Hazel Hawkins
MEMORIAL HOSPITAL

REGULAR AND SPECIAL MEETING OF THE FINANCE COMMITTEE
SAN BENITO HEALTH CARE DISTRICT
911 SUNSET DRIVE, HOLLISTER, CALIFORNIA
THURSDAY, OCTOBER 19, 2023 - 4:30 P.M.
SUPPORT SERVICES BUILDING, 2ND FLOOR – GREAT ROOM

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

1. Call to Order

2. Approve Minutes of the Finance Committee Meeting of September 21, 2023
   - Motion/Second

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

4. Consider Recommendation for Board Approval of Security Agreement with Interpol Private Security
   - Report
   - Committee Questions
   - Motion/Second

5. Consider Recommendation for Board Approval of Agreement with Imperial Health Plan, Medicare Advantage Plan
   - Report
   - Committee Questions
   - Motion/Second

6. 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 **Committee,** which are not on this agenda.

7. Adjournment

   The next Finance Committee meeting is scheduled for **Monday, November 13, 2023** at **4:30 p.m.**

The complete Finance Committee packet including subsequently distributed materials and presentations is available at the Finance Committee meeting and in the Administrative Offices of the District. All items appearing

Hazel Hawkins
MEMORIAL HOSPITAL

on the agenda are subject to action by the Finance Committee. Staff and Committee recommendations are subject to change by the Finance Committee.

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.

MEMORIAL HOSPITAL
SKILLED NURSING FACILITIES
HOME HEALTH AGENCY

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

October 19, 2023

CFO Financial Summary for the District Board:

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

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

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

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

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

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

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

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

	CURRENT MONTH					YEAR-TO-DATE				
	ACTUAL 09/30/23	BUDGET 09/30/23	POS/NEG VARIANCE	PERCENT VARIANCE	PRIOR YR 09/30/22	ACTUAL 09/30/23	BUDGET 09/30/23	POS/NEG VARIANCE	PERCENT VARIANCE	PRIOR YR 09/30/22
GROSS PATIENT REVENUE:										
ACUTE ROUTINE REVENUE	3,412,521	4,612,453	(1,199,932)	(26)	4,060,175	8,834,932	14,132,252	(5,297,321)	(38)	12,656,096
SNF ROUTINE REVENUE	2,115,900	2,025,000	90,900	5	1,989,000	6,746,578	6,210,000	536,578	9	6,059,500
ANCILLARY INPATIENT REVENUE	4,204,005	5,135,822	(931,817)	(18)	5,168,867	11,380,523	16,246,588	(4,866,065)	(30)	16,130,121
HOSPITALIST\PEDS I\P REVENUE	159,902	184,678	(24,776)	(13)	166,153	412,654	566,339	(153,685)	(27)	574,842
TOTAL GROSS INPATIENT REVENUE	9,892,328	11,957,953	(2,065,625)	(17)	11,384,195	27,374,686	37,155,179	(9,780,493)	(26)	35,420,559
ANCILLARY OUTPATIENT REVENUE	26,519,508	23,031,676	3,487,832	15	22,431,490	79,981,138	74,417,052	5,564,086	8	67,061,267
HOSPITALIST\PEDS O\P REVENUE	50,629	59,424	(8,795)	(15)	59,539	156,948	182,227	(25,279)	(14)	191,881
TOTAL GROSS OUTPATIENT REVENUE	26,570,137	23,091,100	3,479,037	15	22,491,029	80,138,086	74,599,279	5,538,807	7	67,253,148
TOTAL GROSS PATIENT REVENUE	36,462,465	35,049,053	1,413,412	4	33,875,224	107,512,772	111,754,458	(4,241,686)	(4)	102,673,707
DEDUCTIONS FROM REVENUE:										
MEDICARE CONTRACTUAL ALLOWANCES	9,531,584	10,085,597	(554,013)	(6)	9,170,686	28,210,292	32,174,862	(3,964,570)	(12)	29,297,518
MEDI-CAL CONTRACTUAL ALLOWANCES	10,854,106	9,485,715	1,368,391	14	8,555,486	31,664,297	30,410,788	1,253,509	4	25,689,832
BAD DEBT EXPENSE	543,514	393,214	150,300	38	344,314	1,919,672	1,255,526	664,146	53	894,090
CHARITY CARE	99,316	36,697	62,619	171	33,934	169,949	117,358	52,591	45	105,530
OTHER CONTRACTUALS AND ADJUSTMENTS	4,292,423	3,953,930	338,493	9	3,846,800	12,823,664	12,675,683	147,981	1	10,981,335
HOSPITALIST\PEDS CONTRACTUAL ALLOW	21,887	12,165	9,722	80	3,803	17,000	38,891	(21,892)	(56)	59,647
TOTAL DEDUCTIONS FROM REVENUE	25,342,830	23,967,318	1,375,512	6	21,955,023	74,804,874	76,673,108	(1,868,234)	(2)	67,027,951
NET PATIENT REVENUE	11,119,635	11,081,735	37,900	0	11,920,201	32,707,898	35,081,350	(2,373,452)	(7)	35,645,756
OTHER OPERATING REVENUE	611,098	582,499	28,599	5	703,398	1,787,048	1,747,497	39,551	2	2,656,956
NET OPERATING REVENUE	11,730,732	11,664,234	66,498	1	12,623,599	34,494,946	36,828,847	(2,333,901)	(6)	38,302,712
OPERATING EXPENSES:										
SALARIES & WAGES	4,652,324	4,607,253	45,071	1	4,671,174	13,946,503	14,089,218	(142,715)	(1)	14,790,583
REGISTRY	283,889	200,000	83,889	42	596,591	746,683	600,000	146,683	24	1,787,301
EMPLOYEE BENEFITS	2,207,384	2,412,262	(204,878)	(9)	2,476,037	6,148,244	7,449,049	(1,300,806)	(18)	7,871,891
PROFESSIONAL FEES	1,610,950	1,602,560	8,390	1	1,615,745	4,714,073	4,907,452	(193,380)	(4)	4,556,934
SUPPLIES	1,031,899	1,226,272	(194,373)	(16)	1,224,773	2,916,252	3,683,758	(767,506)	(21)	3,745,258
PURCHASED SERVICES	931,582	1,058,396	(126,814)	(12)	1,256,876	3,189,493	3,245,749	(56,256)	(2)	3,756,433
RENTAL	124,077	130,294	(6,217)	(5)	139,545	367,267	393,405	(26,138)	(7)	467,611
DEPRECIATION & AMORT	327,556	320,773	6,783	2	320,532	979,373	962,327	17,046	2	955,245
INTEREST	36,616	25,417	11,199	44	4,460	87,686	76,251	11,435	15	17,116
OTHER	365,085	423,085	(58,000)	(14)	520,897	1,200,295	1,295,891	(95,596)	(7)	1,411,148
TOTAL EXPENSES	11,571,363	12,006,312	(434,949)	(4)	12,826,630	34,295,869	36,703,100	(2,407,231)	(7)	39,359,519
NET OPERATING INCOME (LOSS)	159,370	(342,078)	501,448	(147)	(203,032)	199,078	125,747	73,331	58	(1,056,807)

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

	CURRENT MONTH					YEAR-TO-DATE				
	ACTUAL 09/30/23	BUDGET 09/30/23	POS/NEG VARIANCE	PERCENT VARIANCE	PRIOR YR 09/30/22	ACTUAL 09/30/23	BUDGET 09/30/23	POS/NEG VARIANCE	PERCENT VARIANCE	PRIOR YR 09/30/22
NON-OPERATING REVENUE\EXPENSE:										
DONATIONS	72,526	5,000	67,526	1,351	9,765	73,659	15,000	58,659	391	139,108
PROPERTY TAX REVENUE	205,711	205,711	0	0	195,915	617,133	617,133	0	0	587,745
GO BOND PROP TAXES	170,388	170,388	0	0	164,964	511,163	511,164	(1)	0	494,893
GO BOND INT REVENUE\EXPENSE	(68,721)	(68,721)	0	0	(72,048)	(206,163)	(206,163)	0	0	(216,143)
OTHER NON-OPER REVENUE	14,866	13,843	1,023	7	10,255	58,376	41,529	16,847	41	38,620
OTHER NON-OPER EXPENSE	(32,880)	(32,700)	(180)	1	(37,664)	(98,322)	(98,100)	(222)	0	(114,148)
INVESTMENT INCOME	(6,483)	0	(6,483)		0	(5,432)	0	(5,432)		246
COLLABORATION CONTRIBUTIONS	0	0	0	0	0	0	0	0	0	0
TOTAL NON-OPERATING REVENUE/(EXPENSE)	355,407	293,521	61,886	21	271,188	950,414	880,563	69,851	8	930,321
NET SURPLUS (LOSS)	514,777	(48,557)	563,334	(1,160)	68,157	1,149,491	1,006,310	143,181	14	(126,486)
EBIDA	$ 773,547	$ 203,249	$ 570,298	280.59%	$ 333,435	$ 1,922,186	$ 1,761,736	$ 160,450	9.10%	$ 664,157
EBIDA MARGIN	6.59%	1.74%	4.85%	278.42%	2.64%	5.57%	4.78%	0.79%	16.48%	1.73%
OPERATING MARGIN	1.36%	(2.93)%	4.29%	(146.32)%	(1.61)%	0.58%	0.34%	0.24%	69.03%	(2.76)%
NET SURPLUS (LOSS) MARGIN	4.39%	(0.42)%	4.80%	(1,154.09)%	0.54%	3.33%	2.73%	0.60%	21.95%	(0.33)%

