Physician and Non-Physician Health Professional Services[5]	$975	37%
Community and Hospital Outpatient Procedures and Services	$245	9%
Abortion and Family Planning Access	$90	3%
Services and Supports for FQHCs and RHCs	$50	2%
Emergency and Inpatient Care		**21%**
Emergency Department (ED) (Facility and Physician) Services	$355	13%
Designated Public Hospitals	$150	6%
Ground Emergency Medical Transportation	$50	2%
Behavioral Health		**11%**
Behavioral Health Throughput *(starts 7/1/25)*	$300	11%
Healthcare Workforce		**6%**
Graduate Medical Education *(started 1/1/2024)*	$75	3%
Medi-Cal Workforce Pool – Labor-Management Committee	$75	3%
Total	**$2,656**	**100%**
Distressed Hospital Loan Program *(one-time: FY 2023-24)*	$150	
Small and Rural Hospital Relief for Seismic Assessment and Construction *(one time: FY 2023-24)*	$50	

- Other MCO Tax-related activity:
  - Ballot Initiative effort continues—"Protect Access to Healthcare Act of 2024"
    - Makes permanent the MCO Tax structure
    - Specifies a different distribution methodology

Office of Health Care Affordability
Implementation Timeline



Source: California Hospital Association

DISTRICT HOSPITAL LEADERSHIP FORUM

Office of Health Care Affordability

- Recent activity
  - January 17th, OHCA staff proposed a ***3% statewide spending growth target***, applicable on an annual basis for 2025-29.
  - January 23rd, OHCA advisory committee met to provider feedback on the proposal.
  - January 24th, OHCA Board met to discuss the proposal. This marks the beginning of the 45-day public comment period.
    - ***Comments due March 11th***

- Next Steps
  - DHLF is a member of the CHA Health Care Affordability Workgroup and will be discussing comment strategy
  - Next OHCA Board Meeting—February 28th
  - Submit comment letter early March

DISTRICT HOSPITAL LEADERSHIP FORUM

CHFFA Bridge Loans

- DHLF secured two $40 million loans to district hospitals in the state budget cycles for FY21 & FY22
  - Purpose of the loans were to assist with cash flow due to delay in QIP payments.
  - Loans had a two-year term and 0% interest
- Loans Administered by California Health Facilities Financing Authority
- DHLF has been engaging the Governor's Office, Department of Finance, CHFFA, Health & Human Services Agency and Legislators to seek an extension of the loan repayment term for the 2nd year of the loans

CHFFA Bridge Loans

Current Status

- District hospitals need to repay the first year of the loans
- Administration, CHFFA, & Legislators are supportive of extending the term of the loan by four years and amortizing the loan over those four years

- DHLF is pursuing two paths:
  1. Attempting to get legislative language into an early action bill in the next month
  2. Running our own bill to extend the term and possibly folding it into a budget trailer bill in the summer

District Hospital Directed Payments

- Recent Events
  - DHCS has finalized a subacute policy of which codes will count
    - Revenue codes: 192, 193, 194, 199
  - DHCS has agreed that DP-NF Medi-Cal days, including duals, will be included in CY24 DHDP payments
    - DHLF is working with DHCS on a method to pay DP-NF days from CY23 via another Medi-Cal supplemental payment program
- Next Steps
  - Hospitals should be reconciling their data with a goal to work with health plan(s) in March/April to ensure missing encounters are submitted to DHCS prior to June 30, 2024

DISTRICT HOSPITAL LEADERSHIP FORUM

Distinct Part – Skilled Nursing (DP-NF)

- For transitioning counties only, DHCS is working to establish a pass-through program to replace the existing FFS supplemental program for districts operating a DP-NF

- Distribution methodology will be a straight per-diem add-on based on all eligible days at eligible district hospitals
  - Only districts that operated a DP-NF for the majority of CY2022 in a transitioning county would be eligible for the supplemental program

- Initial CY23 data will be sent to eligible hospitals next month

- Interim payment to eligible hospitals in the Fall

DISTRICT HOSPITAL LEADERSHIP FORUM

2024 MCO County Transitions

- Beginning in 2024, many Medi-Cal members in 21 counties will transition to a new Medi-Cal managed care plan.

- Notable changes in counties with District Hospitals.

- Please let DHLF know if you are experiencing any issues.

Counties	Major Changes
ALAMEDA	< Anthem exiting
IMPERIAL	< CHW & Molina exiting > Community Health Plan & Kaiser entering
KERN	< Health Net exiting > Anthem entering
MARIPOSA	< Anthem & CHW exiting > Central California Alliance & Kaiser entering
NEVADA	< Anthem & CHW exiting > Partnership entering
PLUMAS	< Anthem & CHW exiting > Partnership entering
SAN BENITO	< Anthem exiting > Central California Alliance entering
SAN DIEGO	< Aetna & Health Net exiting
STANISLAUS	> Kaiser entering
TULARE	> Kaiser entering

DISTRICT HOSPITAL LEADERSHIP FORUM

2024 Cash Flow Timing

Program (Year)	IGT Date	Payment to Hospital Date	Notes
HQAF VIII (CY23) Direct Grant #1	n/a	Mar-24	
Rate Range (CY 2022)	Feb. 23, 2024	Apr/May-24	
QIP PY 5 (CY 22)	Feb. 16, 2024	Apr/May-24	
HQAF VIII (CY23) Direct Grant #2	n/a	May-24	
HQAF VIII (CY23) Managed Care	Mar. 22, 2024	May/Jun-24	
CHFFA Loan Repayment Rd 1a	Feb/Mar-24	n/a	For those who received a loan
HQAF VIII (CY23) Direct Grant #3	n/a	Jun-24	
AB 113 (FY23/24)	Apr-24	May/Jun-24	Interim Payment
AB 113 (FY22/23)	Apr-24	May/Jun-24	Final Reconciliation
AB 915 (FY22/23)	n/a	By Jun-24	
CHFFA Loan Repayment Rd 1b	Summer-24	n/a	For those who received a loan
HQAF VIII (CY23) Direct Grant #4	n/a	Aug-24	
DP-NF (Managed Care CY23)	Sep-24	Nov/Dec-24	
HQAF VIII (CY24) Direct Grants	n/a	Oct-24, Nov-24, Dec-24, May-25	
Rate Range (CY 2023)	Oct/Nov-24	Jan-25	
CHFFA Loan Repayment Rd 2	Winter-24	n/a	For those who received a loan