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

	CURRENT MONTH					YEAR-TO-DATE				
	ACTUAL 09/30/23	BUDGET 09/30/23	POS/NEG VARIANCE	PERCENT VARIANCE	PRIOR YR 09/30/22	ACTUAL 09/30/23	BUDGET 09/30/23	POS/NEG VARIANCE	PERCENT VARIANCE	PRIOR YR 09/30/22
GROSS PATIENT REVENUE:										
ROUTINE REVENUE	3,412,521	4,612,453	(1,199,932)	(26)	4,060,175	8,834,932	14,132,252	(5,297,321)	(38)	12,656,096
ANCILLARY INPATIENT REVENUE	3,989,464	4,773,514	(784,050)	(16)	4,708,363	10,373,453	15,123,005	(4,749,552)	(31)	14,869,878
HOSPITALIST I\P REVENUE	159,902	184,678	(24,776)	(13)	166,153	412,654	566,339	(153,685)	(27)	574,842
TOTAL GROSS INPATIENT REVENUE	7,561,887	9,570,645	(2,008,758)	(21)	8,934,691	19,621,038	29,821,596	(10,200,558)	(34)	28,100,816
ANCILLARY OUTPATIENT REVENUE	26,519,508	23,031,676	3,487,832	15	22,431,490	79,981,138	74,417,052	5,564,086	8	67,061,267
HOSPITALIST O\P REVENUE	50,629	59,424	(8,795)	(15)	59,539	156,948	182,227	(25,279)	(14)	191,881
TOTAL GROSS OUTPATIENT REVENUE	26,570,137	23,091,100	3,479,037	15	22,491,029	80,138,086	74,599,279	5,538,807	7	67,253,148
TOTAL GROSS ACUTE PATIENT REVENUE	34,132,024	32,661,745	1,470,279	5	31,425,719	99,759,124	104,420,875	(4,661,751)	(5)	95,353,965
DEDUCTIONS FROM REVENUE ACUTE:										
MEDICARE CONTRACTUAL ALLOWANCES	9,356,831	9,814,649	(457,818)	(5)	8,828,785	27,401,463	31,333,954	(3,932,491)	(13)	28,516,362
MEDI-CAL CONTRACTUAL ALLOWANCES	10,612,231	9,380,899	1,231,332	13	8,397,490	31,038,908	30,089,356	949,552	3	25,221,930
BAD DEBT EXPENSE	527,795	383,214	144,581	38	374,954	1,859,870	1,225,526	634,344	52	887,769
CHARITY CARE	99,316	36,697	62,619	171	33,934	169,949	117,358	52,591	45	105,530
OTHER CONTRACTUALS AND ADJUSTMENTS	4,270,279	3,889,130	381,149	10	3,805,215	12,745,328	12,476,963	268,365	2	10,771,264
HOSPITALIST\PEDS CONTRACTUAL ALLOW	21,887	12,165	9,722	80	3,803	17,000	38,891	(21,892)	(56)	59,647
TOTAL ACUTE DEDUCTIONS FROM REVENUE	24,888,338	23,516,754	1,371,584	6	21,444,181	73,232,518	75,282,048	(2,049,531)	(3)	65,562,502
NET ACUTE PATIENT REVENUE	9,243,686	9,144,991	98,695	1	9,981,539	26,526,607	29,138,827	(2,612,220)	(9)	29,791,463
OTHER OPERATING REVENUE	611,098	582,499	28,599	5	703,398	1,787,048	1,747,497	39,551	2	2,656,956
NET ACUTE OPERATING REVENUE	9,854,784	9,727,490	127,294	1	10,684,937	28,313,655	30,886,324	(2,572,669)	(8)	32,448,419
OPERATING EXPENSES:										
SALARIES & WAGES	3,717,844	3,695,948	21,896	1	3,756,786	11,060,197	11,298,341	(238,145)	(2)	11,980,092
REGISTRY	256,629	167,000	89,629	54	562,309	648,939	501,000	147,939	30	1,678,139
EMPLOYEE BENEFITS	1,705,793	1,899,607	(193,814)	(10)	1,953,921	4,770,350	5,876,157	(1,105,807)	(19)	6,211,585
PROFESSIONAL FEES	1,608,740	1,600,224	8,516	1	1,613,535	4,707,443	4,900,442	(193,000)	(4)	4,549,794
SUPPLIES	939,981	1,137,966	(197,986)	(17)	1,125,278	2,632,235	3,416,736	(784,501)	(23)	3,441,953
PURCHASED SERVICES	844,863	954,402	(109,539)	(12)	1,140,619	2,922,866	2,926,829	(3,963)	0	3,426,824
RENTAL	123,065	129,269	(6,204)	(5)	138,526	364,252	390,292	(26,041)	(7)	464,577
DEPRECIATION & AMORT	288,164	281,320	6,844	2	280,278	861,196	843,960	17,236	2	835,259
INTEREST	36,616	25,417	11,199	44	4,460	87,686	76,251	11,435	15	17,116
OTHER	312,819	366,744	(53,925)	(15)	466,389	1,055,130	1,123,152	(68,022)	(6)	1,205,725
TOTAL EXPENSES	9,834,513	10,257,897	(423,384)	(4)	11,042,103	29,110,292	31,353,160	(2,242,868)	(7)	33,811,063
NET OPERATING INCOME (LOSS)	20,271	(530,407)	550,678	(104)	(357,166)	(796,637)	(466,836)	(329,801)	71	(1,362,644)

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

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

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

	CURRENT MONTH					YEAR-TO-DATE				
	ACTUAL 09/30/23	BUDGET 09/30/23	POS/NEG VARIANCE	PERCENT VARIANCE	PRIOR YR 09/30/22	ACTUAL 09/30/23	BUDGET 09/30/23	POS/NEG VARIANCE	PERCENT VARIANCE	PRIOR YR 09/30/22
GROSS SNF PATIENT REVENUE:										
ROUTINE SNF REVENUE	2,115,900	2,025,000	90,900	5	1,989,000	6,746,578	6,210,000	536,578	9	6,059,500
ANCILLARY SNF REVENUE	214,541	362,308	(147,767)	(41)	460,504	1,007,070	1,123,583	(116,513)	(10)	1,260,242
TOTAL GROSS SNF PATIENT REVENUE	2,330,441	2,387,308	(56,867)	(2)	2,449,504	7,753,648	7,333,583	420,065	6	7,319,742
DEDUCTIONS FROM REVENUE SNF:										
MEDICARE CONTRACTUAL ALLOWANCES	174,754	270,948	(96,194)	(36)	341,902	808,829	840,908	(32,079)	(4)	781,156
MEDI-CAL CONTRACTUAL ALLOWANCES	241,875	104,816	137,059	131	157,995	625,388	321,432	303,956	95	467,902
BAD DEBT EXPENSE	15,720	10,000	5,720	57	(30,640)	59,802	30,000	29,802	99	6,320
CHARITY CARE	0	0	0	0	0	0	0	0	0	0
OTHER CONTRACTUALS AND ADJUSTMENTS	22,145	64,800	(42,656)	(66)	41,585	78,336	198,720	(120,384)	(61)	210,071
TOTAL SNF DEDUCTIONS FROM REVENUE	454,493	450,564	3,929	1	510,842	1,572,356	1,391,060	181,296	13	1,465,449
NET SNF PATIENT REVENUE	1,875,948	1,936,744	(60,796)	(3)	1,938,662	6,181,292	5,942,523	238,769	4	5,854,293
OTHER OPERATING REVENUE	0	0	0	0	0	0	0	0	0	0
NET SNF OPERATING REVENUE	1,875,948	1,936,744	(60,796)	(3)	1,938,662	6,181,292	5,942,523	238,769	4	5,854,293
OPERATING EXPENSES:										
SALARIES & WAGES	934,480	911,305	23,175	3	914,388	2,886,307	2,790,877	95,430	3	2,810,491
REGISTRY	27,260	33,000	(5,740)	(17)	34,283	97,744	99,000	(1,256)	(1)	109,163
EMPLOYEE BENEFITS	501,591	512,655	(11,064)	(2)	522,116	1,377,893	1,572,892	(194,999)	(12)	1,660,305
PROFESSIONAL FEES	2,210	2,336	(126)	(5)	2,210	6,630	7,010	(380)	(5)	7,140
SUPPLIES	91,919	88,306	3,613	4	99,495	284,017	267,022	16,995	6	303,305
PURCHASED SERVICES	86,719	103,994	(17,275)	(17)	116,256	258,024	318,920	(60,897)	(19)	329,609
RENTAL	1,012	1,025	(13)	(1)	1,018	3,015	3,113	(98)	(3)	3,033
DEPRECIATION	39,392	39,453	(61)	0	40,254	118,177	118,367	(190)	0	119,987
INTEREST	0	0	0	0	0	0	0	0	0	0
OTHER	52,266	56,341	(4,075)	(7)	54,508	145,166	172,739	(27,573)	(16)	205,423
TOTAL EXPENSES	1,736,849	1,748,415	(11,566)	(1)	1,784,527	5,176,973	5,349,940	(172,967)	(3)	5,548,456
NET OPERATING INCOME (LOSS)	139,099	188,329	(49,230)	(26)	154,135	1,004,319	592,583	411,736	70	305,837
NON-OPERATING REVENUE\EXPENSE:										
DONATIONS	0	0	0	0	0	0	0	0	0	0
PROPERTY TAX REVENUE	30,857	30,857	0	0	29,387	92,571	92,571	0	0	88,161
OTHER NON-OPER EXPENSE	(7,288)	(7,288)	0	0	(8,343)	(21,863)	(21,864)	1	0	(25,028)
TOTAL NON-OPERATING REVENUE/(EXPENSE)	23,569	23,569	0	0	21,044	70,708	70,707	1	0	63,133
NET SURPLUS (LOSS)	162,668	211,898	(49,230)	(23)	175,179	1,075,026	663,290	411,736	62	368,970

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

	CURR MONTH 09/30/23	PRIOR MONTH 08/31/23	POS/NEG VARIANCE	PERCENTAGE VARIANCE	PRIOR YR 06/30/23
CURRENT ASSETS					
CASH & CASH EQUIVALENT	12,644,124	14,225,430	(1,581,306)	(11)	13,649,396
PATIENT ACCOUNTS RECEIVABLE	59,732,608	56,838,808	2,893,800	5	51,674,982
BAD DEBT ALLOWANCE	(6,390,402)	(6,143,484)	(246,918)	4	(5,227,791)
CONTRACTUAL RESERVES	(36,237,252)	(33,762,665)	(2,474,587)	7	(30,266,699)
OTHER RECEIVABLES	7,249,461	6,797,449	452,012	7	6,095,092
INVENTORIES	4,047,238	4,054,906	(7,668)	0	4,057,813
PREPAID EXPENSES	2,765,364	2,654,293	111,072	4	2,042,543
DUE TO\FROM THIRD PARTIES	2,037,861	2,037,861	0	0	2,784,747
TOTAL CURRENT ASSETS	45,849,003	46,702,597	(853,594)	(2)	44,810,082
ASSETS WHOSE USE IS LIMITED					
BOARD DESIGNATED FUNDS	5,822,024	5,434,735	387,289	7	4,906,264
TOTAL LIMITED USE ASSETS	5,822,024	5,434,735	387,289	7	4,906,264
PROPERTY, PLANT, AND EQUIPMENT					
LAND & LAND IMPROVEMENTS	3,370,474	3,370,474	0	0	3,370,474
BLDGS & BLDG IMPROVEMENTS	100,098,374	100,098,374	0	0	100,098,374
EQUIPMENT	43,715,153	43,684,281	30,873	0	43,302,208
CONSTRUCTION IN PROGRESS	905,142	905,142	0	0	880,124
CAPITALIZED INTEREST	0	8,869	(8,869)	(100)	0
GROSS PROPERTY,PLANT, AND EQUIPMENT	148,089,144	148,067,140	22,004	0	147,651,180
ACCUMULATED DEPRECIATION	(91,385,628)	(91,043,489)	(342,139)	0	(90,362,507)
NET PROPERTY, PLANT, AND EQUIPMENT	56,703,515	57,023,651	(320,135)	(1)	57,288,673
OTHER ASSETS					
UNAMORTIZED LOAN COSTS	452,786	458,857	(6,071)	(1)	470,999
PENSION DEFERRED OUTFLOWS NET	3,797,637	3,797,637	0	0	3,797,637
TOTAL OTHER ASSETS	4,250,423	4,256,494	(6,071)	0	4,268,636
TOTAL UNRESTRICTED ASSETS	112,624,965	113,417,476	(792,512)	(1)	111,273,655
RESTRICTED ASSETS	53,099	125,571	(72,473)	(58)	125,193
TOTAL ASSETS	112,678,064	113,543,048	(864,984)	(1)	111,398,848

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

	CURR MONTH 09/30/23	PRIOR MONTH 08/31/23	POS/NEG VARIANCE	PERCENTAGE VARIANCE	PRIOR YR 06/30/23
CURRENT LIABILITIES					
ACCOUNTS PAYABLE	5,634,182	5,532,148	(102,034)	2	4,938,613
ACCRUED PAYROLL	2,684,122	4,388,955	1,704,834	(39)	3,345,253
ACCRUED PAYROLL TAXES	2,009,490	1,410,826	(598,664)	42	1,345,303
ACCRUED BENEFITS	5,789,705	5,560,719	(228,986)	4	6,051,228
ACCRUED PENSION (CURRENT)	4,963,931	4,961,787	(2,144)	0	5,061,807
OTHER ACCRUED EXPENSES	103,245	95,781	(7,463)	8	84,460
PATIENT REFUNDS PAYABLE	1,136	1,136	0	0	961
DUE TO\FROM THIRD PARTIES	3,612,135	4,225,310	613,175	(15)	4,400,056
OTHER CURRENT LIABILITIES	4,236,793	4,130,176	(106,617)	3	3,493,074
TOTAL CURRENT LIABILITIES	29,034,738	30,306,839	1,272,101	(4)	28,720,755
LONG-TERM DEBT					
LEASES PAYABLE	6,515,697	6,522,365	6,668	0	6,542,301
BONDS PAYABLE	34,698,801	34,727,321	28,520	0	34,784,361
TOTAL LONG TERM DEBT	41,214,499	41,249,686	35,188	0	41,326,662
OTHER LONG-TERM LIABILITIES					
DEFERRED REVENUE	0	0	0	0	0
LONG-TERM PENSION LIABILITY	14,706,676	14,706,676	0	0	14,706,676
TOTAL OTHER LONG-TERM LIABILITIES	14,706,676	14,706,676	0	0	14,706,676
TOTAL LIABILITIES	84,955,912	86,263,201	1,307,289	(2)	84,754,093
NET ASSETS:					
UNRESTRICTED FUND BALANCE	26,479,561	26,479,561	0	0	26,479,561
RESTRICTED FUND BALANCE	93,099	165,571	72,473	(44)	165,193
NET REVENUE/(EXPENSES)	1,149,491	634,714	(514,777)	81	0
TOTAL NET ASSETS	27,722,151	27,279,847	(442,304)	2	26,644,755
TOTAL LIABILITIES AND NET ASSETS	112,678,064	113,543,048	864,984	(1)	111,398,848

San Benito Health Care District
Hazel Hawkins Memorial Hospital
SEPTEMBER 2023

Description	Target	MTD Actual	YTD Actual	YTD Target
Average Daily Census - Acute	17.44	15.00	12.98	18.54
Average Daily Census - SNF	90.01	93.73	94.84	90.00
Acute Length of Stay	2.64	3.17	2.96	2.65
ER Visits:				
Inpatient	160	98	298	464
Outpatient	1,957	1,956	5,824	5,778
Total	2,117	2,054	6,122	6,242
Days in Accounts Receivable	45.0	51.3	51.3	45.0
Productive Full-Time Equivalents	500.90	480.01	471.89	500.90
Net Patient Revenue	11,081,735	11,119,635	32,707,898	35,081,350
Payment-to-Charge Ratio	31.6%	30.5%	30.4%	31.4%
Medicare Traditional Payor Mix	30.00%	26.21%	26.54%	30.30%
Commercial Payor Mix	21.68%	23.10%	23.23%	21.67%
Bad Debt % of Gross Revenue	1.12%	1.50%	1.80%	1.12%
EBIDA	203,249	773,547	1,922,186	1,761,736
EBIDA %	1.74%	6.59%	5.57%	4.78%
Operating Margin	-2.93%	1.36%	0.58%	0.34%
Salaries, Wages, Registry & Benefits %:				
by Net Operating Revenue	61.89%	60.90%	60.42%	60.11%
by Total Operating Expense	60.13%	61.74%	60.77%	60.32%
Bond Covenants:				
Debt Service Ratio	1.25	3.95	3.95	1.25
Current Ratio	1.50	1.58	1.58	1.50
Days Cash on hand	30.00	34.81	34.81	30.00

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

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

	CASH FLOW		COMMENTS
	Current Month 9/30/2023	Current Year-To-Date 9/30/2023	
CASH FLOWS FROM OPERATING ACTIVITIES:			
Net Income (Loss)	$514,777	$1,149,491	
Adjustments to Reconcile Net Income to Net Cash Provided by Operating Activities:			
Depreciation	342,139	1,023,125	
(Increase)/Decrease in Net Patient Accounts Receivable	(172,297)	(924,463)	
(Increase)/Decrease in Other Receivables	(452,012)	(1,154,370)	
(Increase)/Decrease in Inventories	7,668	10,575	
(Increase)/Decrease in Pre-Paid Expenses	(111,072)	(722,822)	
(Increase)/Decrease in Due From Third Parties	0	746,886	
Increase/(Decrease) in Accounts Payable	102,035	695,572	
Increase/(Decrease) in Notes and Loans Payable	0	0	
Increase/(Decrease) in Accrued Payroll and Benefits	(875,039)	(356,347)	
Increase/(Decrease) in Accrued Expenses	7,463	18,784	
Increase/(Decrease) in Patient Refunds Payable	0	174	
Increase/(Decrease) in Third Party Advances/Liabilities	(613,175)	(787,921)	
Increase/(Decrease) in Other Current Liabilities	106,617	743,720	Semi-Annual Interest - 2021 Insured Revenue Bonds
Net Cash Provided by Operating Activities:	**(1,657,673)**	**(707,087)**	
CASH FLOWS FROM INVESTING ACTIVITIES:			
Purchase of Property, Plant and Equipment	(22,004)	(437,965)	
(Increase)/Decrease in Limited Use Cash and Investments	0	0	
(Increase)/Decrease in Other Limited Use Assets	(387,289)	(915,760)	Bond Principal & Int Payment - 2014 & 2021 Bonds
(Increase)/Decrease in Other Assets	6,071	18,213	Amortization
Net Cash Used by Investing Activities	**(403,222)**	**(1,335,512)**	
CASH FLOWS FROM FINANCING ACTIVITIES:			
Increase/(Decrease) in Bond/Mortgage Debt	(6,668)	(26,604)	Refinancing of 2013 Bonds with 2021 Bonds
Increase/(Decrease) in Capital Lease Debt	(28,520)	(85,560)	
Increase/(Decrease) in Other Long Term Liabilities	0	0	
Net Cash Used for Financing Activities	**(35,188)**	**(112,164)**	
(INCREASE)/DECREASE IN RESTRICTED ASSETS	**0**	**0**	
Net Increase/(Decrease) in Cash	**(1,581,306)**	**(1,005,272)**	
Cash, Beginning of Period	14,225,430	13,649,396	
Cash, End of Period	**$12,644,124**	**$12,644,124**	$0

Cost per day to run the District	$363,202
Operational Days Cash on Hand	34.81

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

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

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

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CALIFORNIA HEALTH FACILITIES FINANCING AUTHORITY

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chffa@treasurer.ca.gov
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MEMBERS

FIONA MA, CPA, CHAIR
California State Treasurer

MALIA M. COHEN
State Controller

JOE STEPHENSHAW
Director of Finance

ANTONIO BENJAMIN

FRANCISCO SILVA

ROBERT CHERRY, M.D.

ROBERT HERTZKA, M.D.

KATRINA KALVODA

KERI KROPKE, M.A., M.A., CCC-SLP

EXECUTIVE DIRECTOR
CAROLYN ABOUBECHARA

October 6, 2023

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

RE: Distressed Hospital Loan Program

Dear Mark Robinson,

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

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

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

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

Sincerely,

DocuSigned by:
Carolyn Aboubechara
EBF51B334FCD46A...

Carolyn Aboubechara
Executive Director

SAN BENITO HEALTH CARE DISTRICT
VENDOR SERVICES AGREEMENT

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

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

1. TERM

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

2. SCOPE OF SERVICES

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

3. PERFORMANCE

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

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

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

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

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

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

4. DISTRICT MANAGEMENT

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

5. PAYMENT

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

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

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

6. INSPECTION

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

7. SUSPENSION OR TERMINATION OF AGREEMENT

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

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

8. DEFAULT OF VENDOR/FORCE MAJEURE

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

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

9. OWNERSHIP OF DOCUMENTS

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

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

10. RECORD AUDIT

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

11. INDEMNIFICATION

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

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

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

12. INSURANCE

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

13. INDEPENDENT CONTRACTOR

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

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

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

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

14. NO BENEFIT TO ARISE TO DISTRICT OFFICERS AND EMPLOYEES

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

15. CONFLICT OF INTEREST

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

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

16. NO WAIVER OF BREACH/TIME

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

17. CONFIDENTIAL INFORMATION/RELEASE OF INFORMATION

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

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

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

18. NOTICES

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

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

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

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

19. THIRD PARTY BENEFICIARIES

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

20. ASSIGNMENT

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

21. GOVERNING LAW

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

22. DISPUTE RESOLUTION; ATTORNEY'S FEES

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

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

23. AUTHORITY TO EXECUTE THIS AGREEMENT

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

24. ENTIRE AGREEMENT

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

25. AMENDMENT

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

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

26. INTERPRETATION OF CONFLICTING PROVISIONS

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

27. SEVERABILITY

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

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

SAN BENITO HEALTH CARE DISTRICT

Date: ____________________ By: ______________________________
Mary Casillas, Interim CEO

INTERPOL PRIVATE SECURITY

Date: 9/25/23

By:
Everett L. Fitzgerald

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

EXHIBIT A
SCOPE OF WORK/SERVICES

HIPAA COMPLIANCE STATEMENT

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

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

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

Now, Therefore, the Parties hereby agree as follows:

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

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

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

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

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

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

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

Hours of Coverage & Description:

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

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

EXHIBIT B
FEES

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

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

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

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

SPECIAL RATES FOR ADDITIONAL SERVICES

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

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

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

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

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

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

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EXHIBIT C
INSURANCE SPECIFICATIONS

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

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

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

OTHER PROVISIONS OR REQUIREMENTS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

HOSPITAL SERVICES AGREEMENT

Between

IMPERIAL HEALTH PLAN OF CALIFORNIA, INC.

And

Hazel Hawkins Memorial Hospital/San Benito Healthcare District

---

HOSPITAL SERVICES AGREEMENT

Between

IMPERIAL HEALTH PLAN OF CALIFORNIA, INC.