DISTRICT HOSPITAL LEADERSHIP FORUM

HUMAN RESOURCES DASHBOARD 2024

DEPARTMENTAL METRICS	January	February	March
# Employees	667		
# New Hires	15		
# Terminations	7		
Overall Turnover	1.0%		
Nursing Turnover	0.78%		

Terms By Union	January	February	March
The California Nurses Association (CNA)	1		
National Union of Healthcare Workers (NUHW)	4		
Non-Union	2		

Terms By Reason (V=Voluntary & IV= Involuntary)	January	February	March
Personal (V)	2		
Retirement (V)	4		
Schedule (V)	1		

Hazel Hawkins
MEMORIAL HOSPITAL

To: San Benito Health Care District Board of Directors

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

Date: February 12, 2024

Re: All Clinics – January 2024

Rural Health and Specialty Clinics' visit volumes

Clinic Location	Total visits current month	Total visits prior year (January 2023)	Fiscal YTD (July 2023 - January 2024)	Prior Fiscal YTD (July 2022 - January 2023)
Orthopedic Specialty	243	420	2,059	3,238
Multi-Specialty	657	781	4,658	4,836
Sunset	984	796	5,860	6,594
Surgery & Primary Care	163	N/A	1,066	1,055
San Juan Bautista	244	392	1,772	2,403
1st Street	790	799	5,342	5,188
4th Street	1,286	1,469	8,458	9,483
Barragan	439	728	3,806	4,762
Total	**4,806**	**5,385**	**33,021**	**37,559**

- The primary driver for the decrease in visits year over year is directly related to the number of clinic providers on staff in 2023 vs. 2024. We are working diligently to backfill those spots and have quality candidates under active review.

- The clinics have experienced a very smooth transition from Anthem Blue Cross Managed Medi-Cal to Central California Alliance for Health (CCAH) with over 8,800 lives assigned to the five primary care clinics thus far.

- We welcomed full-time general surgeon Dr. Joseph Fabry to the surgery clinic.

- Beginning in January 2024, Press Ganey patient satisfaction surveys were introduced in the clinics. The insights garnered from patient responses have been invaluable in driving improvements and recognizing the outstanding levels of care delivered. For the first month, overall Service Line Performance Top Box Score was 79.25%.

CNO Report

February 2024

Nursing

PI projects

- Meaningful line rounds- rounding on all indwelling IVs and catheters for appropriateness and proper care.
- Medication reconciliation- Making sure the patient's home medications are correct on admission and discharge.
- Patient safety related to falls.
- Collaborating with CNA related to creating a team assist or lift assist team.
- Collaborating with CNA regarding the remote telemetry project.

Physicians

- Reprocessed equipment follow up.

Regulatory

- Working through the Mock Survey findings.
- Promoting interoperability- primarily EMR related indicators.

CNO Dashboard
January 2024

Key Metrics	Target	Dec-23	Jan-24	FY 23YTD	FY 2022
ED Visits	2370	2,390	2,249	15,214	14779
Admission %	10%	5%	6%	6%	9%
LWBS %	< 2.0%	0.05%	0.40%	0.40%	0.60%
Door to Provider	10 min	6 min	7 min	7 min	6 min
MS admissions	120	111	107	669	941
ICU admissions	22	19	22	139	136
Deliveries	39	36	32	170	259
OR Inpatient	40	38	30	229	283
OR Outpatient	12	17	8	943	825

Exceeds target
5% below target
>5% below target

Target is 3% improvement over last year

Patient Experience- Overall rating 9-10	Target	Prior Q	Current Q
Med Surg	72% topbox	68% (N=80)	100% (N=1)
ED	72% topbox	66% (N=171)	58% (N=77)

Target is the 50th percentile (72% topbox) in the all Press Ganey database

San Benito Health Care District
Finance Committee Minutes
February 15, 2024 - 4:30pm

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

Public: G.W. Devon Pack

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

2. **REVIEW FINANCIAL UPDATES**
   A. January 2024 Financial Statements
   The Financial Statements for the month ending January 31, 2024, the District's Net Surplus (Loss) is $644,730 compared to a budgeted Surplus (Loss) of ($446,599). The District exceeded its budget for the month by $1,091,329.

   YTD as of January 31, 2024, the District's Net Surplus (Loss) is $7,574,460 compared to a budgeted Surplus (Loss) of $1,034,866. The District is exceeding its budget YTD by $6,539,594.

   Acute discharges were 166 for the month, slightly exceeding budget by 2 discharges or 1**%**. The ADC was 16.68 compared to a budget of 17.97. The ALOS was 3.11. The acute I/P gross revenue was under budget by **$1.3 million** while O/P services gross revenue was **$4.7 million** or 20% over budget. ER I/P visits were 129 and ER O/P visits were over budget by 310 visits or 17%. The RHCs & Specialty Clinics treated 3,906 (includes 439 visits at the Diabetes Clinic) and 900 visits respectively.

   Other Operating revenue was slightly under budget by **$23,638** due mainly to physician collections.

   Operating Expenses were under budget by **$110,916** due mainly to variances in: Interest (penalties) exceeding budget by $190,945 and Registry $146,603. These overages were offset by Employee Benefits being under budget by $514,595 (Health Insurance and Sick Leave accounted for $347,030 and $98,107 in savings respectively).

   Non-operating Revenue exceeded budget by **$48,109** due mainly to higher than budgeted donations.

The SNFs ADC was **88.19** for the month. The Net Surplus (Loss) is **$325,547** compared to a budget of $220,746. YTD, the Net Surplus (Loss) is $2,793,192, exceeding its budget by $1,230,005.

B. January 2024 Finance Dashboard

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

C. IRS Employer FICA Liability

As part of the CARES Act Program, the hospital was given the option to defer payment of the employer portion of the FICA liability for CY 2020. Based on an estimated value with interest, the hospital owes $1.34 million. No employee payments were affected.

3. **ADJOURNMENT**

There being no further business, the Committee was adjourned at 4:59 pm.