And

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

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

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

Pasadena, CA 91106
Attn: CEO

IMPERIAL HEALTH PLAN OF CALIFORNIA, INC. AGREEMENT

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IMPERIAL HEALTH PLAN OF CALIFORNIA, INC. AGREEMENT

RECITALS

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

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

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

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

SECTION 1.
DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 2.
QUALIFICATIONS, OBLIGATIONS AND COVENANTS

2.1 HOSPITAL is responsible for:

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

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

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

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

2.1.5 Standards: HOSPITAL shall:

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

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

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

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

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

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

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

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

2.1.6 Participation in Quality Improvement and Utilization Management Programs.

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

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

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

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

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

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

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

2.1.9 Data Requirements. HOSPITAL shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

2.2 PLAN is responsible for:

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

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

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

SECTION 3.
SCOPE OF SERVICES

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

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

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

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

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

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

SECTION 4.
EXCLUSIONS FROM AND LIMITATIONS OF COVERED SERVICES

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

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

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

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

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

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

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

(f) Fabrication of optical lenses;

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

(h) Direct Observed Therapy for tuberculosis;

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

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

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

SECTION 5.
REIMBURSEMENT, ACCOUNTS, REPORTING AND RECOVERIES

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

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

5.1.2 The Member's attending physician will determine the need for acute care in accordance with usual standards of medical practice in the community nationally recognized criteria, PLAN Utilization Management (UM) guidelines developed and approved by the Quality Assurance Committee and California Department of Health and Welfare Code of Regulations Title 22.

5.1.3 Member's attending physician will determine the Medically Necessary course of treatment to be provided in the HOSPITAL.

5.1.4 Nothing in this Agreement is intended to create (nor shall it be construed to create) any right by PLAN or by PLAN's Participating Providers (except in their capacity as Members of HOSPITAL's medical staff) to interfere with the method(s) by which HOSPITAL or attending physicians render services hereunder.

5.1.5 All rate changes or adjustments shall be made only if the parties have executed a formal amendment to Agreement to provide for same. Rates may not be adjusted without prior written approval of HOSPITAL.

5.2 Claims Submission. HOSPITAL shall submit a complete UB-04 form or submit complete data through electronic transfer, in accordance with the Provider Manual and Attachment B of this Agreement. Reimbursement will be made within thirty (30) calendar days of receipt of an uncontested claim which is accurate, complete and otherwise in accordance with the PLAN provider manual. PLAN shall request missing information related to an unclean claim within 30 calendar days of receipt of the initial claim. All unclean claims will be paid within 30 calendar days of receipt of the information necessary to

determine PLAN liability. After the requested information is submitted to the PLAN, the PLAN will either approve, deny or modify the amount to be reimbursed based on the information provided. The PLAN's claims adjudication process will not conflict with CMS' claims adjudication process. If the HOSPITAL does not submit the requested information to determine PLAN liability within 180 calendar days from the date of the request, the PLAN will notify the HOSPITAL that the claim remains pending as "unclean." All claims for Covered Services must be submitted to the PLAN within twelve (12) months from the date that service was provided. If for any reason it is determined that PLAN overpaid HOSPITAL, PLAN may deduct monies in the amount equal to the overpayment from any future payments to HOSPITAL using an industry standard process so that HOSPITAL is clearly aware how to interpret the claims activity.

5.2.1 A summary report will accompany each check identifying the Members who received Covered Services from HOSPITAL and the appropriate amount of reimbursement disbursed per Member.

5.2.2 HOSPITAL agrees not to submit separate claims for reimbursement for Medicare Members who receive outpatient and emergency medical services during the same calendar day as in-patient admission of the Medicare Member to the HOSPITAL.

5.3 Entire Payment. HOSPITAL will accept from PLAN compensation as payment in full and discharge of PLAN's financial liability for Covered Services provided to eligible PLAN Members by HOSPITAL, and will be reimbursed as listed hereunder in those amounts set forth and in the manner and at the times as specified in Attachment B of this Agreement and in accordance with PLAN Provider Manual policies and procedures. HOSPITAL will look only to PLAN for such compensation with the exception of copayments, coinsurance and deductibles. PLAN has the sole authority to determine reimbursement policies and methodology of reimbursement under this Agreement.

5.4 Member Hold Harmless. HOSPITAL will not submit claims to or demand or otherwise collect reimbursement from a Member, or from other persons on behalf of the Member, for any service included in the program's Covered Services in addition to a claim submitted to the PLAN for that service. Furthermore, HOSPITAL will hold harmless DHCS, CMS and Members in the event PLAN cannot or will not pay for services provided by HOSPITAL under this Agreement.

5.5 Coordination of Benefits. DHCS and CMC are the payors of last resort recognizing Other Health Coverage as primary carrier. HOSPITAL must bill the primary carrier before billing PLAN for reimbursement of Covered Services and, with the exception of authorized share of cost payments, will at no time seek compensation from Members. The HOSPITAL may look to the Member for non-covered services.

5.5.1 The determination of liability will be in accordance with the usual procedures employed by the appropriate Governmental Agencies and applicable law, the Medicare Provider Manual, and the Provider Manual.

5.5.2 The authority and responsibility for Coordination of Benefits will be carried out in accordance with applicable law.

5.5.3 HOSPITAL will make best efforts to report to PLAN the discovery of third party insurance coverage for a Medicare Member within five (5) business days of discovery.

5.5.4 HOSPITAL will recover directly from Medicare for reimbursement of medical services rendered. Medicare payments will be reported to the PLAN on the UB04 encounter form or electronic transfer tape as indicated in the Provider Manual.

5.5.5 For all enrollees eligible for both Medicare and Medicaid, enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. Downstream Provider may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Providers will: (1) accept the MA plan payment as payment in full, or (2) bill the appropriate State source. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)].

5.6 Third Party Liability Tort. In the event that HOSPITAL provides services to Members for injuries or other conditions resulting from the acts of third parties, the Plan will have the right to recover from any settlement, award or recovery from any responsible third party the value of all Covered Services which have been rendered by HOSPITAL pursuant to the terms of this Agreement.

5.6.1 HOSPITAL will cooperate with the PLAN in their efforts to obtain information and collect sums due as result of third party liability tort, including Workers' Compensation claims for Covered Services.

5.6.2 HOSPITAL will make best efforts to report to PLAN the discovery of third party tort action for a Member within five (5) business days of discovery.

5.7 Subcontracts

5.7.1 All subcontracts between HOSPITAL and HOSPITAL's subcontractors pertaining to the provision of Covered Services under this Agreement ("Subcontractors") will be in writing, and will be entered into in accordance with the requirements of DHCS, CMS and, Health and Safety Code Section 1340 et seq.; Title 28, CCR, Section 1300 et seq.; and any other applicable federal and State laws and regulations.

5.7.2 All such subcontracts and their amendments will become effective only upon written approval by PLAN and will fully disclose the method and amount of compensation or other consideration to be received by the Subcontractor from the HOSPITAL.

HOSPITAL will notify the PLAN when any subcontract is amended or terminates. HOSPITAL will make available to PLAN and Governmental Agencies, upon request, copies of all agreements between HOSPITAL and Subcontract(s) for the purpose of providing Covered Services.

5.7.3 All agreements between HOSPITAL and any Subcontractor will require Subcontractor to comply with the following:

(a) Records and Records Inspection. Make all applicable books and records available at all reasonable times for inspection, examination or copying by the Governmental Agencies; and, retain such books and records for a term of at least ten (10) years from the close of DHCS' fiscal year in which the Subcontract is in effect and submit to HOSPITAL and PLAN all reports required by HOSPITAL, PLAN or DHCS.

(b) Surcharges. Subcontractor will not collect a Surcharge for Covered Services for a Member or other person acting on their behalf. If a Surcharge erroneously occurs, Subcontractor will refund the amount of such Surcharge to the Member within fifteen (15) business days of the occurrence and will notify PLAN of the action taken. Upon notice of any Surcharge, PLAN will take appropriate action consistent with the terms of this Agreement to eliminate such Surcharge, including, without limitation, repaying the Member and deducting the amount of the Surcharge and the expense incurred by PLAN in correcting the payment from the next payment due to HOSPITAL.

(c) Notification. Notify the PLAN in the event the agreement with Subcontract is amended or terminated. Notice will be given in the manner specified in Section 10.4 (Notices) below.

(d) Assignment. Agree that assignment or delegation of the subcontract will be void unless prior written approval is obtained from the PLAN.

(e) Additional Requirements. Be bound by the provisions of Section 9.7 (Survival of Obligations After Termination), and Section 7 (Hospital Indemnification), and any other provisions of this Agreement that state that they apply to subcontractors.

SECTION 6.
RECORDS AND CONFIDENTIALITY

6.1 Maintenance of Records. HOSPITAL shall maintain books, charts, documents, papers, reports, management information systems, procedures and records (including, but not limited to, financial, accounting, and administrative records, patient medical records, encounter data, prescription files, laboratory results, subcontracts and Authorizations) and supporting documentation related to Members and Services provided hereunder to Members both medical and non-medical, to the cost thereof, to the manner and amount of payments,

including payments received from Members or others on their behalf, to the manner in which HOSPITAL administers its daily business, and to the financial condition of HOSPITAL ("Records"). Records include notes, documents, reports and other information related to Provider disputes and determinations. HOSPITAL shall maintain Records in accord with the general standards applicable to that book or record keeping, and shall ensure that an individual is responsible for securing and maintaining such Records. Records shall be legible, current, organized, accurate, comprehensive, and kept in a secure location with detail (i) consistent with appropriate medical and professional practice and prevailing community standards, (ii) which permits effective internal professional review and external medical audit process, and (iii) which facilitates an adequate system for follow- up treatment. The Member's medical record shall reflect (i) whether the Member has executed an advance directive, (ii) the language needs of the Member, and (iii) any request for, offer of and refusal of language interpretation services. The Provider Manual outlines additional Medical Records requirements. HOSPITAL shall be fully bound by the requirements in Title 42 of the Code of Federal Regulations, relating to the maintenance and disclosure of Member Records received or acquired by federally assisted alcohol or drug programs. HOSPITAL shall preserve Records for the longer of (i) ten (10) years after termination of this Agreement, and (ii) the period of time required by state and federal law and Membership Contracts, including the period required by, to the extent applicable, the Knox-Keene Act and Regulations, and by the Medicare Program, unless a longer period is stipulated. If there is any litigation, claim, negotiation, audit, review, examination, evaluation, or other action pending at the end of such period, then HOSPITAL shall retain said Records until such action is completed.

6.2 Access to and Copies of Records. PLAN and its authorized agents shall have access to and may inspect the Records, subject to reasonable request and notification requirements, and subject to any legal requirements regarding confidentiality. HOSPITAL shall transmit Record information by fax when requested. HOSPITAL shall provide copies of Records to PLAN upon request, at no charge for the first copy and at Twenty-five cents ($.25) per page for any additional copies. HOSPITAL shall, subject to any legal requirements regarding confidentiality, provide access to Records and other information as required by Government Officials and accrediting organizations. Medical Records for Members shall be available to providers at Member encounters as set forth in Title 28 CCR Section 1300.67.1 (c). Members shall have access to their Medical Records, and where legally appropriate, may receive copies of, amend, or correct their Medical Records. HOSPITAL shall provide any notice to, or obtain any consent from, Members or, as appropriate, persons authorized to consent on behalf of Members, as may be required by any applicable federal or State laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the California Medical Information Act ("CMIA"), regarding the receipt, use and disclosure of Protected Health Information and Medical Information, as those terms are defined in HIPAA and CMIA respectively.

6.3 Copies of Clinical Information. For all Members receiving covered Services, HOSPITAL will promptly forward copies of initial consultation reports upon completion of consult, and summaries of patient care or patient results upon completion of patient care or discharge, to the Member's Primary Care Physician. HOSPITAL shall provide copies of such clinical information to the Primary Care Physician at no charge.

6.4 Disclosure to Government Officials. HOSPITAL shall comply with all provisions of law regarding access to books, documents and records. Without limiting the foregoing, HOSPITAL shall maintain, provide access to, and provide copies of Records, this Agreement and other information to the Director of the Department, DHCS, External Quality Review Organizations, the Bureau of State Audits, the State Auditor, the Joint Legislative Audit Committee, the California Department of General Services, the California Department of Industrial Relations, certified Health Plan Employer Data Information Set ("HEDIS") auditors from the National Committee on Quality Assurance, the California Cooperative Healthcare Reporting Initiative, the U.S. Department of Justice, the Secretary of the U.S. Department of Health and Human Services, the U.S. Comptroller General, the Centers for Medicare and Medicaid Services, Peer Review Organizations, their designees, representatives, auditors, vendors, consultants and specialists and such other officials entitled by law (collectively, "Government Officials") as may be necessary for compliance by PLAN with the provisions of all state and federal laws and contractual requirements governing PLAN, including, but not limited to, the Act and the regulations promulgated thereunder and the requirements of Medicare program. Such information shall be available for inspection, examination and copying at all reasonable times at HOSPITAL's place of business or at some other mutually agreeable location in California. Copies of such information shall be provided to Government Officials promptly upon request. The disclosure requirement includes, but is not limited to, the provision of information upon request by DHCS, subject to any lawful privileges, relating to threatened or pending litigation by or against DHCS. HOSPITAL shall use all reasonable efforts to immediately notify DHCS of any subpoenas, document production requests, or requests for records received by HOSPITAL related to this Agreement.

6.5 Reporting

6.5.1 HOSPITAL, upon reasonable advance request, shall supply PLAN or PLAN's designated agent with periodic reports and information pertaining to (i) Services provided to Members by HOSPITAL or its subcontracted health care providers, (ii) Provider directory and network information, and (iii) HOSPITAL's financial resources, on such forms and within such times as requested by PLAN, and which will enable PLAN to meet all federal and state legal and contractual reporting requirements. HOSPITAL shall also supply PLAN with other reports as reasonably requested.

6.5.2 HOSPITAL certifies and warrants that all reports, invoices, papers, documents, books of account, instruments, data, information, forms of evidence and other Records submitted to Plan or Government Officials pursuant to this Agreement are current, accurate, timely, true, complete and in full compliance with legal and contractual requirements, and do not contain any material misrepresentations or omissions. HOSPITAL shall immediately notify PLAN if any of HOSPITAL's certifications and warranties cease to be true at any time during the term of this Agreement.

6.6 Confidentiality of Information

6.6.1 Notwithstanding any other provision of this Agreement, names of Members receiving public social services hereunder are confidential and are to be protected from unauthorized disclosure. For the purpose of this Agreement, all information, records, data, and data elements collected and maintained for the operation of the Agreement and pertaining to Members shall be protected by HOSPITAL from unauthorized disclosure. HOSPITAL and its employees, agents, and subcontractors shall protect from unauthorized disclosure names and other identifying information concerning persons either receiving services pursuant to this Agreement or persons whose names or identifying information become available or are disclosed to HOSPITAL, its employees, agents, or subcontractors as a result of services performed under this Agreement, except for statistical information not identifying any such person.

6.6.2 With respect to any identifiable information concerning any Member or person that is obtained by HOSPITAL, HOSPITAL, its employees, agents and subcontractors (i) will not use any such information for any purpose other than carrying out the express terms of HOSPITAL's obligations under this Agreement, (ii) will promptly transmit to PLAN all requests for disclosure of such information except Member requests for Medical Records in accordance with applicable law, and (iii) will not disclose except as specifically permitted by this Agreement, any such information to any party other than PLAN or DHCS, without prior written authorization specifying that the information is releasable under Title 42, and regulations adopted thereunder, and (iv) will, at the expiration or termination of this Agreement, return all such information to PLAN or maintain such information according to written procedures sent to PLAN by DHCS for this purpose. Upon PLAN's request, HOSPITAL shall provide a signed Declaration of Confidentiality in the format set forth in the Provider Manual, prior to the Effective Date.

6.6.3 HOSPITAL shall comply with all federal, state and local laws which provide for the confidentiality of Records and other information. HOSPITAL shall not disclose any confidential Records or other confidential information received from PLAN or Government Officials or prepared in connection with the performance of this Agreement, unless PLAN or Government Officials specifically permits HOSPITAL to disclose such Records or information. HOSPITAL shall promptly transmit to PLAN any and all requests for disclosure of such confidential Records or information. HOSPITAL shall not use any confidential information gained by HOSPITAL in the performance of this Agreement except for the sole purpose of carrying out HOSPITAL's obligations under this Agreement. HOSPITAL shall comply with Title 42 and all other applicable provisions of law which provide for the confidentiality of records and prohibit their being opened for examination for any purpose not directly connected with the administration of public social services. Whether or not covered by such sections, confidential medical or personnel records and the identities of clients and complainants shall not be disclosed unless there is proper consent to such disclosure or a court order requiring disclosure. Confidential information gained by HOSPITAL from access to any such records, and from contact with its clients and complainants, shall be used by HOSPITAL only in connection with its conduct of the program under this Agreement.

6.6.4 HOSPITAL shall protect the security and confidentiality of all eligibility and enrollment data and all other personal information and protected health information about Members in accordance with the Information Practices Act, Civil Code Section 1798 et seq., and all other applicable State and federal laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the regulations promulgated thereunder. All financial, statistical, personal, technical and other data and information relating to the State's operations which are designated confidential by the State and which become available to HOSPITAL shall be protected by HOSPITAL from unauthorized use and disclosure. HOSPITAL shall not use any individual identifiable information or other confidential information for any purpose other than carrying out the provisions of this Agreement. Upon request by PLAN, HOSPITAL shall provide a copy of its policies and procedures for preserving the confidentiality of medical records, as outlined in California Health and Safety Code Section 1364.5. HOSPITAL shall make itself available to DHCS at no cost to DHCS to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against DHCS, its directors, officers or employees based upon claimed violation of HIPAA, the HIPAA regulations or other laws relating to security and privacy, except where HOSPITAL is a named adverse party.

SECTION 7.
INSURANCE AND INDEMNIFICATION

7.1 Hospital Insurance. Throughout the term of this Agreement and any extension thereto, HOSPITAL will maintain appropriate insurance programs or policies as follows:

7.1.1 Each participating HOSPITAL covered by this Agreement will secure and maintain, at its sole expense, liability insurance, or other risk protection programs, in the amounts of at least ONE MILLION DOLLARS ($1,000,000) per person per occurrence and THREE MILLION DOLLARS ($3,000,000) in aggregate, including "tail coverage" in the same amounts whenever claims made malpractice coverage is involved.

7.1.2 Notification of PLAN by HOSPITAL of cancellation or material modification of the insurance coverage or the risk protection program will be made to PLAN at least thirty (30) days prior to any cancellation. Upon PLAN's request, documents evidencing professional liability insurance or other risk protection required under this Subsection will be provided to PLAN upon execution of this Agreement.

7.1.3 General Liability Insurance. In addition to Subsection 6.1.1 above, HOSPITAL will also maintain, at its sole expense, a policy or program of comprehensive liability insurance (or other risk protection) with minimum coverage including and no less than Three Hundred Thousand Dollars ($300,000) per person for HOSPITAL'S property together with a Combined Single Limit Body Injury and Property Damage Insurance of not less than Three Hundred Thousand Dollars ($300,000). Documents evidencing such coverage will be provided to PLAN upon request. The HOSPITAL

will arrange with the insurance carrier to have automatic notification of insurance coverage termination or modification given to PLAN.

7.1.4 Workers' Compensation. HOSPITAL'S employees will be covered by Workers' Compensation Insurance in an amount and form meeting all requirements of applicable provisions of the California Labor Code. Documents evidencing such coverage will be provided to PLAN upon request. The HOSPITAL will arrange with the insurance carrier to have automatic notification of insurance coverage termination or modification given to PLAN.

7.2 Plan Insurance. PLAN, at its sole cost and expense, will procure and maintain a professional liability policy to insure PLAN and its agents and employees, acting within the scope of their duties, in connection with the performance of PLAN's responsibilities under this Agreement.

7.3 Hospital Indemnification. HOSPITAL shall indemnify and hold harmless PLAN its officers, directors, agents, and employees, from and against any and all loss, damage, liability, or expense (including without limitation, reasonable attorney's fees), of any kind arising by reason of the acts or omissions of HOSPITAL and its officers, directors, agents, employees, agents and shareholders acting alone or in collusion with others. HOSPITAL also agrees to hold harmless both the State and Members in the event that PLAN cannot or will not pay for services performed by HOSPITAL pursuant to this Agreement. The terms of this section shall survive the termination of this Agreement.

7.4 PLAN Indemnification: PLAN shall indemnify and hold harmless HOSPITAL its officers, directors, agents, and employees, from and against any and all loss, damage, liability, or expense (including without limitation, reasonable attorney's fees), of any kind arising by reason of the acts or omissions of PLAN and its officers, directors, agents, employees, agents and shareholders acting alone or in collusion with others. The terms of this section shall survive the termination of this Agreement.

SECTION 8.
DISPUTE RESOLUTION

8.1 Dispute Resolution. For disputes unresolved by the PLAN provider appeals process, PLAN and HOSPITAL agree to meet and confer in good faith to resolve any disputes that may arise under or in connection with this Agreement. In all events and subject to the provisions of this Section which follow, HOSPITAL shall be required to comply with the provisions of the Government Claims Act (Government Code Section 900, et. seq.) with respect to any dispute or controversy arising out of or in any way relating to this Agreement or the subject matter of this Agreement (whether sounding in contract or tort, and whether or not involving equitable or extraordinary relief) (a "Dispute").