Respectfully submitted,

Sandra DiLaura
Interim-Controller

Hazel Hawkins
MEMORIAL HOSPITAL

February 15, 2024

CFO Financial Summary for the District Board:

For the month ending January 31, 2024, the District's Net Surplus (Loss) is $644,730 compared to a budgeted Surplus (Loss) of ($446,599). The District exceeded its budget for the month by $1,091,329.

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HAZEL HAWKINS MEMORIAL HOSPITAL - COMBINED
HOLLISTER, CA 95023
FOR PERIOD 01/31/24

	CURRENT MONTH					YEAR-TO-DATE				
	ACTUAL 01/31/24	BUDGET 01/31/24	POS/NEG VARIANCE	PERCENT VARIANCE	PRIOR YR 01/31/23	ACTUAL 01/31/24	BUDGET 01/31/24	POS/NEG VARIANCE	PERCENT VARIANCE	PRIOR YR 01/31/23
GROSS PATIENT REVENUE:										
ACUTE ROUTINE REVENUE	3,856,434	4,200,275	(343,841)	(8)	3,927,930	23,083,926	32,814,222	(9,730,296)	(30)	30,300,460
SNF ROUTINE REVENUE	2,057,580	2,092,500	(34,920)	(2)	2,132,350	15,295,468	14,512,500	782,968	5	14,432,800
ANCILLARY INPATIENT REVENUE	4,018,365	5,074,077	(1,055,712)	(21)	4,932,843	27,795,371	37,235,290	(9,439,919)	(25)	35,540,246
HOSPITALIST\PEDS I\P REVENUE	210,023	190,834	19,189	10	173,748	1,110,093	1,323,517	(213,424)	(16)	1,309,673
TOTAL GROSS INPATIENT REVENUE	10,142,402	11,557,686	(1,415,284)	(12)	11,166,871	67,284,857	85,885,529	(18,600,672)	(22)	81,583,178
ANCILLARY OUTPATIENT REVENUE	27,941,002	23,232,279	4,708,723	20	23,258,002	188,906,078	167,550,218	21,355,860	13	158,190,525
HOSPITALIST\PEDS O\P REVENUE	81,692	61,400	20,292	33	59,730	433,692	425,861	7,831	2	430,996
TOTAL GROSS OUTPATIENT REVENUE	28,022,694	23,293,679	4,729,015	20	23,317,732	189,339,770	167,976,079	21,363,691	13	158,621,521
TOTAL GROSS PATIENT REVENUE	38,165,096	34,851,365	3,313,731	10	34,484,603	256,624,627	253,861,608	2,763,019	1	240,204,700
DEDUCTIONS FROM REVENUE:										
MEDICARE CONTRACTUAL ALLOWANCES	11,233,292	9,976,886	1,256,406	13	9,344,847	68,835,558	73,051,264	(4,215,706)	(6)	70,098,007
MEDI-CAL CONTRACTUAL ALLOWANCES	9,843,477	9,452,178	391,299	4	9,625,389	68,291,050	68,822,863	(531,813)	(1)	60,082,772
BAD DEBT EXPENSE	776,991	389,870	387,121	99	128,865	4,572,147	2,847,945	1,724,202	61	2,490,056
CHARITY CARE	40,879	36,376	4,503	12	45,678	311,288	266,020	45,268	17	264,479
OTHER CONTRACTUALS AND ADJUSTMENTS	4,342,167	3,942,064	400,103	10	4,024,386	31,125,117	28,687,510	2,437,607	9	25,200,690
HOSPITALIST\PEDS CONTRACTUAL ALLOW	35,746	12,062	23,684	196	(12,604)	48,177	88,175	(39,998)	(45)	76,379
TOTAL DEDUCTIONS FROM REVENUE	26,272,552	23,809,436	2,463,116	10	23,156,560	173,183,337	173,763,777	(580,440)	0	158,212,382
NET PATIENT REVENUE	11,892,544	11,041,929	850,615	8	11,328,043	83,441,290	80,097,831	3,343,459	4	81,992,318
OTHER OPERATING REVENUE	558,861	582,499	(23,638)	(4)	1,010,826	4,026,652	4,077,470	(50,818)	(1)	8,406,861
NET OPERATING REVENUE	12,451,405	11,624,428	826,977	7	12,338,868	87,467,942	84,175,301	3,292,641	4	90,399,180
OPERATING EXPENSES:										
SALARIES & WAGES	4,880,068	4,769,338	110,730	2	4,688,946	32,952,072	32,992,119	(40,047)	0	33,889,643
REGISTRY	362,880	200,000	162,880	81	281,097	2,055,389	1,400,000	655,389	47	3,606,926
EMPLOYEE BENEFITS	1,889,684	2,546,327	(656,644)	(26)	2,316,977	14,279,096	17,135,068	(2,855,972)	(17)	19,497,045
PROFESSIONAL FEES	1,631,360	1,652,446	(21,086)	(1)	1,835,771	11,470,426	11,467,350	3,076	0	11,330,513
SUPPLIES	1,147,096	1,188,604	(41,508)	(4)	1,086,617	7,354,883	8,345,461	(990,578)	(12)	8,713,667
PURCHASED SERVICES	1,097,789	1,093,674	4,115	0	1,183,127	7,423,805	7,585,172	(161,367)	(2)	8,663,927
RENTAL	142,252	131,560	10,692	8	163,794	956,013	918,379	37,634	4	1,101,808
DEPRECIATION & AMORT	310,541	320,781	(10,240)	(3)	329,248	2,278,941	2,245,431	33,510	2	2,265,909
INTEREST	216,362	25,417	190,945	751	13,171	405,689	177,919	227,770	128	44,784
OTHER	470,274	436,401	33,873	8	457,584	2,955,952	3,028,180	(72,228)	(2)	3,074,577
TOTAL EXPENSES	12,148,305	12,364,548	(216,243)	(2)	12,356,331	82,132,266	85,295,079	(3,162,813)	(4)	92,188,797
NET OPERATING INCOME (LOSS)	303,100	(740,120)	1,043,220	(141)	(17,463)	5,335,676	(1,119,778)	6,455,454	(577)	(1,789,618)

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HAZEL HAWKINS MEMORIAL HOSPITAL - COMBINED
HOLLISTER, CA 95023
FOR PERIOD 01/31/24