8.2 Judicial Reference. The parties may mutually agree in writing (but shall not be obligated to agree) that a Dispute shall be heard and decided by a referee appointed pursuant to California Code of Civil Procedure Section 638 (or any successor provision thereto, if applicable), who shall hear and determine any and all of the issues in any such action or proceeding, whether of fact or law, and to report a statement of decision, subject to judicial review and enforcement as provided by California law, and in accordance with Chapter 6 (References and Trials by Referees), of Title 8 of Part 2 of the California Code of Civil Procedure, or any successor chapter. The referee shall be a retired judge of the California superior or appellate courts determined by agreement between the parties, provided that in the absence of such agreement either party may bring a motion pursuant to the said Section 638 for appointment of a referee before the appropriate judge of the Sacramento Superior Court. The parties acknowledge that they forego any right to trial by jury in any judicial reference proceeding. The parties agree that the only proper venue for the submission of claims to judicial reference shall be the courts of general jurisdiction of the State of California located in Los Angeles. The parties reserve the right to contest the referee's decision and to appeal from any award or order of any court. The designated non prevailing party in any Dispute shall be required to fully compensate the referee for his or her services hereunder at the referee's then respective prevailing rates of compensation. For the avoidance of doubt, neither party shall be obligated or required to submit the Dispute to judicial reference, arbitration or any other alternative dispute resolution procedure.

8.3 Limitations. Notwithstanding anything to the contrary contained in this Agreement, any suit, judicial reference or other legal proceeding must be initiated within one (1) year after the date the Dispute arose or such Dispute shall be deemed waived and forever barred; provided that, if a shorter time period is prescribed under the Government Claims Act (Government Code Section 900, et. seq.), then, the shorter time period (if any) prescribed under the Government Claims Act shall apply.

8.4 Venue. Unless otherwise specified in this Section, all actions and proceedings arising in connection with this Agreement shall be tried and litigated exclusively in the state or federal (if permitted by law and a party elects to file an action in federal court) courts located in the County of Sacramento California.

SECTION 9.
TERM AND TERMINATION

9.1 Initial Term and Renewal. This Agreement shall be effective as of the Effective Date and shall remain in effect for a term of one (1) year, and will thereafter renew automatically for one (1) year terms unless terminated sooner as set forth below.

9.2 Termination Without Cause. HOSPITAL or PLAN may terminate this Agreement without cause at any time upon providing the other party with ninety (90) days prior written notice.

9.3 Immediate Termination for Cause by PLAN. The PLAN may terminate this Agreement immediately by written notice to HOSPITAL upon the occurrence of any of the following events:

9.3.1 The suspension or revocation of HOSPITAL'S license; or

9.3.2 HOSPITAL fails to meet PLAN Credentialing Criteria;

9.3.3 The discontinuance by HOSPITAL of the provision of Covered Services as confirmed and agreed by both parties hereto; or

9.3.4 If PLAN determines pursuant to procedures and standards adopted in its Utilization Management Program or Quality Improvement Program that HOSPITAL has provided or arranged for the provision of services to Members which are not medically necessary or provided or failed to provide Covered Services in a manner which violates any provision of this Agreement or the Provider Manual; or

9.3.5 If PLAN determines that the continuation hereto constitute as a threat to the health, safety or welfare of any Member; or

9.3.6 If PLAN determines that HOSPITAL has filed a petition for bankruptcy or reorganization, insolvency, as defined by law, or PLAN determines that HOSPITAL is unable to meet financial obligations as described in this Agreement; or

9.3.7 If HOSPITAL breaches Section 10.10 (Marketing Activity and Patient Solicitation) (such breach of said Section 10.10 shall not be subject to the cure specified in Section 9.4 (Termination for Cause with Cure Period)).

9.4 Immediate Termination for Cause by HOSPITAL. The HOSPITAL may terminate this Agreement immediately by written notice to PLAN upon the occurrence of any of the following events:

9.4.1 revocation of PLAN's license necessary for the performance of this Agreement;

9.4.2 PLAN breaches any material term, covenant, or condition of this Agreement.

9.4.3 PLAN's stop-loss insurance, reinsurance or insolvency insurance is canceled or not renewed.

9.5 Termination for Cause With Cure Period. In the event of a material breach by either party other than those material breaches set forth in Section 9.3 (Immediate Termination for Cause by Plan) above of this Agreement, the non-breaching party may terminate this Agreement upon thirty (30) days written notice to the breaching party setting forth the reasons for such termination; provided, however, that if the breaching party cures such breach within twenty (20) days of receipt of this notice, then this Agreement will not be terminated because of such breach unless the breach is not subject to cure.

9.6 Continuation of Services Following Termination. Should this Agreement be terminated, HOSPITAL will, upon mutual agreement, continue to provide Covered Services to Members who are under the care of HOSPITAL at the time of termination until the services being rendered to the Members by HOSPITAL are completed, unless PLAN has made

appropriate provision for the assumption of such services by another hospital. HOSPITAL will ensure an orderly transition of care for Members, including but not limited to the transfer of Member medical records. Payment by PLAN for the continuation of services by HOSPITAL after the effective date of termination will be subject to the terms and conditions set forth in this Agreement including, without limitation, the compensation provisions herein. The costs to HOSPITAL of photocopying such records will be reimbursed by the PLAN at a cost not to exceed $.25 per page.

9.7 Member Notification Upon Termination. Notwithstanding Section 9.3 (Immediate Termination for Cause by PLAN), upon the receipt of notice of termination by either PLAN or HOSPITAL, and in order to ensure the continuity and appropriateness of medical care to Medicare Members, PLAN at its option, may immediately inform Members of such termination notice.

9.8 Survival of Obligations After Termination. Termination of this Agreement will not affect any right or obligations hereunder which will have been previously accrued, or will thereafter arise with respect to any occurrence prior to termination. Such rights and obligations will continue to be governed by the terms of this Agreement. The following obligations of HOSPITAL will survive the termination of this Agreement regardless of the cause giving rise to termination and will be construed for the benefit of the Member: a) Section 9.5, Continuation of Services Following Termination; b) Section 6, Records And Confidentiality; and, c) Section 7.3, HOSPITAL Indemnification. Such obligations and the provisions of this Section will supersede any oral or written agreement to the contrary now existing or hereafter entered into between HOSPITAL and any Member or any persons acting on their behalf. Any modification, addition, or deletion to the provisions referenced above or to this Section will become effective on a date no earlier than thirty (30) days after the DHCS has received written notice of such proposed changes. HOSPITAL will assist PLAN in the orderly transfer of Members to other Participating Hospitals.

9.9 Access to Medical Records Upon Termination. Upon termination of this Agreement and request by PLAN, HOSPITAL will allow the copying and transfer of medical records of each Member to the HOSPITAL assuming the Member's care at termination. Such copying of records will be at PLAN's expense if termination was not for cause. PLAN will continue to have access to records in accordance with the terms hereof.

9.10 Interruption of Services. Should a substantial part of the services which HOSPITAL has agreed to provide hereunder be interrupted for a period in excess of thirty (30) days, PLAN shall have the right to terminate this Agreement upon providing ten (10) days prior written notice to HOSPITAL.

9.10.1 In the event the operations of HOSPITAL's facilities, or any substantial portion thereof, are interrupted by war, fire, insurrection, riots, the elements, earthquakes, acts of God, or without limiting the foregoing, any other cause beyond the control of HOSPITAL, the HOSPITAL shall be relieved of its obligations with respect to the provisions of this Agreement (or such portions hereof which HOSPITAL is thereby rendered incapable of performing) for the duration of such interruptions.

9.10.2 Nothing contained herein shall be construed to limit or reduce PLAN's obligation to pay HOSPITAL for Covered Services rendered to Members prior to or subsequent to an event described herein.

SECTION 10.
GENERAL PROVISIONS

10.1 Assignment. Neither party may assign its rights, duties or obligations under this Agreement, either in whole or in part, without the prior written consent of the other.

10.2 Amendment. This Agreement may be amended at any time upon written agreement of both parties. This Agreement may only be amended by the PLAN upon thirty (30) days written notice to the HOSPITAL if the amendment is required due to change in regulatory provisions. No obligation under this Agreement or an Attachment hereto may be waived by any party hereto except by an instrument in writing in the form of an Amendment.

10.2.1 If the HOSPITAL does not give written notice of termination within sixty (60) days, as authorized by Section 10.4 (Notices), HOSPITAL agrees that any such amendment by PLAN will be a part of the Agreement.

10.2.2 Unless HOSPITAL notifies PLAN that it does not accept such amendment, the amendment, will become effective sixty (60) days after the date of PLAN's notice of proposed amendment.

10.2.3 Notwithstanding the foregoing, PLAN may amend this Agreement with prior written notice to HOSPITAL in order to maintain compliance with State and Federal Law and the agreement. Such amendment shall be binding upon HOSPITAL and shall not require the consent of HOSPITAL.

10.3 Severability. If any term, provision, covenant, or condition of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions hereof will remain in full force and effect and will in no way be affected, impaired, or invalidated as a result of such decision.

10.4 Notices. All notices required or permitted to be given by this Agreement shall be in writing and may be delivered personally, by certified or registered U.S. Postal Service mail, return receipt requested, postage prepaid, or by U.S. Postal Service Express mail, Federal Express or other overnight courier that guarantees next day delivery, and shall be deemed sufficiently given if served in the manner specified in this Section. Notices shall be delivered or mailed to the parties at the addresses set forth beneath their respective names on the signature page of this Agreement. Each party may change its address by giving notice as provided in this Section. Notices given by certified or registered mail, return receipt requested, shall be deemed given on the date of delivery shown on the receipt card, or if no delivery date is shown, the postmark date. Notices delivered by U.S. Postal Service Express mail, Federal Express or overnight courier that guarantees next day delivery shall be deemed given twenty-four (24) hours after delivery of the notice to the U.S. Postal Service, Federal Express or overnight courier.

10.5 Entire Agreement. This Agreement, together with the Attachments and the PLAN Provider Manual, contains the entire agreement between PLAN and HOSPITAL relating to the rights granted and the obligations assumed by this Agreement. Any prior agreement, promises, negotiations or representations, either oral or written, relating to the subject matter of this Agreement not expressly set forth in this Agreement are of no force or effect.

10.6 Headings. The headings of articles and paragraphs contained in this Agreement are for reference purposes only and will not affect in any way the meaning or interpretation of this Agreement.

10.7 Governing Law. The laws of the State of California, the United States of America, and the contractual obligations of PLAN will govern the validity, construction, interpretation and enforcement of this Agreement. Any provision required to be in this Agreement by law, regulation, or the Plan-to-Plan Agreement will bind PLAN and HOSPITAL whether or not provided in this Agreement.

10.8 Treatment Alternatives. PLAN or HOSPITAL will not interfere with and will allow the physician-patient communication regarding appropriate treatment alternatives nor will a penalty be accessed to the physician for discussing medically necessary or appropriate medical care for the patient.

10.9 Reporting Fraud and Abuse. HOSPITAL is responsible for reporting all cases of suspected fraud and abuse, as defined in 42 CFR, Section 455.2, where there is reason to believe that an incident of fraud and/or abuse has occurred by Members or by PLAN contracted physicians within 10 days to PLAN for investigation.

10.10 Marketing Activity and Patient Solicitation. HOSPITAL will not engage in any activities involving the direct marketing of Members without the prior approval of PLAN and DHCS.

10.11 Direct Solicitation. HOSPITAL will not engage in direct solicitation of Members for enrollment, including but not limited to door-to-door marketing activities, mailers and telephone contacts.

10.12 Nondisclosure and Confidentiality. Both parties shall not disclose the payment provisions of this Agreement except as may be required by law.

10.13 Non-Exclusive Agreement. To the extent compatible with the provision of Covered Services to Members for which HOSPITAL accepts responsibility hereunder, HOSPITAL reserves the right to provide hospital services to persons who are not Members. Nothing contained herein will prevent HOSPITAL from participating in any other prepaid health care program.

10.14 Counterparts. This Agreement may be executed in two (2) or more counterparts, each one of which will be deemed an original, but all of which will constitute one and the same instrument.

10.15 HIPAA. HOSPITAL and PLAN each acknowledge that it is a "Covered Entity" as that term is defined in the Standards for Privacy of Individually Identifiable Health Information adopted by the U.S. Department of Health and Human Services, as modified (the "HIPAA

Privacy Rule"). Each party shall adequately protect the confidentiality of individually identifiable health information and shall comply with the HIPAA Privacy Rule and with all State and Federal Laws governing the confidentiality of Members' individually identifiable health information. If the HOSPITAL identifies any inappropriate uses of or breach of the HIPAA Privacy Rule with respect to PLAN or Members, the HOSPITAL must notify PLAN's Privacy Officer immediately.

SECTION 11.
RELATIONSHIP OF PARTIES

11.1 Overview. None of the provisions of this Agreement are intended, nor will they be construed to create, any relationship between the parties other than that of independent parties contracting with each other solely for the purpose of effectuating the provisions of this Agreement; neither is this Agreement intended, except as may otherwise be specifically set forth herein, to create a relationship of agency, representation, joint venture or employment between the parties. Unless mutually agreed, nothing contained herein will prevent HOSPITAL from independently participating as a provider of services in any other health maintenance organization or system of prepaid health care delivery.

11.2 Oversight Functions. Nothing contained in this Agreement will limit the right of PLAN to perform its oversight and monitoring responsibilities as required by applicable state and federal law, as amended.

11.3 Relationship of HOSPITAL and Contracting Physicians. It is expressly understood and agreed that no Contracting Physician or other physician shall be entitled to admit, or treat, or prescribe for Member in HOSPITAL if physician is not in good standing of HOSPITAL's Medical Staff with appropriate clinical privileges to admit and treat Members in HOSPITAL. Medical Staff membership and clinical privileges may be granted to Contracting Physicians by HOSPITAL's Governing Board, acting in conjunction with its Medical Staff, in accordance with the standards, procedures, and other provisions of HOSPITAL's Medical Staff Bylaws and the Rules and Regulations relating thereto which have been adopted by HOSPITAL's Medical Staff with the approval of said Board.

11.4 HOSPITAL Privileges of PLAN Participating Physicians. Nothing contained in this Agreement shall be construed to grant any greater rights to Participating Physicians with respect to the granting and retention of Medical Staff membership and privileges than are available to any other licensed physician; however, HOSPITAL agrees to consider, conforming to timelines in the applicable policies and procedures, any and all applications for Medical Staff membership or privileges submitted by physicians wishing to become a Participating Physician, but prevented from doing so for lack of privileges at a Primary Hospital. HOSPITAL shall render such decisions within one hundred and eighty (180) days of such application as long as the application is submitted with all requirements. Incomplete applications shall not follow this timeline. If application is denied, HOSPITAL shall submit to applicant, in writing, an explanation of the reasons for such denials.

HOSPITAL and any delegate performing the covenants of the HOSPITAL shall not deny medical staff membership or clinical privileges for reasons other than a physician's individual qualifications as determined by professional and ethical criteria, uniformly applied to all medical staff applicants and Members. Determination of medical staff membership or clinical privileges shall not be made upon the basis of:

11.4.1 The existence of a contract with the HOSPITAL or with others;

11.4.2 Membership in or affiliation with any society, medical group or teaching facility or upon the basis of any criteria lacking professional justification, such as sex, race, creed, disability, or national origin.

HOSPITAL shall henceforth notify PLAN when it revokes or modifies privileges of any physician who is also contracted with the PLAN. Written notification shall be submitted to the PLAN at the time of occurrence.

11.5 HOSPITAL does not waive the provisions of Evidence Code 1157 with regard to Medical Staff records.

SECTION 12.
ADDITIONAL LEGAL REQUIREMENTS

12.1 Compliance With Laws.

12.1.1 HOSPITAL represents, certifies and warrants that it is currently, and for the duration of this Agreement shall remain in compliance with all applicable local, State and federal laws and regulations as they become effective, including, but not limited to, those (i) regarding licensure and certification, (ii) necessary for participation in the Medicare Program, including the antifraud and abuse laws and regulations and the patient self-determination amendments of the Omnibus Budget Reconciliation Act of 1990, (iii) regarding advance directives including, but not limited to, Title 42 CFR Sections 422.128 and 438.6(i) and California Probate Code Sections 4673 to 4678 and Sections 4800 to 4806, and applicable regulations, (iv) regulating the operations and safety of facilities, including but not limited to, Title 22 CCR Section 53230, (v) regarding federal and State Occupational Health and Safety Administration (OSHA) standards, (vi) regarding communicable disease and immunization reporting, (vii) regarding not allowing smoking within any portion of any indoor facility used for the provision of health services for children as specified in the U.S. Pro-Children Act of 1994 (20 United States Code Section 6081 and following), (viii) regarding the provision of information to Members concerning Prostate Specific Antigen testing consistent with the standard set forth in California Business and Professions Code Section 2248, (ix) regarding provisions of the Health Insurance Portability and Accountability Act of 1996 and regulations, and provisions of the California Confidentiality of Medical Information Act, (x) set forth in Public Contract Code Section 6108 relating to the Sweat-free Code of Conduct, and (xi) relating to copyright laws. Payment under this Agreement will not be used

for the acquisition, operation or maintenance of computer software in violation of copyright laws.

12.1.2 As required by Title 31 U.S.C. Section 1352, if payments under this Agreement are $100,000 or more, HOSPITAL certifies to the best of its knowledge and belief that no Federally appropriated funds have been paid or will be paid, by or on behalf of HOSPITAL, to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Agreement, and the extension, continuations, renewal, amendment, or modification of this Agreement. If payments under this Agreement are $100,000 or more, HOSPITAL shall submit to PLAN the "Certification Regarding Lobbying" set forth in the Provider Manual. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Agreement, HOSPITAL shall complete and submit to PLAN standard form LLL, "Disclosure of Lobbying Activities" in accordance with its instructions. HOSPITAL shall file such disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affects the accuracy of the information contained in any disclosure form previously filed by HOSPITAL. HOSPITAL shall require that the language of this certification be included in all subcontracts at all tiers which exceed $100,000 and that all subcontractors shall certify and disclose accordingly. All such disclosure forms of subcontractors shall be forwarded to PLAN.

12.1.3 HOSPITAL shall not employ, maintain a contract with or contract with directly or indirectly, entities or individuals excluded, suspended or terminated from participation in the Medicare Program, for the provision of any Services to Members, including but not limited to, health care services, utilization review, medical social work, or administrative services with respect to Members.

12.1.4 HOSPITAL shall provide, as applicable, the ownership disclosure statement(s), the business transactions disclosure statement(s), the convicted offenses disclosure statement(s), and the exclusion from state or federal health programs disclosure statement(s), prior to the Effective Date, on an annual basis, upon any change in information, and upon request, if required by law or by PLAN's contract with other health plans for the provision of Medicare Services. Legal requirements include, but are not limited to, Title 22 CCR Section 51000.35, 42 USC Sections 1320 a-3 (3) and 1320 a-5 et seq., and 42 CFR Sections 455.104, 455.105 and 455.106. HOSPITAL shall also provide, as applicable, the "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions" and shall comply with its instructions, if required by law. Such Debarment Certification and its instructions are set forth in the Provider Manual.

12.1.5 If HOSPITAL uses economic profiling information related to any of its individual physicians or other health care Practitioners, it shall provide a copy of such information related to an individual Practitioner, upon request, to that Practitioner in accordance with the requirements of Section 1367.02 of the California Health and Safety Code. Additionally, HOSPITAL, upon request, shall make available to PLAN its policies and procedures related to economic profiling used by HOSPITAL. The term "economic profiling" as used in this Section 7.1 (e) shall be defined in the same manner as that term is defined in Section 1367.02 of the Health and Safety Code. The requirement of this Section 7.1 (e) to provide a copy of economic profiling information to an individual Practitioner shall survive termination of this Agreement in accordance with Section 1367.02 of the Health and Safety Code.

12.1.6 HOSPITAL shall immediately notify PLAN of (i) investigations of HOSPITAL in which there are allegations relating to fraud, waste or abuse, and (ii) suspected cases where there is reason to believe that an incident of fraud, waste or abuse has occurred. HOSPITAL shall comply with PLAN's antifraud plan, including it policies and procedures relating to the investigation, detection and prevention of and corrective actions relating to fraud, waste and abuse. HOSPITAL represents, certifies and warrants that it is currently, and for the duration of this Agreement shall remain in compliance with all applicable State and federal laws and regulations designed to prevent or ameliorate fraud, waste and abuse including, but not limited to, applicable provisions of the federal and State civil and criminal law, Program integrity requirements at 42 CFR Section 438.608, the Federal False Claims Act (31 USC Section 3729 et seq.), Employee Education About False Claims Recovery (42 USC Section 1396a(a)(68)), the California State False Claims Act (California Government Code Section 12650 et seq.), and the anti- kickback statute (Section 1128B(b) of the Social Security Act).

12.1.7 If required by Health and Safety Code Section 1375.4, (1) HOSPITAL shall meet the financial requirements that assist PLAN in maintaining the financial viability of arrangements for the provision of Services in a manner that does not adversely affect the integrity of the contract negotiation process, (2) HOSPITAL shall abide by PLAN's process for corrective action plans if there is a deficiency, and (3) PLAN shall disclose information to HOSPITAL that enables HOSPITAL to be informed regarding the financial risk assumed under this Agreement. In cases where the Solvency Regulations apply (28 CCR Sections 1300.75.4 through 1300.75.4.8), PLAN and HOSPITAL shall meet the requirements set forth in such Regulations. Members may request general information from PLAN or HOSPITAL about any bonuses or incentives paid by PLAN, if applicable.