	CURRENT MONTH					YEAR-TO-DATE				
	ACTUAL 01/31/24	BUDGET 01/31/24	POS/NEG VARIANCE	PERCENT VARIANCE	PRIOR YR 01/31/23	ACTUAL 01/31/24	BUDGET 01/31/24	POS/NEG VARIANCE	PERCENT VARIANCE	PRIOR YR 01/31/23
NON-OPERATING REVENUE\EXPENSE:										
DONATIONS	49,966	5,000	44,966	899	214,315	196,488	135,000	61,488	46	373,527
PROPERTY TAX REVENUE	205,711	205,711	0	0	195,915	1,439,977	1,439,974	3	0	1,371,405
GO BOND PROP TAXES	170,388	170,388	0	0	164,964	1,192,714	1,192,716	(2)	0	1,154,749
GO BOND INT REVENUE\EXPENSE	(68,721)	(68,721)	0	0	(72,048)	(481,048)	(481,047)	(1)	0	(504,333)
OTHER NON-OPER REVENUE	16,987	13,843	3,144	23	14,223	125,030	96,901	28,129	29	90,149
OTHER NON-OPER EXPENSE	(32,700)	(32,700)	0	0	(69,231)	(230,169)	(228,900)	(1,269)	1	(297,314)
INVESTMENT INCOME	0	0	0	0	1,315	(4,209)	0	(4,209)		2,010
COLLABORATION CONTRIBUTIONS	0	0	0	0	0	0	0	0	0	0
TOTAL NON-OPERATING REVENUE/(EXPENSE)	341,630	293,521	48,109	16	449,454	2,238,784	2,154,644	84,140	4	2,190,193
NET SURPLUS (LOSS)	644,730	(446,599)	1,091,329	(244)	431,991	7,574,460	1,034,866	6,539,594	632	400,576
EBIDA	$ 886,305	$ (194,785)	$ 1,081,090	(555.01)%	$ 737,553	$ 9,371,903	$ 2,797,528	$ 6,574,375	235.00%	$ 2,313,382
EBIDA MARGIN	7.12%	(1.68)%	8.79%	(524.78)%	5.98%	10.71%	3.32%	7.39%	222.38%	2.56%
OPERATING MARGIN	2.43%	(6.37)%	8.80%	(138.23)%	(0.14)%	6.10%	(1.33)%	7.43%	(558.55)%	(1.98)%
NET SURPLUS (LOSS) MARGIN	5.18%	(3.84)%	9.02%	(234.77)%	3.50%	8.66%	1.23%	7.43%	604.37%	0.44%

HAZEL HAWKINS MEMORIAL HOSPITAL - ACUTE FACILITY
HOLLISTER, CA 95023
FOR PERIOD 01/31/24

	CURRENT MONTH					YEAR-TO-DATE				
	ACTUAL 01/31/24	BUDGET 01/31/24	POS/NEG VARIANCE	PERCENT VARIANCE	PRIOR YR 01/31/23	ACTUAL 01/31/24	BUDGET 01/31/24	POS/NEG VARIANCE	PERCENT VARIANCE	PRIOR YR 01/31/23
GROSS PATIENT REVENUE:										
ROUTINE REVENUE	3,856,434	4,200,275	(343,841)	(8)	3,927,930	23,083,926	32,814,222	(9,730,296)	(30)	30,300,460
ANCILLARY INPATIENT REVENUE	3,754,384	4,702,187	(947,803)	(20)	4,459,975	25,680,878	34,633,373	(8,952,495)	(26)	32,684,544
HOSPITALIST I\P REVENUE	210,023	190,834	19,189	10	173,748	1,110,093	1,323,517	(213,424)	(16)	1,309,673
TOTAL GROSS INPATIENT REVENUE	7,820,841	9,093,296	(1,272,455)	(14)	8,561,652	49,874,897	68,771,112	(18,896,215)	(28)	64,294,677
ANCILLARY OUTPATIENT REVENUE	27,941,002	23,232,279	4,708,723	20	23,258,002	188,906,078	167,550,218	21,355,860	13	158,190,525
HOSPITALIST O\P REVENUE	81,692	61,400	20,292	33	59,730	433,692	425,861	7,831	2	430,996
TOTAL GROSS OUTPATIENT REVENUE	28,022,694	23,293,679	4,729,015	20	23,317,732	189,339,770	167,976,079	21,363,691	13	158,621,521
TOTAL GROSS ACUTE PATIENT REVENUE	35,843,535	32,386,975	3,456,560	11	31,879,385	239,214,667	236,747,191	2,467,476	1	222,916,198
DEDUCTIONS FROM REVENUE ACUTE:										
MEDICARE CONTRACTUAL ALLOWANCES	11,061,424	9,698,906	1,362,518	14	9,046,742	67,348,357	71,105,180	(3,756,823)	(5)	68,160,810
MEDI-CAL CONTRACTUAL ALLOWANCES	9,771,922	9,343,870	428,052	5	9,455,738	67,212,398	68,071,691	(859,293)	(1)	58,908,759
BAD DEBT EXPENSE	716,099	379,870	336,229	89	91,222	4,667,352	2,777,945	1,889,407	68	2,455,490
CHARITY CARE	40,879	36,376	4,503	12	38,528	311,288	266,020	45,268	17	257,329
OTHER CONTRACTUALS AND ADJUSTMENTS	4,301,282	3,875,104	426,178	11	4,000,734	30,843,248	28,223,110	2,620,138	9	24,828,282
HOSPITALIST\PEDS CONTRACTUAL ALLOW	35,746	12,062	23,684	196	(12,604)	48,177	88,175	(39,998)	(45)	76,379
TOTAL ACUTE DEDUCTIONS FROM REVENUE	25,927,352	23,346,188	2,581,164	11	22,620,360	170,430,819	170,532,121	(101,302)	0	154,687,048
NET ACUTE PATIENT REVENUE	9,916,183	9,040,787	875,396	10	9,259,024	68,783,848	66,215,070	2,568,778	4	68,229,151
OTHER OPERATING REVENUE	558,861	582,499	(23,638)	(4)	1,010,826	4,026,652	4,077,470	(50,818)	(1)	8,406,861
NET ACUTE OPERATING REVENUE	10,475,044	9,623,286	851,758	9	10,269,850	72,810,500	70,292,540	2,517,960	4	76,636,012
OPERATING EXPENSES:										
SALARIES & WAGES	3,923,185	3,829,550	93,635	2	3,783,926	26,249,937	26,470,574	(220,637)	(1)	27,430,236
REGISTRY	313,603	167,000	146,603	88	249,749	1,885,303	1,169,000	716,303	61	3,430,108
EMPLOYEE BENEFITS	1,498,417	2,013,012	(514,595)	(26)	1,839,247	11,007,133	13,475,263	(2,468,131)	(18)	15,410,814
PROFESSIONAL FEES	1,629,150	1,650,109	(20,959)	(1)	1,833,561	11,454,956	11,450,993	3,963	0	11,314,533
SUPPLIES	1,044,776	1,099,246	(54,470)	(5)	1,008,340	6,661,615	7,722,055	(1,060,440)	(14)	8,080,655
PURCHASED SERVICES	1,002,066	986,211	15,855	2	1,128,433	6,839,591	6,839,869	(278)	0	7,937,180
RENTAL	141,233	130,516	10,717	8	163,371	948,929	911,109	37,820	4	1,095,177
DEPRECIATION & AMORT	270,764	281,320	(10,556)	(4)	289,797	2,002,321	1,969,240	33,081	2	1,989,104
INTEREST	216,362	25,417	190,945	751	13,171	405,689	177,919	227,770	128	44,784
OTHER	410,111	378,202	31,909	8	397,623	2,605,296	2,624,503	(19,207)	(1)	2,664,141
TOTAL EXPENSES	10,449,667	10,560,583	(110,916)	(1)	10,707,217	70,060,769	72,810,525	(2,749,756)	(4)	79,396,731
NET OPERATING INCOME (LOSS)	25,377	(937,297)	962,674	(103)	(437,367)	2,749,731	(2,517,985)	5,267,716	(209)	(2,760,719)

HAZEL HAWKINS MEMORIAL HOSPITAL - ACUTE FACILITY
HOLLISTER, CA 95023
FOR PERIOD 01/31/24

	CURRENT MONTH					YEAR-TO-DATE				
	ACTUAL 01/31/24	BUDGET 01/31/24	POS/NEG VARIANCE	PERCENT VARIANCE	PRIOR YR 01/31/23	ACTUAL 01/31/24	BUDGET 01/31/24	POS/NEG VARIANCE	PERCENT VARIANCE	PRIOR YR 01/31/23
NON-OPERATING REVENUE\EXPENSE:										
DONATIONS	49,966	5,000	44,966	899	214,315	196,488	135,000	61,488	46	373,527
PROPERTY TAX REVENUE	174,854	174,854	0	0	166,528	1,223,978	1,223,978	0	0	1,165,696
GO BOND PROP TAXES	170,388	170,388	0	0	164,964	1,192,714	1,192,716	(2)	0	1,154,749
GO BOND INT REVENUE\EXPENSE	(68,721)	(68,721)	0	0	(72,048)	(481,048)	(481,047)	(1)	0	(504,333)
OTHER NON-OPER REVENUE	16,987	13,843	3,144	23	14,223	125,030	96,901	28,129	29	90,149
OTHER NON-OPER EXPENSE	(25,412)	(25,412)	0	0	(60,888)	(179,155)	(177,884)	(1,271)	1	(238,916)
INVESTMENT INCOME	0	0	0	0	1,315	(4,209)	0	(4,209)		2,010
COLLABORATION CONTRIBUTIONS	0	0	0	0	0	0	0	0	0	0
TOTAL NON-OPERATING REVENUE/(EXPENSE)	318,061	269,952	48,109	18	428,409	2,073,799	1,989,664	84,135	4	2,042,883
NET SURPLUS (LOSS)	343,438	(667,345)	1,010,783	(152)	(8,957)	4,823,530	(528,321)	5,351,851	(1,013)	(717,836)

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HAZEL HAWKINS SKILLED NURSING FACILITIES
HOLLISTER, CA
FOR PERIOD 01/31/24

	CURRENT MONTH					YEAR-TO-DATE				
	ACTUAL 01/31/24	BUDGET 01/31/24	POS/NEG VARIANCE	PERCENT VARIANCE	PRIOR YR 01/31/23	ACTUAL 01/31/24	BUDGET 01/31/24	POS/NEG VARIANCE	PERCENT VARIANCE	PRIOR YR 01/31/23
GROSS SNF PATIENT REVENUE:										
ROUTINE SNF REVENUE	2,057,580	2,092,500	(34,920)	(2)	2,132,350	15,295,468	14,512,500	782,968	5	14,432,800
ANCILLARY SNF REVENUE	263,981	371,890	(107,909)	(29)	472,868	2,114,492	2,601,917	(487,425)	(19)	2,855,702
TOTAL GROSS SNF PATIENT REVENUE	2,321,561	2,464,390	(142,829)	(6)	2,605,218	17,409,960	17,114,417	295,543	2	17,288,502
DEDUCTIONS FROM REVENUE SNF:										
MEDICARE CONTRACTUAL ALLOWANCES	171,868	277,980	(106,112)	(38)	298,105	1,487,202	1,946,084	(458,882)	(24)	1,937,198
MEDI-CAL CONTRACTUAL ALLOWANCES	71,555	108,308	(36,753)	(34)	169,651	1,078,652	751,172	327,480	44	1,174,013
BAD DEBT EXPENSE	60,892	10,000	50,892	509	37,643	(95,205)	70,000	(165,205)	(236)	34,566
CHARITY CARE	0	0	0	0	7,150	0	0	0	0	7,150
OTHER CONTRACTUALS AND ADJUSTMENTS	40,885	66,960	(26,075)	(39)	23,652	281,868	464,400	(182,532)	(39)	372,407
TOTAL SNF DEDUCTIONS FROM REVENUE	345,200	463,248	(118,048)	(26)	536,200	2,752,518	3,231,656	(479,138)	(15)	3,525,334
NET SNF PATIENT REVENUE	1,976,361	2,001,142	(24,781)	(1)	2,069,018	14,657,442	13,882,761	774,681	6	13,763,168
OTHER OPERATING REVENUE	0	0	0	0	0	0	0	0	0	0
NET SNF OPERATING REVENUE	1,976,361	2,001,142	(24,781)	(1)	2,069,018	14,657,442	13,882,761	774,681	6	13,763,168
OPERATING EXPENSES:										
SALARIES & WAGES	936,327	939,788	(3,461)	0	905,021	6,673,917	6,521,545	152,372	2	6,459,407
REGISTRY	49,277	33,000	16,277	49	31,348	170,087	231,000	(60,913)	(26)	176,819
EMPLOYEE BENEFITS	387,699	533,315	(145,617)	(27)	477,729	3,267,013	3,659,805	(392,792)	(11)	4,086,231
PROFESSIONAL FEES	2,210	2,337	(127)	(5)	2,210	15,470	16,357	(887)	(5)	15,980
SUPPLIES	102,189	89,358	12,831	14	78,277	692,941	623,406	69,535	11	633,012
PURCHASED SERVICES	95,723	107,463	(11,740)	(11)	54,694	575,447	745,303	(169,857)	(23)	726,747
RENTAL	1,019	1,044	(25)	(2)	423	7,085	7,270	(185)	(3)	6,631
DEPRECIATION	39,778	39,461	317	1	39,451	276,620	276,191	429	0	276,804
INTEREST	0	0	0	0	0	0	0	0	0	0
OTHER	60,163	58,199	1,964	3	59,962	350,656	403,677	(53,021)	(13)	410,435
TOTAL EXPENSES	1,674,384	1,803,965	(129,582)	(7)	1,649,114	12,029,235	12,484,554	(455,319)	(4)	12,792,066
NET OPERATING INCOME (LOSS)	301,978	197,177	104,801	53	419,904	2,628,207	1,398,207	1,230,000	88	971,102
NON-OPERATING REVENUE\EXPENSE:										
DONATIONS	0	0	0	0	0	0	0	0	0	0
PROPERTY TAX REVENUE	30,857	30,857	0	0	29,387	215,999	215,996	3	0	205,709
OTHER NON-OPER EXPENSE	(7,288)	(7,288)	0	0	(8,343)	(51,014)	(51,016)	2	0	(58,399)
TOTAL NON-OPERATING REVENUE/(EXPENSE)	23,569	23,569	0	0	21,044	164,985	164,980	5	0	147,311
NET SURPLUS (LOSS)	325,547	220,746	104,801	48	440,949	2,793,192	1,563,187	1,230,005	79	1,118,412

HAZEL HAWKINS MEMORIAL HOSPITAL
HOLLISTER, CA
For the month ended 01/31/24

	CURR MONTH 01/31/24	PRIOR MONTH 12/31/23	POS/NEG VARIANCE	PERCENTAGE VARIANCE	PRIOR YR 06/30/23
CURRENT ASSETS					
CASH & CASH EQUIVALENT	18,691,735	19,141,516	(449,781)	(2)	13,649,396
PATIENT ACCOUNTS RECEIVABLE	67,464,984	62,620,823	4,844,160	8	51,674,982
BAD DEBT ALLOWANCE	(7,583,417)	(7,080,605)	(502,812)	7	(5,227,791)
CONTRACTUAL RESERVES	(44,059,682)	(39,903,437)	(4,156,246)	10	(32,708,039)
OTHER RECEIVABLES	9,721,833	8,507,773	1,214,060	14	8,381,301
INVENTORIES	4,045,397	3,991,556	53,842	1	4,057,813
PREPAID EXPENSES	2,079,436	2,688,418	(608,982)	(23)	2,042,543
DUE TO\FROM THIRD PARTIES	1,978,192	1,978,192	0	0	2,784,747
TOTAL CURRENT ASSETS	52,338,478	51,944,236	394,242	1	44,654,951
ASSETS WHOSE USE IS LIMITED					
BOARD DESIGNATED FUNDS	6,366,795	6,099,974	266,821	4	3,825,798
TOTAL LIMITED USE ASSETS	6,366,795	6,099,974	266,821	4	3,825,798
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	43,918,877	43,821,068	97,809	0	43,302,208
CONSTRUCTION IN PROGRESS	977,711	956,198	21,513	2	880,124
CAPITALIZED INTEREST	0	0	0	(100)	0
GROSS PROPERTY,PLANT, AND EQUIPMENT	148,365,435	148,246,114	119,322	0	147,651,180
ACCUMULATED DEPRECIATION	(92,738,245)	(92,413,121)	(325,124)	0	(90,362,507)
NET PROPERTY, PLANT, AND EQUIPMENT	55,627,190	55,832,992	(205,802)	0	57,288,673
OTHER ASSETS					
UNAMORTIZED LOAN COSTS	428,502	434,573	(6,071)	(1)	470,999
PENSION DEFERRED OUTFLOWS NET	18,285,289	18,285,289	0	0	18,285,289
TOTAL OTHER ASSETS	18,713,791	18,719,862	(6,071)	0	18,756,288
TOTAL UNRESTRICTED ASSETS	133,046,254	132,597,065	449,189	0	124,525,709
RESTRICTED ASSETS	40,127	67,051	(26,924)	(40)	125,193
TOTAL ASSETS	133,086,381	132,664,116	422,266	0	124,650,902

HAZEL HAWKINS MEMORIAL HOSPITAL
HOLLISTER, CA
For the month ended 01/31/24

	CURR MONTH 01/31/24	PRIOR MONTH 12/31/23	POS/NEG VARIANCE	PERCENTAGE VARIANCE	PRIOR YR 06/30/23
CURRENT LIABILITIES					
ACCOUNTS PAYABLE	5,646,697	6,008,135	361,438	(6)	4,938,613
ACCRUED PAYROLL	5,031,789	4,431,134	(600,654)	14	3,345,253
ACCRUED PAYROLL TAXES	1,583,772	1,541,062	(42,710)	3	1,497,221
ACCRUED BENEFITS	6,155,666	6,345,005	189,339	(3)	6,051,228
ACCRUED PENSION (CURRENT)	4,956,003	4,956,003	0	0	5,061,807
OTHER ACCRUED EXPENSES	79,023	71,559	(7,463)	10	84,460
PATIENT REFUNDS PAYABLE	7,244	1,310	(5,934)	453	961
DUE TO\FROM THIRD PARTIES	(1,506,719)	(1,084,412)	422,307	39	196,789
OTHER CURRENT LIABILITIES	3,518,803	3,362,789	(156,014)	5	3,132,834
TOTAL CURRENT LIABILITIES	25,472,277	25,632,585	160,309	(1)	24,309,166
LONG-TERM DEBT					
LEASES PAYABLE	5,476,119	5,482,831	6,712	0	5,529,504
BONDS PAYABLE	34,584,721	34,613,241	28,520	0	34,784,361
TOTAL LONG TERM DEBT	40,060,840	40,096,072	35,232	0	40,313,865
OTHER LONG-TERM LIABILITIES					
DEFERRED REVENUE	0	0	0	0	0
LONG-TERM PENSION LIABILITY	36,485,864	36,485,864	0	0	36,485,864
TOTAL OTHER LONG-TERM LIABILITIES	36,485,864	36,485,864	0	0	36,485,864
TOTAL LIABILITIES	102,018,980	102,214,521	195,541	0	101,108,895
NET ASSETS:					
UNRESTRICTED FUND BALANCE	23,376,814	23,376,814	0	0	23,376,814
RESTRICTED FUND BALANCE	116,127	143,051	26,924	(19)	165,193
NET REVENUE/(EXPENSES)	7,574,460	6,929,729	(644,730)	9	0
TOTAL NET ASSETS	31,067,401	30,449,595	(617,806)	2	23,542,007
TOTAL LIABILITIES AND NET ASSETS	133,086,381	132,664,116	(422,266)	0	124,650,902

Hazel Hawkins Memorial Hospital
Expanse Comparison
YTD as of January 31, 2024

	YTD Actual	YTD Budget	Vaiance	Prior YTD Actual	Vaiance
Operating Expenses:					
Salaries & Wages	32,952,072	32,992,119	(40,047)	33,889,643	(937,571)
Registry	2,055,389	1,400,000	655,389	3,606,926	(1,551,537)
Employee Benefits	14,279,096	17,135,068	(2,855,972)	19,497,045	(5,217,949)
as a % of Salaries & Wages	43.33%	51.94%	-8.6%	57.53%	-14.2%
Professional Fees	11,470,426	11,467,350	3,076	11,330,513	139,913
Supplies	7,354,883	8,345,461	(990,578)	8,713,667	(1,358,784)
Purchase Services	7,423,805	7,585,172	(161,367)	8,663,927	(1,240,122)
Rental	956,013	918,379	37,634	1,101,808	(145,795)
Depreciation	2,278,941	2,245,431	33,510	2,265,909	13,032
Interest	405,689	177,919	227,770	44,784	360,905
Other	2,955,952	3,028,180	(72,228)	3,074,577	(118,625)
Total Operating Expenses	**82,132,266**	**85,295,079**	**(3,162,813)**	**92,188,799**	**(10,056,533)**
Percentage of Expense Reduction			-3.7%		-10.9%

Hazel Hawkins
MEMORIAL HOSPITAL

San Benito Health Care District
Hazel Hawkins Memorial Hospital
JANUARY 2024

Description	Target	MTD Actual	YTD Actual	YTD Target
Average Daily Census - Acute	17.97	16.68	14.69	18.68
Average Daily Census - SNF	90.00	88.19	93.44	90.00
Acute Length of Stay	3.40	3.11	2.99	2.97
ER Visits:				
Inpatient	163	129	800	1,174
Outpatient	1,810	2,120	14,414	13,986
Total	1,973	2,249	15,214	15,160
Days in Accounts Receivable	45.0	56.2	56.2	45.0
Productive Full-Time Equivalents	500.90	484.06	477.54	500.90
Net Patient Revenue	11,041,929	11,892,544	83,441,290	80,097,831
Payment-to-Charge Ratio	31.7%	31.2%	32.5%	31.6%
Medicare Traditional Payor Mix	30.56%	28.93%	26.53%	30.39%
Commercial Payor Mix	21.20%	22.21%	23.48%	21.48%
Bad Debt % of Gross Revenue	1.12%	2.05%	1.79%	1.12%
EBIDA	-194,785	886,305	9,371,903	2,797,528
EBIDA %	-1.68%	7.12%	10.71%	3.32%
Operating Margin	-6.37%	2.43%	6.10%	-1.33%
Salaries, Wages, Registry & Benefits %:				
by Net Operating Revenue	64.65%	57.28%	56.35%	61.21%
by Total Operating Expense	60.78%	58.71%	60.01%	60.41%
Bond Covenants:				
Debt Service Ratio	1.25	8.50	8.50	1.25
Current Ratio	1.50	2.05	2.05	1.50
Days Cash on hand	30.00	50.18	50.18	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 January 31, 2024

	CASH FLOW		COMMENTS
	Current Month 1/31/2024	Current Year-To-Date 1/31/2024	
CASH FLOWS FROM OPERATING ACTIVITIES:			
Net Income (Loss)	$644,730	$7,574,460	
Adjustments to Reconcile Net Income to Net Cash Provided by Operating Activities:			
Depreciation	325,124	2,375,743	
(Increase)/Decrease in Net Patient Accounts Receivable	(185,104)	(2,082,734)	
(Increase)/Decrease in Other Receivables	(1,214,060)	(1,345,533)	
(Increase)/Decrease in Inventories	(53,842)	12,415	
(Increase)/Decrease in Pre-Paid Expenses	608,982	(36,894)	
(Increase)/Decrease in Due From Third Parties	0	806,555	
Increase/(Decrease) in Accounts Payable	(361,438)	708,088	
Increase/(Decrease) in Notes and Loans Payable	0	0	
Increase/(Decrease) in Accrued Payroll and Benefits	454,026	1,771,716	
Increase/(Decrease) in Accrued Expenses	7,463	(5,439)	
Increase/(Decrease) in Patient Refunds Payable	5,934	6,282	
Increase/(Decrease) in Third Party Advances/Liabilities	(422,307)	(1,703,508)	
Increase/(Decrease) in Other Current Liabilities	156,014	385,969	Semi-Annual Interest - 2021 Insured Revenue Bonds
Net Cash Provided by Operating Activities:	**(679,208)**	**892,660**	
CASH FLOWS FROM INVESTING ACTIVITIES:			
Purchase of Property, Plant and Equipment	(119,322)	(714,257)	
(Increase)/Decrease in Limited Use Cash and Investments	0	0	
(Increase)/Decrease in Other Limited Use Assets	(266,821)	(2,540,997)	Bond Principal & Int Payment - 2014 & 2021 Bonds
(Increase)/Decrease in Other Assets	6,071	42,497	Amortization
Net Cash Used by Investing Activities	**(380,072)**	**(3,212,757)**	
CASH FLOWS FROM FINANCING ACTIVITIES:			
Increase/(Decrease) in Capital Lease Debt	(6,712)	(53,385)	
Increase/(Decrease) in Bond Mortgage Debt	(28,520)	(199,640)	Refinancing of 2013 Bonds with 2021 Bonds
Increase/(Decrease) in Other Long Term Liabilities	0	0	
Net Cash Used for Financing Activities	**(35,232)**	**(253,025)**	
(INCREASE)/DECREASE IN RESTRICTED ASSETS	**0**	**41,000**	
Net Increase/(Decrease) in Cash	**(449,782)**	**5,042,338**	
Cash, Beginning of Period	19,141,516	13,649,396	
Cash, End of Period	**$18,691,734**	**$18,691,734**	$0
Cost per day to run the District	$372,475		
Operational Days Cash on Hand	50.18		

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	37,061,367	36,004,686	37,198,238	37,873,381	-	-	-	-	-	255,080,842
Actual Bad Debt Expense	712,509	663,649	543,514	751,015	695,471	428,999	776,991	-	-	-	-	-	4,572,148
BD Exp as a percent of Gross Revenue	2.07%	1.83%	1.50%	2.03%	1.93%	1.15%	2.05%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	1.79%
Budgeted YTD BD Exp	2,847,945	1.12%											
Actual YTD BD Exp	4,572,148	1.79%											
Amount under (over) budget	(1,724,203)	-0.67%											
Prior Year percent of Gross Revenue	**1.15%**												
Percent of Decrease (Inc) from Prior Year	-55.9%												

YTD Charity Exp Budget	266,020
YTD Charity Exp Actual	311,288
Amt under (over) budget	(45,268)
Charity Exp % of Gross Rev	0.12%

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Hazel Hawkins Memorial Hospital
IRS Employer FICA Liability
As of January 31, 2024

Tax Quarter Ending:	Principal	Penalty	Interest	Total
- June 30, 2020 *	433,710.08	43,371.01	32,889.68	509,970.77
- September 30, 2020	380,982.06	38,098.21	26,073.55	445,153.82
- December 31, 2020	329,268.86	32,926.87	25,270.56	387,466.29
Totals	1,143,961.00	114,396.09	84,233.78	1,342,590.87

* Estimate of Interest pending.

1/18/2024

MSR Mechanical., LLC
4501 California Ct. Benicia, Ca. 94510
Tel: 1-800-897-4100
CL# 1042634

Hazel Hawkins Hospital

Attn: Will Pollard

RE: Hazel Hawkins Boiler Retrofit

Scope of Work:

- Supply forklift and trucking to remove,haul, and store new boiler (supplied by others) from storage facility to hospital rigging zone when an installation day is set.
- Supply line stops and manpower to raise existing hot water valving that is in rigging path of new boiler. New shutoff valves will be installed during line stops.(2)
- Once line stops and valves are installed,old boiler (B-2) will be rolled to an area adjacent to the existing rigging opening above. A crane will be supplied and used by MSR for rigging purposes to remove old boiler from boiler room and to rig in new boiler that MSR will transport to site on rigging day. (all work to be done during normal working hours.)
- MSR will haul Old boiler to a recycler for disposal.
- Once boiler is rigged into shaft, MSR will roll new boiler into area previously used by the old boiler. (B2)
- The new boiler will be installed as per Promethean Mechanical prints from 12/8/2023
- M2.0 and S1 prints are to be followed with new stainless steel venting tied into concrete chimney area,Hilti Kwik bolt TZ 2 anchors with special inspections,and grout leveling of baseframe during anchorage as per S1 prints.
- Repair and install new insulation as needed by MSR
- Controls by others.
- Startup included and sub-contracted to California Boiler Works

Total price for the above scope is…….$128,500.00

- All work to be on straight time

Exclusions:

- *Demolition or disposal of existing systems or components beyond inclusions.*
- *.Permits*
- *Chemical pipe cleaning*

- *roofing*
- *Rigging other than noted*
- *Anchorage other than noted*
- *Spring isolators*
- *Flex connectors or valves other than noted*
- *Draining and filling by facilities*
- *Any electrical or controls*
- *Any pipe freezes due to faulty valves or replacement of any valves*
- *Repair or warranty of pre-existing equipment and/or conditions.*
- *Any rigging of new or old equipment to and from the mechanical room other than noted*
- *Any general contractor related work such as framing, drywall, painting, patching, access panels and doors, coring, t-bar removal & replacement, concrete and/or housekeeping pads. (Other than noted above).*
- *Hazardous materials identification or removal.*
- *Structural review, engineering, calculations, or modifications.*
- *Seismic calculations*
- *Any/all code upgrades.*
- *Hazardous materials identification or removal.*
- *Mechanical design engineering, Title 24, design and as-built drawings, plan check and permit fees.*
- *Full-time onsite supervision and/or project management. Other than noted*
- *Any/all work not mentioned above.*

Clarifications:

This proposal is based upon an agreeable working schedule, with all work occurring during normal working hours where possible. Construction schedule is pursuant to a lead time issued by the manufacturer for all equipment and materials provided by us.

The above quotation includes all applicable state and local taxes. All materials specified or supplied shall be warranted per terms and conditions of the original manufacturer's limited warranty provisions, but in no instance shall such assurances be for a period of less than one year. All MSR labor shall be warranted for a period of 1 year days from the date of first beneficial use.

This proposal is valid for 30 days from date listed on the above. After that time period it is subject to adjustment for the appropriate cost increases.

We trust this provides you with the information you require at this time. If you have any questions, concerns, or require further information regarding any of the above quoted work, please feel free to contact us. We look forward to discussing this proposal and any other opportunities that may be available.

Thank you for the opportunity to be of service, we appreciate your business.

Sincerely yours,

Bob Kapferer

MSR Mechanical LLC

Project Manager