12.1.8 HOSPITAL shall maintain an organizational structure sufficient to conduct the proposed operations and ensure that its financial resources are sufficient for sound business operations. If applicable, HOSPITAL shall submit financial information consistent with the filing requirements of DMHC unless otherwise specified by DHCS. If HOSPITAL is required to file monthly financial statements with DMHC, then HOSPITAL shall simultaneously file monthly financial statements

with DHCS. In addition, HOSPITAL shall file monthly financial statements with DHCS upon request.

12.1.9 If payments under this Agreement are in excess of $100,000, HOSPITAL shall comply with the following provisions unless this Agreement is exempt under 40 CFR Section 15.5. (i) HOSPITAL shall comply with all applicable standards, orders or requirements issued under section 306 of the Clean Air Act (42 USC Section 1857 (h)), section 508 of the Clean Water Act (33 USC Section 1368), Executive Order 11738, and the Environmental Protection Agency regulations (40 CFR Part 15). (ii) HOSPITAL shall comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC Section 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC Section 1251 et seq.), as amended.

12.2 Nondiscrimination.

12.2.1 HOSPITAL shall not discriminate against Members or deny benefits to Members, on the basis of race, color, creed, religion, language, sex, gender, marital status, political affiliation, ancestry, sexual orientation, sexual preference, national origin, health status, age (over 40), physical or mental disability, medical condition (including cancer), pregnancy, childbirth, or related medical conditions, veteran's status, income, source of payment, status as a Member of PLAN, or filing a complaint as a Member of PLAN. Members may exercise their patient rights without adversely affecting how they are treated by HOSPITAL. HOSPITAL shall not condition treatment or otherwise discriminate on the basis of whether a Member has executed an advance directive. HOSPITAL shall fully comply with all federal, state and local laws which prohibit discrimination, including but not limited to, Title VI of the Civil Rights Act of 1964, Title 45 CFR Part 91 the Age Discrimination Act of 1975, Section 504 of the Rehabilitation Act of 1973, 42 U.S.C. Section 2000(d), 45 C.F.R. Part 80 and 84, Title 28 CFR Part 36, Title IX of the Educational Amendments of 1973, California Government Code Section 11135, California Civil Code Section 51 and rules and regulations promulgated thereto, and all other laws regarding privacy and confidentiality. HOSPITAL shall provide reasonable access and accommodation to persons with disabilities to the extent required of a health services provider under the Americans with Disabilities Act and regulations, guidelines issued pursuant to the ADA, any applicable state law.

12.2.2 During the performance of this Agreement, HOSPITAL, its employees and agents, shall not unlawfully discriminate, deny benefits to, harass, or allow harassment against any employee or applicant for employment because of race, religion, color, national origin, ancestry, physical disability including Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), and AIDS-Related Complex (ARC), mental disability, medical condition (including health impairments related to or associated with cancer for which a person

has been rehabilitated or cured), marital status, political affiliation, age (over 40), sex, gender sexual preference, sexual orientation, pregnancy, childbirth, or related medical conditions, or the use of family and medical care leave and pregnancy disability leave pursuant to state and federal law. Hospital, its employees and agents, shall insure that the evaluation and treatment of its employees and applicants for employment are free of such discrimination and harassment. Hospital, its employees and agents, shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 (a-f), and following) and the applicable regulations promulgated there under (California Code of Regulations, Title 2, Section 7285.0 and following). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code Section 12990 (a-f), set forth in Chapter 5 of Division 4 of Title 2 of the California Code of Regulations are incorporated into this Agreement by reference and made a part hereof as if set forth in full. Hospital shall give written notice of its obligations under this clause to labor organizations with which it has a collective bargaining or other agreement.

12.2.3 Federal Equal Opportunity Requirements.

(a) HOSPITAL will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. HOSPITAL will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. HOSPITAL shall post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973 and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC Section 4212). Such notices shall state HOSPITAL's obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

(b) HOSPITAL will, in all solicitations or advancements for employees placed by or on behalf of HOSPITAL, state that all qualified applicants will receive consideration for employment without regard to race, color, religion,

sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

(c) HOSPITAL will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of HOSPITAL's commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

(d) HOSPITAL will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

(e) HOSPITAL will comply with and furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

(f) In the event of HOSPITAL's noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Agreement may be cancelled, terminated, or suspended in whole or in part and the Agreement may be declared ineligible for further federal and state contracts in accordance with procedures authorized in Federal Executive Order No. 11246 as amended and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

(g) HOSPITAL will include the provisions of subparagraphs (c)(1) through (c)(7) in every subcontract unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 USC 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor. HOSPITAL will take such action with respect to any subcontract as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions including sanctions for noncompliance provided, however, that in the event HOSPITAL becomes involved in, or is threatened with litigation by a subcontractor as a result of such direction by DHCS, HOSPITAL may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

ATTACHMENT A
DISCLOSURE FORM

TAX I.D.#

______________________________ ______________________________
Name of Hospital

The undersigned hereby certifies that the following information regarding the Hospital is true and correct as of the date set forth below:

Form of Hospital (Corporation, Partnership, Sole Proprietorship, Individual, etc.):

____

If a proprietorship, Co-Owner(s). If a partnership, partners

____

If a corporation, stockholders owning more than ten percent (10%) of the stock of the Provider

____

If a corporation, President, Secretary, Treasurer, Directors and Other Officers:

____

Stockholders owning more than ten percent (10%) of the stock of the Provider:

____

Major creditors holding more than five (5) percent of Provider debt:

____

If not already disclosed above, is Hospital, or a co-owner, partner, stockholder, director or officer either directly or indirectly related to or affiliated with Plan? Please explain:

____
____
____
____
____

Dated: ______________ Signature: ______________

Name: ______________
(Please type or print)

Title: ______________
(Please type or print)

ATTACHMENT B
REIMBURSEMENT

A. In exchange for Covered Services provided by Hospital to Enrollees in accordance with the terms of this Agreement, authorized by Health Plan when applicable, and within the scope of Hospital's licensing and certification, Health Plan shall pay Hospital's clean claims for such services at the following rates:

Services	**Reimbursement**
Inpatient services	115% of Hospital's Medicare Allowable Payment

Medicare Allowable Payment (Inpatient Services) will be updated in accordance with CMS changes within forty-five (45) days of receipt of new effective date.

Subject to the provisions stated herein. Hospital agrees to accept as payment in full from Health Plan for Covered Services rendered to Health Plan's Medicare Advantage Members, 115% of Hospital's Medicare allowable in effect as of the date such services are rendered and in accordance with Medicare Advantage laws, rules and regulations, less any co-payments, coinsurance, deductibles or other cost-share amounts due from such Members.

Included DRG Reimbursement Components: Notwithstanding anything to the contrary in the Agreement, the parties agree that Plan shall reimburse for Medicare inpatient prospective payment system components, in the same manner as original Medicare, including the following:

1. Base Rate MS-DRG (Includes Operating Federal Specific Portion and Capital Federal Specific Portion);

2. Capital IME

3. Disproportionate Share (Operating and Capital)

4. Bad Debt - Payor agrees to reimburse Hospital an amount as determined below for that portion of Hospital's bad debt that results from uncollected Medicare Advantage Member co-payments and deductibles. The amount reimbursed by Payor shall equal Medicare's percentage of Hospital's bad debt attributable to Medicare Advantage Members' copayments and deductibles. Payor shall have the right to audit the amounts claimed by Hospital. Hospital shall provide documentation satisfactory to Payor that Hospital has complied in all respects with all CMS regulations and rules related to Medicare beneficiary collection and bad debt write offs in connection with collection and attempts at collection of copayments and deductibles of Members enrolled in Medicare Advantage product and all other Medicare patients of Hospital. Such documentation shall be provided to Payor no later than two hundred ten (210) days following the close of the fiscal year for which bad debt reimbursement is claimed by Hospital. Failure of Hospital to provide complete documentation within such time period shall result in a fifty per cent (50%) reduction in the reimbursement. Payment of any undisputed amounts will be made by Payor within ninety (90) days following receipt by Payor of Hospital's documentation and invoice for the amount it claims for bad debt reimbursement. Notwithstanding anything to the contrary in the Agreement, the parties agree that Payor shall not reimburse Hospital for bad debt and/or any other term in addition to the base rate and the outlier in the event the CMS changes its reimbursement policies regarding such. In the event of any such

change, Payor's reimbursement will be adjusted to reflect such change without requiring contract amendment.

5. Uncompensated Care

6. Outlier Payments

7. CMS approved New Technology pass through amounts

8. Factor 8 components if approved and paid by CMS

Excluded DRG Reimbursement Components: Notwithstanding anything to the contrary in the Agreement, the parties agree that Plan shall not reimburse Hospital for the following Medicare inpatient prospective payment system components:

1. Operating IME

2. Operating and Capital GME

3. Nursing

Outpatient/Emergency Room services	135% of Medicare APC rates, less applicable copayments, coinsurance and deductibles

APC Payments shall be consistent with CMS guidelines effective on the date of service the Outpatient Services are rendered.

Notwithstanding any other reimbursement or compliance terms specified in this Agreement for all Covered Services rendered to Medicare Advantage Members (including but not limited to Members enrolled in Medicare-Medicaid alignment plans or their equivalent), the final payment amount to Hospital as determined under this Agreement shall not be reduced by value based purchasing, sequestration or any other mandatory savings reductions.

Physician Outpatient Service Reimbursement

1. For Medicare, Primary Care Provider Services are reimbursable at **One Hundred and Thirty Five Percent (135%) of Prevailing CMS Medicare rates**, for authorized services for which claims shall be processed in accordance with CMS Medicare Processing and Payment Guidelines, timely filing and timely payment , under terms mutually acceptable to both Health Plan and Provider, to enable Provider to provide health care services, to health plan members in the Medicare Advantage program; If there is no payment rate in the local and geographically adjusted Medicare Fee-For-Service schedule, as of the date of service, payment shall be reimbursed at **Thirty Percent (30%) of Billed Charges.**
2. For Medicare, Specialty Provider Services are reimbursable *at* **One Hundred and Thirty Five Percent (135%) of Prevailing CMS Medicare rates**, for authorized services for which claims shall be processed in accordance with CMS Medicare Processing and Payment Guidelines, timely filing and timely payment, under terms mutually acceptable to both Health Plan and Provider, to enable Provider to provide health care services, to health plan members in the Medicare Advantage program; If there is no payment rate in the local and geographically adjusted Medicare Fee-For-Service schedule, as of the date of service, payment shall be reimbursed at **Thirty Percent (30%) of Billed Charges.**

ATTACHMENT C
HOSPITAL IDENTIFICATION SHEET

The following must match the W-9 supplied by provider. Please enter "NA" if not applicable or not available.

Hospital Name		Billing Address (Pay to address):

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DBA Name - if applicable		
Telephone No.		
Fax No.		Primary Address:
Tax I.D. # (Tin)		
License No.		
DEA No.		
State ID No.		Secondary Address:
Group NPI No.		
Email Address		
		Number (#) of Beds: